

Equity, Humility, and Culturally Responsive Education in Health Professional Schools

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Abstract

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Health disparities are not just the product of genetic strengths, weaknesses of the human body, and unconscious exclusionary behaviors. In great part, they have also been the product of conscious and systemic efforts to exclude diverse populations from most social institutions and systems, including educational and health. Regardless of the growing educational and scientific advances achieved in the world and efforts to reduce disparities in health care, in the U.S., minoritized populations continue to have limited access to health professional schools. They experience disrespect, face biases, and are stereotyped in learning, teaching, and working environments affected by factors such as race, ethnicity, gender, sexual orientation, and disabilities. Health care professionals' (HCPs) discriminatory behaviors are not only embedded in services provided. They are also hidden in curriculum, school climates, extracurricular trainings, and comments provided by faculty.

This study examines how the University of Washington School of Public Health-Department of Global Health (UW SPH DGH) students, staff, and faculty describe their preparation and readiness to work in cross-cultural settings. It is an effort to help understand challenges to prepare culturally responsive health professionals, increase equity, and reduce

health disparities in minoritized populations. The study uses a mixed methods design, including data collected from a survey and individual interviews. The quantitative data allows access to a broad number of individual perspectives and helps obtain an overview of training and readiness to serve members of diverse minoritized populations. The experiences of participants in the institution are better described by a smaller sample of interviewees. The data collected identifies some of the perceived cross-cultural strengths and weaknesses of the DGH, SPH, and the university. It shows how increasing sensitivity, cultural humility, and providing culturally responsive education and services are matters of paramount importance for the reduction of health care disparities in the U.S. and across the globe.

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Dedication

To my parents who taught me the importance of education, selflessness, and devoted care. My sister Mila, an example of courage, indescribable strength, amazing spirit, and extraordinary sense of humor. You will always live in my memories and actions.

To my daughters, who's existence and friendship have been my rock since I first held them.

General definitions

American Indian or Alaska Native – American Indian term used by colonizers to describe Native Americans. It includes individuals having origins in any of the original peoples of North, central, and South America and who maintains tribal affiliation or community attachment (U.S. Census Bureau, 2018). Alaska Natives are the indigenous people of Alaska in the U.S.

Asian Ancestry – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (U.S. Census Bureau, 2010b, 2018).

African Ancestry / Blacks: Black or African American refers to individuals having origins Africa, descending from in any of the Black racial groups. It includes African American; Afro-Caribbean such as Haitian and Jamaican, and Sub-Saharan African such as Kenyan and Nigerian with the exception of Sudanese and Cape Verdean (U.S. Census Bureau, 2010c, 2018).

Ancestry: It refers to individuals’ “ethnic origin or descent, ‘roots,’ or heritage, or the place of birth of the person or the person’s parents or ancestors...”(U.S. Census Bureau, 2010a)

Australian and Oceanian Ancestry: Individuals descending from inhabitant of islands in the tropical Pacific Ocean, Polynesia, Melanesia, and Micronesia. Oceania has been also referred as a continent comprising Australia and the nearby islands (WorldAtlas, 2017).

Caucasian: Caucasian refers to individuals from or related to a Southern European region. The Caucasus, between the Black and Caspian seas. It is also used to refer to people known as White. However, the later includes people who are not necessarily from this region (Merriam-Webster’s, n.d.).

Cultural Groups is defined as a number of people who share language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.

Cultural background is defined as individual’s language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.

Diverse population: Diversity populations are groups of individuals who have different language cultures, races/ethnicities, gender identities, sexual orientations, ages, and disabilities (“Engaging Diverse Populations,” 2017)

Hispanic or Latinx background: Individuals or members of groups of any race who have heritage or nationality from Latin American Countries

Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands (U.S. Census Bureau, 2018).

People of color (PoC): a person who is not white or of European parentage

Predominantly White Institutions: It refers to institutions in which more than 50% of its members is composed by individuals of White European ancestry, Middle Eastern, or North African origins. In the U.S. Department of Education (U.S. DoE), there is no definition of PWI. However, it categorizes six institutions serving minoritized students. Minority serving

institutions (MSIs) as the U.S. department of Education describes them obtain their qualification based on the ‘significant’ percentages of “minority” students. The U.S. DoE also includes a list of credited MSIs.(Bourke, 2016; sage reference, n.d.)

Racial minorities: Individuals minoritized based on their racial identification as Black or African American, Asian, American Indian and Alaska Native, Native Hawaiian, other Pacific Islander, or a race other than White (U.S. Census Bureau, 2017).

Ethnic minorities: minoritized individuals and groups who have different ethnic background than the dominant populations.

Minoritized group: members of populations who have had less advantages than dominant populations. It refers to people who has different racial, ethnic, religious, sexual orientation, disability or gender than the dominant population.

Underrepresented minorities (URM): It refers to individuals or groups who have been excluded or prevented from access or received lower quality of services. In general, this term is used to refer to members of diverse populations. In the U.S. DoE it is used to describe individuals from ethnic groups, particularly women in science and engineering careers

Minority institutions: For the purpose of education, this term is used by the U.S. DoE to describe institutions of higher education exceeding 50 percent of enrollment with a single minoritized group or a combination of these groups.

White: Individuals of Europe, the Middle East, or North Africa origins (U.S. Census Bureau, 2018)

White European ancestry: In the U.S. it refers to individual of European descendance (Minahan, 2013)

Chapter I

Introduction

Health disparities, around the world and in the U.S, are not just the product of genetic strengths, weaknesses of the human body, and unconscious exclusionary behaviors. They have been in great part the product of conscious and systemic efforts to exclude diverse populations from most social institutions and systems, including educational, political, economic, and health. Across the globe, race, ethnicity, aboriginal or native status, gender identity, age, and disability strongly influence individual's poverty levels as well as quality and access to healthcare and other services. Particularly, in members of minoritized populations, poverty has been acknowledged as the most significant cause of poor health (Foege, 2018; Smedley, Stith, and Nelson, 2003).

Regardless of the many and growing scientific advances achieved in the world, educational and health inequities and disparities among diverse populations have been increasing and persisting. Particularly in the U.S., despite efforts to increase equity and access to services, minoritized populations continue to face many challenges in accessing appropriate care. Many scholars show evidence that members of diverse cultural groups served by local and global health care professionals (HCPs) are treated with disrespect, and do not receive proper diagnoses, treatment, and services (Hall et al., 2015; Leitner, Hehman, and Snowden, 2018; Smedley et al., 2003; Williams and Wyatt, 2015). Biases and stereotypes impacting health disparities can be conscious, insidious, implicit, and promoted by policies and regulations.

The impact of HCPs' biases has gained attention. Oftentimes, they rush to make clinical decision guided by ethnoracial stereotypes. While deficient recommendations and poor quality of services have been negatively influencing health outcomes of racial, ethnic and other minoritized

populations, they have also been benefiting members of the U.S. majority White population who oftentimes receive unnecessary health care and services (Dovidio and Fiske, 2012; Fiscella and Sanders, 2016; Smedley et al., 2003). Biases are not only embedded in HCPs' services. They are also hidden in curriculum offered in programs of study, school climates, comments provided by faculty, and during HCPs extracurricular education and training (Fiscella and Sanders, 2016). Considering that most health professionals are part of or have been raised under the perspectives of dominant populations, it seems evident that traditions, fears of losing privilege, and ignorance are likely to prevent HCPs from providing appropriate services. Sensitivity, cultural humility, and responsiveness to cross-cultural views are matters of paramount importance for the reduction of disparities experienced by diverse population in the U.S. and across the globe (Berger and Peerson, 2016; Degni, Suominen, Essén, El Ansari, and Vehviläinen-Julkunen, 2012; Kools, Chimwaza, and Macha, 2015; Zanolini et al., 2018).

In efforts to better understand HCPs' challenges to reduce biases, increase health equity, and eliminate health disparities in minoritized populations, this study examines how the University of Washington School of Public Health-Department of Global Health ((UW SPH DGH) students, staff, and faculty describe their preparation and readiness to work in cross-cultural settings. The next section of this chapter offers background information, summarizes some of the vast scholarship that documents the impact of HCP's biases and discrimination; and describes how HCP's lack of cross-cultural communication skills and cultural humility influence health outcomes and can increase health disparities in minoritized populations.

Background

The provision of inclusive learning and working environments as well as the development of school curriculum that prepares students to become culturally and linguistically

responsive professionals can be directly associated with the overall health of populations. The lack of strong and equitable public health is a problem in the U.S. and everywhere in the world. This can be observed in the growing health disparities experienced by diverse and other vulnerable populations at the local and global levels. Some of the factors contributing to persistent health disparities among minoritized populations are direct consequences of individual, systemic, structural, and institutional racism and other forms of oppression. The persistent struggles for power and privilege by many members of dominant populations have generated other types of discrimination caused by conscious and unconscious bias (Banaji, 2016; De Chesnay and Anderson, 2012; Sabin, Nosek, Greenwald, and Rivara, 2009; van Ryn and Saha, 2011). Prejudices and biases are not new phenomena. They have been present throughout human civilization, negatively impacting individuals from diverse cultural groups.

“Civilization” a History of Dehumanization

"Injustice anywhere is a threat to justice everywhere."
— Martin Luther King Jr.

The differentiation of people and groups is not a creation of the new world. Ancient civilizations and empires, including the Greeks, Romans, Spanish, Mongolians, and British committed atrocities against members of populations that had characteristics different from their own (James, 2017; Stoler, 1997). Some examples of these are the Crusades caused by religious conflicts between Christians and Muslims; World War I caused by the European divide, extreme nationalism, and a long history of religious and ethnic conflicts; Holodomor, the genocide of Ukrainians as an ethnic community (Klymenko, 2016); the Great Chinese Famine which was based on rural discrimination (Li and Lumey, 2016); World War II, orchestrated by the Nazis' idea of a master race; and the use of Eugenics to discriminate against people based on race,

disability, and religious beliefs (Barondess, 1996). Darwin's theory of evolution and his advocacy for human intervention to support evolutionary improvement led some scholars to create the concept of Eugenics and other scientific claims to differentiate people by the color of their skin (Darwin, 2008; International Congress of Eugenics, 1934; James, 2017).

Human history shows how populations have created ways to differentiate one from another. In the name of science, self-proclaimed dominant populations have used the theory of Eugenics to model their views and experiences. Particularly in the U.S., European-origin Americans have benefitted greatly at the expense of diverse populations. They use physical and other socially constructed differences to politicize the concept of race, develop theories of superiority to oppress those they think of as weaker or inferior, and use a term that has been called "civilization" to control and make subservient members of diverse cultural groups (Gobineau, 1915; Heng, 2018; Smith, 1852). In the world, superiority claims or theories have been used to degrade and take advantage of diverse populations.

The negative use of Eugenics to chastise people considered inferior has created social chaos, including many laws that dehumanize, discriminate, and abuse women, Natives, Blacks, Asians, and other populations categorized as ethnic and people of color. Eugenics also has been used to institutionalize the differently abled and criminalize gays, lesbians, and bisexuals among others (Weinstein, Geller, Negussie, and Baciu, 2017). Whether differentiations are made to distinguish people by their race, ethnicity, gender identity, disability status, or religion, those who believe that members of one group are superior to others demonstrate their confusion of moral values and invite others to question their intelligence (Foege, 2018; Hetherington, 1916). Unfortunately, ideas of superiority have been embedded in the formation of social institutions in many countries, including those with highly diverse populations such as the U.S.

U.S. History of Discrimination and Health Disparities

"Nothing in all the world is more dangerous than sincere ignorance and conscientious stupidity."
Martin Luther King Jr.

In the U.S. diversity has been one of its greatest assets and strengths. Deplorably, it also became a source of bigotry and hatred ignited by racial, ethnic, religious, and political conflicts, thirst for power, and widespread ignorance. The idea of White superiority followed many individuals who arrived in the U.S. centuries ago looking for new opportunities. It has also followed many others whose ancestors claimed to be fleeing injustices in Europe. The idea of a homogeneous group entitled with privileges, access to resources, and land led many White European immigrants to design systems of oppression. These discriminatory systems have deprived members of groups considered lesser or inferior from social, economic, and political power, creating and increasing health and other disparities in non-White and other minoritized populations.

In the history of the U.S., landowners, presidents, and other U.S. political and financial figures validate Foege's (2018) argument that "[t]radition often blocks rational thoughts" (p. 227). Over generations, slavery, genocide, exclusion, and poverty have been part of the U.S. history of immigration and health challenges faced by members of diverse populations. Poverty, the most significant cause of poor health, limits opportunities to all necessary services and keeps its victims in a vicious cycle that includes lack of housing, health, food, transportation, access to higher educational opportunities, and lack of access to health care and services (Price, Khubchandani, and Webb, 2018). These obstacles, maintained by existing systems of oppression, continue to keep minoritized and other diverse populations living in poverty. Income and income distribution, unemployment and job insecurity, working conditions, early childhood development, food insecurity, housing, health services, aboriginal status, gender, race, disability,

and access to education strongly affect how people are born, grow, and live (Bryant, Raphael, Schrecker, and Labonte, 2011). It is important to acknowledge that all these social determinants of health are also impacted by prejudice, discrimination, social exclusion and inclusion, and access to social networks.

Along with all the positive discoveries, advances, and inventions to enrich human life, social constructions and political ideas to establish superiority, supremacy, power, and privilege have created a disparate reflection of what should have been the outcomes of the greatest medical milestones of modern civilization--health equity and human wellbeing. As centuries have passed, many members of the U.S. dominant White population have shown their uncivilized nature, transforming social developments into disparities, inequalities, and inequities (Foege, 2018; Gobineau, 1915; Heng, 2018; Satcher, Pamies, and Woelfl, 2006; Smedley et al., 2003; Smith, 1852).

The damages of historical atrocities against members of minoritized populations include physical and mental abuse, forced sterilizations and abortions, genocide, denial of access to quality education, housing, and employment (Pounder et al., 2003; Ranjani, 2017). In addition, doctors used slaves to test discoveries and inventions. It was a common practice and the foundation of modern medicine (Washington, 2008). Many of the current scientific advances, including anesthesia, the vaginal speculum, and surgical procedures such as lobotomies, vesico-vaginal fistula, cesareans, ovariectomy, bladder stones, and genito-urinary surgeries were developed and practiced on slaves under the cruel assumption that they had a higher tolerance to pain than Whites (Ojanuga, 1993; Washington, 2008). Later, prisoners and differently-abled people, including children, were used to test and experiment with organ transplants, vaccines, and pharmaceuticals. Two of the most well-known cases of the use of vulnerable populations for

experimentation are the Willowbrook and the Tuskegee experiments (Barth, 2005; Rothman, 1982).

In the Willowbrook experiment, mentally challenged children institutionalized in Willowbrook State School in Staten Island, New York, were purposely infected with hepatitis and used to track the development of this viral infection and test the effectiveness of gamma globulin injections as protection against hepatitis (Pecorino, 2018). The Tuskegee experiment conducted by the U.S. Public Health Service consisted of the recording of the natural history of Syphilis using Black males. Participants were told that they were being examined for “bad blood.” Initially set up to last six months, this experiment lasted 40 years and participants were never informed nor given appropriate treatment for the condition even after the selection of penicillin as a preferred drug to treat syphilis (“Tuskegee Study Timeline CDC - NCHHSTP,” 2018).

The evolution of knowledge and science has come at the price of pain, suffering, and the lives of many members of diverse vulnerable populations. The consequences of these and other abuses have become a downward spiral. Health disparities in racial, ethnic, and other vulnerable populations remain one of the most persistent and difficult issues to address (Weinstein et al., 2017). Some of the more relevant factors impeding advancement in the reduction of health disparities and the promotion of health equity are lack of diversity and understanding about diverse populations among the HCP workforce (Rose, 2013; Satcher et al., 2006; Smedley et al., 2003).

Diverse Populations and Health Professional Schools

In the 21st century, diverse populations continue to have limited access to health profession schools. Even the limited number of minoritized students admitted to most HCPs

programs regularly deal with curriculum that does not include their histories and experiences and they face unwelcoming educational climates (Harper and Hurtado, 2007; Shollen, Bland, Finstad, and Taylor, 2009; Smedley, Butler, Bristow, and IOM, 2004; Sue, Lin, Torino, Capodilupo, and Rivera, 2009). The health professions, like many others, do not reflect a substantially diverse workforce. In addition, the predominately White workforce has been educated with a colorblind ideology and pedagogy, thus lacking understanding of the needs of diverse populations. Consequently, many health disparities and inequities experienced by member of diverse populations, in addition to being caused by social determinants of health, are exacerbated by differential treatments given to them by HCPs (Illingworth, 2006; Smedley et al., 2003; Weinstein et al., 2017). This situation is now being partially addressed by health profession schools.

Over many years, institutions of higher education have developed various interventions to eliminate or reduce the effects of bias and discrimination against diverse students and populations served by their graduates, increasing their abilities to provide services across cultures (Park et al., 2006; Sue et al., 2009). Yet, numerous studies include narratives of the negative experiences of underrepresented minoritized (URM) during their college life and question some of the behaviors of health providers toward minorities and other vulnerable populations. URM students and populations served by HCPs continue to encounter prejudice, discrimination, and stereotypes. Most of these are caused by conscious and unconscious bias, microaggressions, racism, and many other -isms (Boysen, 2012; Sabin et al., 2009).

Studies completed by Sue (Sue, 2010a, 2010b) and Boysen (Boysen, 2012) show that non-minoritized faculty, administrators, staff, and students are more likely to unconsciously attack, insult, and invalidate members of URM groups. According to Sue, URM students are negatively affected by information contained in textbooks, lectures, and other teaching materials

that perpetrate injustices and discrimination against their groups. Campus climate can also impact URM students' learning environment, increasing their marginalization and limiting their chances to succeed. Campus climate frames the overall learning experience of a student body. It can set the stage for continued perpetration of injustices during professional life.

One way to address some of the factors contributing to the increasing local and global health inequities and disparities is deliberately ensuring that members of the current and future professional workforce are trained to equally serve all populations. Particularly, students, faculty, and staff in health profession schools should learn how to identify, understand, and address the causes of many health disparities. This knowledge can help increase equity in health facilities and other organizations providing support services, developing research projects, and implementing health-related interventions.

Research shows that by helping faculty, staff, and students understand and address the impact of ethnoracial, gender, disability, and other forms of discriminations, health professional schools can better prepare their entire institutional community and increase equity in the communities their graduates will serve (Banaji, 2016; Beattie, 2013; LaVeist and Isaac, 2013; Sabin et al., 2009; Sue et al., 2009). More importantly, educational institutions that promote equity and support diversity in its population, instructional content, assessment, and pedagogy can develop professionals who have the knowledge, skills and attitudes necessary to provide culturally responsive services (Banks and Banks, 2013; Booker, Merriweather, and Campbell-Whatley, 2016; Gay, 2018).

Contemporary Health Care Inequities

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”
— Martin Luther King Jr.

Health inequities are systematic differences in the health status of diverse populations, including children, women, and members of racial, ethnic, and other vulnerable populations. Every day in 2017, 16,000 children died in the world from preventable diseases. Maternal mortality can range from 1 in 16 to 1 in 10,000 depending on the development of the country. Non-communicable diseases drive people into poverty and represent 87 percent of premature deaths in low-resource settings. Health inequalities in HIV infections between and within countries are not related to biological or genetic reasons (WHO, 2017). Although health disparities have been largely attributed to economics, there is evidence that discrimination when people are averse to differences, see differences as threats, or determine individuals' inclusion or exclusion without requesting additional information, influences health outcomes of those discriminated against (Ndiaye, Krieger, Warren, Hecht, and Okuyemi, 2008; Weinstein et al., 2017). Agencies such as the World Health Organization (WHO) and the United Nations (UN) have documented how health disparities impact laws, policies, and regulations that influence the denial of equal treatment to diverse populations, including healthcare delivery and HCPs practices (Babyar, 2018).

In the U.S. the 2014 National Healthcare Quality reports indicated that low-income populations have 62 percent less effective and lower quality care and services than high-income individuals, representing the largest disparities in quality measures (AHRQ, 2015). In 2015, members of diverse populations “received worse quality of care than reference [White] group. Differences are statistically significant, equal to or larger than 10 [percent], and favor the reference group” (AHRQ, 2016, p.8). Furthermore, Black populations receive 60 percent worse care than White populations. Blacks are followed by Hispanics who received 43 percent, Asians 32 percent, and Native American and Alaska Natives 20 percent worse care, respectively (Fiscella and Sanders, 2016). These populations also have more health problems than Whites.

Other disparities can be seen in mortality rates caused by strokes and prostate and cervical cancer, which are 50 percent higher for Blacks than Whites. Blacks are also less likely to be recommended for oral cancer surgery than their White counterparts, and Latina and Chinese women are less likely to receive breast cancer prevention hormones than White women (Dovidio and Fiske, 2012). Overall, racial, ethnic and other minoritized populations receive poorer quality of care that is not related to structural factors. HCPs bias can impact patients' trust, responses, and adherence to treatments as well as the likelihood to seek medical care (Berger and Peerson, 2016; Brooks and Hopkins, 2017; Dovidio and Fiske, 2012; Durey et al., 2016; Topp and Chipukuma, 2016a, 2016b).

Discrimination impacts both HCPs and the populations they serve. In many countries around the world, female HCPs face gender discrimination, physical and sexual violence, limited or no participation in decision making processes, and lack of opportunity for leadership positions (Babyar, 2018). In the U.S., in 2015 members of minoritized populations in health professions only held 11 and 19 percent of leadership and mid-management positions, respectively. Although African Americans and Latinos comprised 25 percent of the population in 2010, they only represented 7.5 percent of students in health profession schools. In addition, women represented only 21 percent of faculty in medical schools. These facts are of great concern as they impact clinical research and funding.

HCPs' discrimination and prejudices against populations have negative effects on patient/client relations as well as individuals' symptoms, adherence to treatments, and overall satisfaction with services received (Babyar, 2018; Degni et al., 2012; Kutob et al., 2013). HCPs bias and discrimination in clinical and non-clinical settings are reasons for strengthening teaching strategies, cross-cultural understanding and communication, the use and promotion of materials in the clients' language, and the use of interpretive services. These factors contribute to

improved diagnosis, referrals, quality of services, and individuals' wellbeing (Babyar, 2018; Betancourt, 2003; Lynch and Hanson, 2004; Nunez, 2000). Furthermore, evidence shows that health profession schools that address implicit and explicit biases, prejudices, and overt racism through cross-cultural education and other initiatives contribute to reducing health disparities caused by HCPs (Murray-Garcia, Harrell, Garcia, Gizzi, and Simms-Mackey, 2014).

Purpose of the Study

The SPH and the DGH at the UW have taken various steps to prepare faculty, staff, and students to interact and serve diverse populations in cross-cultural settings. The SPH has developed internal reports and follows recommendations to improve campus climate and other factors impacting diverse populations. However, no studies have been published assessing faculty, staff, and students' perceptions of their preparedness to interact with and serve diverse populations in cross-cultural settings. This study explores perceptions of students, faculty, and staff about their cross-cultural education preparedness and implementation of concepts learned in theory and practice. It identifies where they have taken their cross-cultural communication and equity training and describes some of the impact of equity, race and cross-cultural training taken in and outside of college curriculum. Data collected identifies some of the strengths and gaps on courses and workshops taken by participants and describes existing leadership support for diversity, equity, and inclusion.

The goals of the study are directly related to its conceptual framework as they seek to expand the UW, SPH, and DGH efforts to address biases, increase equity, and reduce health disparities. In general, this research seeks to increase awareness about why biases and discrimination are important barriers to education and health equity, and how power and privilege imbalances experienced during human development and throughout educational

experiences are likely to be carried into professional healthcare practice (Banaji, 2016; De Chesnay and Anderson, 2012; Sabin et al., 2009; Sue, 2010a, 2010b; Sue et al., 2007, 2009; van Ryn and Saha, 2011). Consequently, the provision of inclusive learning and working environments connected to the development of pre-practice for culturally and linguistically responsive professionals can be directly associated with the overall healthcare. The experiences and perspectives of students, staff, and faculty participating in this study may contribute to developing a HCP workforce able to serve all populations. As stated by Dr. Ed Taylor, UW Dean and Vice Provost, in Trends and Issues in Higher Education, Talking about Race and Equity (p.14):

When we truly listen to the experiences of others, we have the opportunity to engage in deep, personal reflection about their lives and our own narratives. This enables us to gain a greater understanding and appreciation of how the threads of our individual truths weave together to create a community that finds its strength in the diversity of its fabric.

Research Goals and Objectives

This study describes the perceptions of participants about changes in their beliefs, knowledge, attitudes, and behaviors after receiving training addressing issues related to linguistic, cross-cultural, and racial diversity; individual, systemic and structural discrimination; and social justice and equity in the DGH and the population their graduates will serve. The selected sample population includes PhD, Graduate Certificate, and Master's in Public Health in Global Health (MPH-GH) students registered in Winter 2018 and 2019 terms, and 2017 and 2018 MPH-GH graduates. This study also examines the knowledge, awareness, skills, and attitudes of faculty and staff assisting these students during the completion of their respective programs.

More specifically this study is designed to a) identify pertinent training the SPH and other programs and departments offer and promote to the selected population; b) describes how training received or lack of training received impacts the students, staff, and faculty's beliefs, knowledge, and attitudes towards populations with backgrounds different from their own; c) assess the perceptions of participants about their abilities to effectively work in cross-cultural settings; d) identify perceived training and practical gaps; and e) provide the DHG with recommendations for educational improvement.

Conceptual Framework

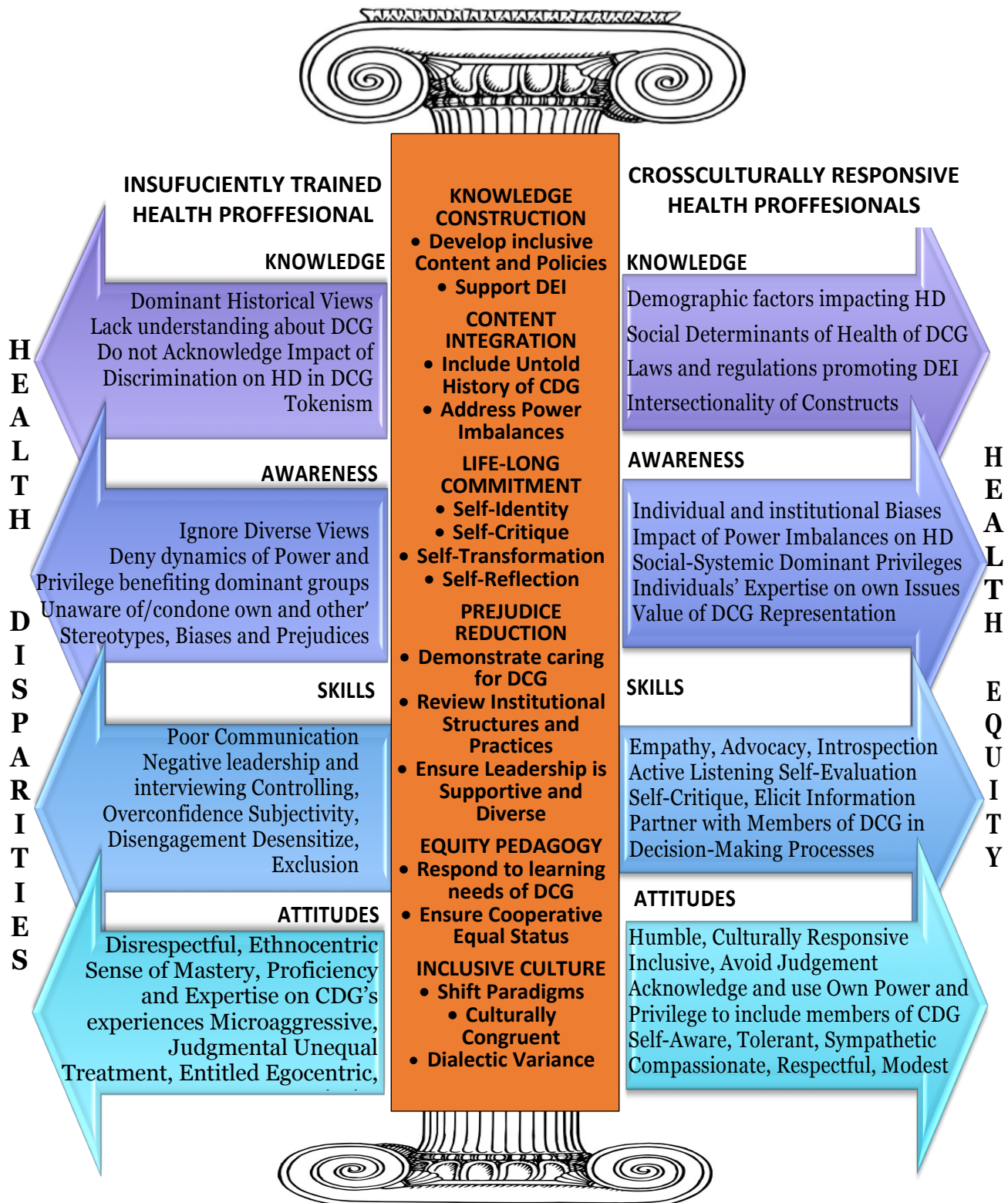
Unequal distribution of power and privilege have created individual, structural, institutional, and systemic racism and discrimination against diverse populations. Ideals such as “all men are created equal,” the “E pluribus Unum,” and meritocracy have been promoted as hallmarks of U.S. society and its belief system. However, socio-economic and political developments impacting diverse populations show a strong disconnect between these ideals and realities of inclusion and equity. This is evident in education and health services provided to members of diverse populations. Regardless of the many and growing advances, educational and health inequities and disparities among diverse populations are persistent in the U.S. (Bezruchka, 2010; Foege, 2018; Smedley et al., 2004, 2003; Weinstein et al., 2017).

Figure 1.1 shows the conceptual model of this study which was developed by the investigator. From Health Disparities to Health Equity presents the main principles and elements of multicultural education, culturally responsive pedagogy, and cultural humility as a pillar of knowledge that can help cultural humility and strengthen cross-cultural education in health profession schools. The model includes a section in each side of the pillar. The section on the left relates to views and impact of an insufficiently trained health professional workforce and the

section on the right relates to a culturally humble and responsive health professions workforce. Each section includes four arrows. The content in each arrow states specific factors embedded into knowledge, awareness, skills, and attitudes impacting the quality of preparation of HCPs to provide services to culturally diverse populations. The direction of the arrows contained in each section points to outcomes of cross-cultural interactions of HCPs at the individual, organizational, and systemic levels. The outcome of areas explored on the left section is increased health disparities and on the right section the outcome is health equity. This conceptual model seeks to demonstrate how the elements and principles of Multicultural Education/Culturally Responsive Pedagogy (MCE/CRP) and cultural humility presented in the pillar of knowledge could help move from insufficiently trained to a culturally responsive health professions workforce.

The pillar of MCE/CRP and cultural humility knowledge describes several concepts and addresses various aspects important to the development of a culturally responsive health professions workforce. Some of them are directly related to that way in which diversity in health professions influence current and future health care services (Smedley et al., 2004). These concepts include a) the construction of cross-cultural knowledge is influenced by the development of inclusive content and policies that support diversity, equity, and inclusion (Gay, 2018; IOM, 2003; Jernigan, Hearod, Tran, Norris, and Buchwald, 2016; Like, 2011; OMH, 2013; Smedley et al., 2004, 2003); b) integration of content must include the untold history of culturally diverse groups and information that addresses existing power imbalances (Banks, 2014); c) lifelong commitment is a journey of continuous self-identity discovery, self-critique, self-reflection, and self-transformation for achieving equity (Borden, 2018; Isaacson, 2014; Pinderhughes, 1989; Tervalon and Murray-Garcia, 1998); d) lack of commitment to equity could lead to increased health disparities (Smedley et al., 2003); e) prejudice reduction is achieved by

**MULTICULTURAL EDUCATION /CULTURALLY RESPONSIVE PEDAGOGY
CULTURAL HUMILITY**



HD: Health Disparities DCG: Diverse Cultural Groups DEI: Diversity, Equity, Inclusion

Figure 1.1 Transformational Conceptual Model: From Insufficiently Trained to Humble and Culturally Responsive Health Professions Workforce

demonstrating caring for members of diverse cultural groups, reviewing institutional structures and practices that have promoted discrimination against them, ensuring that existing leadership is supportive of diversity, equity, and inclusion; and ensuring that members from diverse cultural groups have representation in leadership positions (Banks, 2014; Gay, 2018) ; f) equity pedagogy addresses the needs of culturally diverse learners by using inclusive teaching strategies (Gay, 2018); g) inclusive culture can help HCPs shift paradigms; HCPs support needs to be congruent with preferred cultural values, beliefs, worldview, and practices of healthcare learners, consumers, and other stakeholders; finally, HCPs must understand dialectic variances due to social, geographic, individual and group factors, impacting their communication and interactions with healthcare learners and consumers (Gay, 2018; IOM, 2003; Jernigan et al., 2016; Like, 2011; Luquis and Perez, 2014; Sabin et al., 2009).

The sections included at the left and right of the pillar represent how the lack of and how the implementation of principles and elements of MCE/CRP and cultural humility could impact knowledge, awareness, skills, and attitudes of HCPs. It shows how the lack of or use of these principles could lead to increased health disparities or health equity. Similar to characterizations of data in some mathematical figures, the arrows or information provided in this conceptual model indicate that the left of the pillar represents negative outcomes and the information on the right represents positive outcomes. The assumptions made in the model infer that when HCPs do not receive appropriate cross-cultural education training and are not held accountable for treatment given to members of culturally diverse groups, they contribute to increasing health disparities in these groups. When HCPs' knowledge is guided by dominant historical views, their lack the understanding about diverse cultural groups is more likely to promote inequities (IOM, 2003; OMH, 2013). Oftentimes, HCPs and leaders in health professional schools do not acknowledge the impact of discrimination on health disparities experienced by members of

culturally diverse groups (Banaji, 2016; Foege, 2018; Smedley et al., 2004; van Ryn and Saha, 2011).

In many health professional schools, tokenism (symbolic effort) is used to maintain an appearance of inclusion of members of culturally diverse groups in learning, leadership, and workforce (Smedley et al., 2004). When HCPs are unaware of or ignore the experiences and views of culturally diverse groups, they deny dynamics of power and privileges that have been benefiting members of the dominant population and they also condone their own and other individuals' biases, stereotypes, and prejudices (Hall et al., 2015; Luquis and Perez, 2014; Rose, 2013; Sue, 2010a). HCPs who do not receive or embrace cultural humility and cross-cultural education could in turn have poor communication skills, possess negative leadership traits, and lack skills to elicit information and engage members of culturally diverse groups (Sabin et al., 2009; Satcher et al., 2006; Smedley et al., 2003; Sue, 2010a, 2010b). They can become overconfident, controlling, subjective, and insensitive, causing disengagement and exclusion of member of diverse populations (Berner and Graber, 2008; Degni et al., 2012; Grissinger, 2017; Staats, 2014; Topp and Chipukuma, 2016a).

Most HCPs who lack appropriate culturally responsive training present disrespectful and ethnocentric attitudes, believe in their superiority, mastery, proficiency or expertise on the experiences of members of diverse groups (OMH, 2013; Smedley et al., 2004, 2003). They feel entitled and are egocentric, leading to microaggressive, judgmental, and unequal treatment towards members of diverse cultural groups. The previous factors negatively impact the health of members of vulnerable populations and increase health disparities.

Figure 1.1 shows some of the elements that constitute a cross-culturally responsive health professional. It describes how elements and principles of MCE/CRP and Cultural Humility can positively impact the knowledge, awareness, skills, and attitudes of HCPs. Learning about the

demographic factors that impact health services and create health disparities increases chances of providing appropriate services. Culturally responsive HCPs have knowledge and follow laws and standards that regulate and promote diversity, equity, and inclusion (IOM, 2003; OMH, 2013; Smedley et al., 2003). They also understand how the intersectionality of social constructs impact individuals' health (Lopez and Gadsden, 2016). Culturally responsive health professionals are aware of the impact of biases and power imbalances on the health outcomes of the populations they serve (Yeager and Bauer-Wu, 2013). They value the expertise of their clients and develop the necessary skills to engage their participation in decision-making processes. Culturally responsive HCPs are tolerant, compassionate, and respectful (Smedley et al., 2003; "The 7 Essential Qualities of a Physician-AUA Med School," 2014). Self-aware of their own identities and privileges, they maintain high levels of humility when impacting the health and future of the populations they serve.

Summary

Regardless of continued and steady improvement of the overall health of the U.S. population, health disparities in the world and particularly in the U.S. may have increased as a consequence of a long history of racism, ethnocentrism, and other forms of discrimination against minoritized populations. Biases, prejudices, and stereotypes toward members of diverse cultural groups have reinforced power imbalances in health profession schools and service organizations. HCPs biases contribute to mistreatment of members of diverse populations while seeking health services. It may also contribute to misdiagnoses, diagnoses delays, and lack of patients' adherence to treatments. In the U.S. and around the world, most HCPs and individuals in leadership positions in the health professions are members of dominant populations and many of them lack the cultural humility, knowledge, awareness, skills, and attitudes to support equity

efforts and demonstrate behaviors modeling how to equally serve members of all populations. In spite of efforts to increase diversity, equity, and inclusion in health professional schools, biases, prejudices, and stereotypes continue to impact access for underrepresented minoritized (URM) students, faculty, and staff.

Chapter II

Review of Research and Scholarship

A variety of the theories addressing equity and diversity have influenced academic and sociopolitical thoughts. Some of these theories can help explain the way in which HCPs perceive their preparedness to interact with and effectively serve culturally diverse individuals and communities. The next section of this chapter presents perspectives of Postmodern, Critical, and Whiteness studies; dimensions, principles, and elements of MCE scholarship; standards to achieve Culturally and Linguistically Appropriate Services (CLAS); relevant aspects presented in cultural competency trainings; more importantly, it discusses the importance of developing cultural humility to eliminate health and other disparities. Different theories, concepts and views about diversity, equity, and inclusion share many of the same questions and concerns, and thus all of the scholarship reviewed in this narrative is relevant to cultural humility and culturally responsive health education.

Postmodernism

Postmodern discourse attempts to differentiate the ways people live during a period of time while criticizing perspectives used in the previous period. For example, Modernism is questioned and attacked for its construction of hierarchies (Bioland, 1995; Smedley et al., 2003). In educational theory, postmodernism exposes and challenges inequities, but it is sometimes impacted by dual and contradictory thoughts among scholars (Chambers, 2000). Hill, McLaren, Cole, and Rikowski (1999) discuss how Postmodernism maintains modernist views seeking to keep exclusive stands, power, and privilege. These scholars referred to Postmodernism as “an obstacle to the formation of open and radical perspectives which challenge inequalities and the deepening of the rule of capital in all areas of social life” (Hill et al., 1999, Chapter 1, para. 3).

Instead of looking at Postmodernism as an attitude or state of mind towards life, Hill et al. (1999) saw their relationship to this theory as a commitment to social justice and a search to end social inequalities.

Niesche and Gowlett (2015) and Chadderton (2013) question the status quo and invite a combination of theories (Chadderton, 2013; Niesche, 2013, 2015). Niesche and Gowlett (2015) discuss the use of Poststructural theorizing, including Foucault's notions of power and the subject and Butler's performativity and discursive agency. They suggest that in addition to deconstructing existing ideas, it is important to create positive change by disrupting conceptions of leadership seen from mainstream lenses and providing theoretical tools to create space for new and genuine leadership. Chadderton (2013) specifically discusses the combination of Critical Race Theory (CRT) with Poststructural views to investigate educational experiences of minoritized youth, including how the perpetuation of racial inequalities impact the development of their self-identity; deconstruct and challenge hegemonic systems of belief; and open up space for history about experiences of marginalized groups. Furthermore, scholars such as Ryan (1998) seek to use the negative connotation of Postmodern thought as a starting point for critical thinking and the development of new approaches to address issues of oppression and inequities.

Ryan highlights the increasing emphasis of scholars and practitioners on equity (Ryan, 1998). Ryan discusses the need for addressing the inability of educational institutions to properly solve issues impacting members of diverse populations. These issues include biases, differential treatment, discrimination based on individuals' race, ethnicity, class, and sexual preference among others. In his work Ryan also discusses the importance of resistance as a form of political action to reduce domination and increase leadership that promotes fair practices, addresses racist and other discriminatory acts, and promotes inclusion and social justice. Certainly, to adequately explore discourses about oppression, one must question the power and

privileges of members of dominant populations and examine Critical and White Privilege Theories to dismantle systems of oppression (Applebaum, 2010; Blum, 2008; DiAngelo, 2016; Margolin, 2015; McIntosh, 2015).

Chadderton (2013) summarized ideas from works of several CRT scholars including Lynn, Parker, Delgado, Duncan, Ladson-Billings, Solorzano, and Yosso for resisting oppression and concluded that a combination of theories can help unveil the way racism works and impact the political and social landscape. These ideas include “ongoing resistance in the field of education to center race and racism as a category of analysis” (para. 1); addressing racism as a critical issue impacting equity instead of as a descriptive; analyzing the interaction between race and White supremacy; exploring the impact of conscious and unconscious discriminations against members of diverse cultural groups; eliminating all forms of oppression; and including and promoting understanding of social, political, and historical experiences impacting diverse populations.

Similar to Chadderton (2013), Niesche (2013, 2015) encouraged the use of a combination of theories and perspectives to address inequities (Niesche, 2013, 2015; Niesche and Gowlett, 2015). Furthermore, Niesche and Gowlett (2015) highlight how efforts related to feminism, race, and ethnicity have been marginalized by dominant inquiry, indicating that although discussions of social justice have been a continuum, they have mostly been descriptive. Niesche and Gowlett's (2015) and Chadderton's (2013) work show how power dynamics presented by Structuralists could be used to build upon ideas of Critical Theory scholars to recognize the irrationality and long-term damaging effects of systems of oppression, address social challenges experienced by diverse populations, and to overcome inequities.

Critical Theories

CRT roots come from Critical legal studies (CLS) scholarship which saw hegemony as a government strategy to maintain its power to dominate and subordinate diverse groups (Crenshaw, 2011; Ledesma and Calderón, 2015; McCoy and Rodricks, 2015; Tate, 1997). CRT challenges the normalization of White Eurocentric values and describes how the unjust distribution of power and capital have caused social, legal, political, and educational consequences to racial, ethnic and other diverse populations (McCoy and Rodricks, 2015). Critical Theories, including Feminist Theories, CRT, and Queer Theories, acknowledge the influences of Postmodern ideas. The perspectives of these theories are spread across a spectrum of many other educational theoretical frameworks, including Critical Pedagogy, power, teaching curriculum, feminist pedagogies, teacher education, mass media and communications studies, vocational and technical studies, research summaries about critical theory, and research using methods of critical sciences (Capper, 1998, 2015; McCoy and Rodricks, 2015; Nichols and Allen-Brown, 2001).

CRT and derived theories such as AsianCrit, FemCrit, LatCrit, and TribalCrit, have been used to address issues of oppression and discrimination against members of diverse cultural groups (Ladson-Billings and Tate, 1995; Yosso, 2005). Ladson-Billings and Tate (1995) indicate that regardless of the existing Civil Rights Laws, race was untheorized and racism continued to be an endemic system embedded in U.S. society. These scholars highlighted the importance of understanding the significance of race dynamics in the U.S. as social constructions that have promoted the value of property rights over human rights. Ladson-Billings and Tate (1995) also discussed the importance of challenging claims of neutrality, objectivity, color-blindness and meritocracy to achieve equity. Factors such as the naturalization of Whiteness and oversimplification of race were explored by Ladson-Billings and Tate (1995) who concluded that

in the U.S. society Whiteness is the ultimate property. Whiteness “include[s] only the cultural practices of Whites” (p. 58). Furthermore, it describes the “property functions of whiteness,” which include: (1) rights of disposition; (2) rights to use and enjoyment; (3) reputation and status property; and (4) the absolute right to exclude” (p. 59).

Ladson-Billings and Tate (1995) and Yosso (2005) described how CLS failed to incorporate race and racism in the analysis of oppressive structures. In their work, these scholars reflect the perspectives of the victims of racism, opening space for the development of CRT. Yosso (2005) indicated that CRT initially presented a White and Black binary, leaving women, and other people of color who had been marginalized because of their class, sexual orientation, immigration status and primary language excluded from the discussion. Yosso (2005) also discussed the importance of using a multidimensional discourse to address the needs of African Americans, Native Americans, Asian and Pacific Islanders, Chicanos and Latinos, and women. Some strategies to address the needs of diverse cultural groups are further discussed in the section on Multicultural Education.

Multicultural education was conceptualized as a reform movement to promote educational equity for diverse cultural groups. Ladson-Billings and Tate (1995) denounced some limitations of multicultural education, indicating that it was being reduced to trivialities related to food, dancing, music and folktales of diverse cultural groups, creating a fantasy of unity, understanding, respect and tolerance. Multicultural education was not addressing tension between cultural groups and had been absorbed by the system instead of being considered an educational reform to embrace diversity (Ladson-Billings and Tate, 1995). CRT scholars recognized the work of Multicultural education scholars but rejected the paradigm that was allowing the status quo to prevail. CRT scholars increased usage as a theoretical framework, analytical tool, and research methodology in higher education. They continued to advocate for a

social justice approach, including the voices of many diverse students, faculty, and staff (Ladson-Billings and Tate, 1995).

CRT grew stronger over the past decades. Many Critical scholars in higher education have used perspectives of this theory to address issues of White supremacy, including colorblindness, meritocracy, and integrationism. CRT has been also used to address the idea of post-racialism embedded in campus climate, selective admissions, college transfer, and in higher education and federal policies created to provide appropriate services to diverse populations (Ledesma and Calderón, 2015). A transdisciplinary race-equity methodology using CRT has been used to explore the effects of racism in morbidity, mortality, and overall wellbeing of diverse cultural groups (Ford and Airhihenbuwa, 2010). It describes how power imbalances of students, faculty, staff, and members of research communities in public health learning and practice continue to be critical to equity (Ford and Airhihenbuwa, 2010). McCoy and Rodricks, (2015) also describe how institutions fail to address discrimination issues impacting faculty and students from diverse cultural groups.

Higher education still needs to address how the relationship of systems of oppression, such as Racism and White supremacy in the form of White Privilege, impact the overall experience of students, faculty, and staff and the population the future professionals will serve (Patton, 2016). CRT addresses intersectionality of theories, political identity, the involvement and voices of students, parents, and communities in policy and research, and the dilemma of race in the academy and public health (Ford and Airhihenbuwa, 2010; Parker, 2003). Developments of CRT in public health education and practice have increased relevance considering the growing diversity of the U.S. Ledesma and Calderón (2015) explore curricular and pedagogical biases, scholars' strategies to counter marginalization, and denial of the existence of racial issues. Furthermore, Capper (1998, 2015) and McCoy and Rodricks (2015) present theoretical

perspectives and tenets addressing the elimination of biased and racist behaviors. These tenets include 1) the presence of racism as endemic and pervasive 2) Whiteness as property, 3) majoritarian and counter narratives, 4) interest convergence, 4) critique of liberalism, 4) intersectionality, and 5) commitment to social justice. In the health field, Ford and Airhihenbuwa (2010) share Gilmore's definition of racism as a state-sponsored and sanctioned exploitation of vulnerable populations, causing them premature death. These scholars indicate that racism must be eliminated to achieve the objectives of public health. They also conclude that principles of race equity, social justice, and CRT can help address social determinants of health.

Whiteness and White Privilege Studies

White Privilege and White Fragility theories are potentially valuable in developing cross-cultural competence because they expose issues of White power and privilege; challenge White people to acknowledge systems of oppression and their consequences; and disrupt and dismantle connections among racism, sexism, and others forms of individual and systemic discrimination, oppression, and lack of success by minoritized populations (Applebaum, 2010; Blackmore, 2013; Cabrera, Franklin, and Watson, 2016; McIntosh, 2015; Rainer, 2015). Critical White scholars address oppression and inequities directly from their source, White people. These scholars also emphasize the need for Whites to engage in self-reflection and actions to dismantle White Privilege.

In response to the continued discriminatory behaviors many Whites exhibit towards people of color, feminist scholars and anti-racism activists have been working to help White people understand the sources and manifestations of systems of oppression. Unfolding the knowledge that White supremacy has been developed and embedded in social, economic and political systems, these scholars show how White privilege impacts every aspect of U.S.

society. For example, (DiAngelo, 2016, 2018) and McIntosh (1988, 2007, 2015) challenge White people to explore how strategies used by previous and existing institutions and systems have benefited themselves, especially males. Brooks (2013), Chesler, (2005), Stanley (2017), Stead (2016) discuss how self and agency are key to social justice.

Brooks (2013) specifically looks into the problems and possibilities to address ignorance, bigotry, and different forms of racism and biases, impacting higher education. Chesler (2005) presents different frames to understand the history of racial biases, race relations, oppression, and discrimination in the U.S., the struggle of minoritized populations to achieve equity in institutions of higher education, and the impact of exclusive faculty and curriculum on the performance of URM students. Finally, Stead (2016) discusses the importance of higher education to fight against racism and highlights the importance of making changes in the curriculum, the pedagogy used, and administrative processes by, among other strategies, decolonizing systems and eradicating domination of privilege groups.

The challenge for scholars addressing White Privilege is to ask White people to consciously evaluate individual views and structural norms that have given them power and privileges. Scholars must unite efforts to defeat ignorance, traditions, stigma, and lack of sensitivity. It might be the only way to dismantle educational and other systems of oppression causing growing inequities. For inequities to end, our society must address the persistent systemic oppression and the elements of Whiteness and White privilege, starting at the individual level and moving into the institutions dominated by many of these same individuals. “While anti-racist efforts ultimately seek to transform institutionalized racism, anti-racist education may be most effective by starting at the micro level” DiAngelo, 2011, p.66).

DiAngelo (2011) discusses the way in which White people grow protected from stress caused by racial tensions. She indicates that when White people face a minimum level of racial

stress, they become intolerant and present offensive responses that the author defines as White Fragility DiAngelo (2011). DiAngelo concluded that for change to occur and equity to exist, all white people must sustain conscious and explicit engagement with race and take responsibility because up to today, this responsibility for change has not been equally shared.

Other scholars use CRT to provide what has been called the “missing link” to the application of critical race-based analysis to higher education policy and programs. Sleeter (2017) uses tenets of CRT to critique how teacher education continues to be overwhelmingly dominated by cohorts of predominantly White teacher candidates who express resistance to and fatigue from discussion about race, Critical Race Theory, and the Whiteness of teacher education. Sleeter (2017) states that Whiteness can be constructively confronted by engaging White faculty members and by ensuring that they take responsibility to include themselves as part of the problem and the solution to racial and other inequities in higher education. Cabrera et al (2016) indicate that the missing link to address White Privilege has been the lack of acknowledgement of the advantages obtained by Whites under the assumption of the existence of White superiority. These scholars conclude that to achieve social justice White people must learn to work collaboratively and consciously avoid the creation and recreation of different forms of oppression.

Multicultural Education and Public Health Care

When the public health care system was developed, it was primarily concerned with sanitation, water and food safety, and control and cure of diseases through emphasis on prevention, diagnosis, and treatment (IOM, 2003). Regardless of efforts of public health professionals to maintain a healthy population, health disparities in members of diverse cultural groups have been determined by their experienced gradient of social, economic, and educational

inclusion, exclusion, discrimination, and access to services and care (Smedley et al., 2003). Smedley et al. indicate that the effects of these detriments have created some of the biggest public health care challenges---poverty and increased health disparities caused by individual and systemic discrimination and oppression (Smedley et al., 2003). These scholars also said that while HCPs might not be able to directly impact individual and social poverty, they can take action to eliminate the impact of their own prejudices, biases, and use of stereotypes when interacting with members of culturally diverse populations.

Smedley et al. (2003).indicates that “America’s racial health problem should be at the leading edge of all our efforts to ameliorate racial and ethnic health disparities through cultural competence, multicultural medicine, anti-bias, and diversity training efforts” (p. 493). According to IOM (2003) Luquis and Perez (2014), Betancourt (2003); Betancourt, Green, and Carrillo (2002), Satcher et al.(2006), and Smedley et al. (2003), Multicultural education became a key strategy to improve HCPs awareness, knowledge, and skills to obtain, negotiate, and manage health information. These scholars also raised concerns about efforts to unify characteristics of different cultural groups because they could lead to stereotyping and oversimplifications of individuals’ culture (Betancourt, 2003; Betancourt et al., 2002; IOM, 2003; Pérez and Luquis, 2008; Satcher et al., 2006; Smedley et al., 2003).

Over the past decades, health profession schools and training programs began recognizing the importance of MCE, cultural competence training (CCT), and the use of CRP to improve access and effectiveness. Unfortunately, these efforts have not been sufficient given the elective or extracurricular nature in which they are offered (Smedley et al., 2004). Most health educators still lack the pedagogical training necessary to teach and serve culturally diverse populations. According to Sullivan in Satcher et al. (2006) cultural diversity has existed and greatly increased in the U.S. since its formation. People from all over the world have come to

this land, bringing different languages, customs, beliefs and religions, making diversity one of the greatest assets and strengths of this nation. Too often, this diversity has been a source of bigotry, hatred, and oppression (Foege, 2018). HCPs lack of sensitivity to the experiences of diverse populations is part of the same ethos. It still haunts members of diverse populations who continue to be treated with disrespect and are less likely to receive proper treatment in healthcare facilities.

As an example, Schroeder, (2016) describes the experience of Ron Wyatt (61), an African American doctor and medical director in the Division of Healthcare Improvement at the Joint Commission. Dr. Wyatt, after returning from a trip to Africa, went to a hospital with a 104 degrees fever. The information provided by his wife and power of attorney was dismissed and the patient was forced to complete the intake. The nurse dismissed the couple's concerns because Dr. Wyatt's fever had declined after taking medications. In the examination room, she mistakenly pulled the name of another patient in the computer and asked Dr. Wyatt to prove that it was not his information. Later, a doctor briefly came in and superficially completed a physical exam without looking at Dr. Wyatt's face and ordered IV fluids. Although his temperature increased, and the nurse told the doctor that more should be done, the doctor asked Dr. Wyatt to take Tylenol after getting home. While waiting for Dr. Wyatt, the only staff of color in the area told Mrs. Wyatt "Don't let it bother you. We see this all the time." Schroeder, (2016) cites previous research concluding that the history of segregation and abuses against diverse population continues to impact the development of trusting relationships in healthcare settings. He indicates that members of diverse populations still face the outcomes of implicit and explicit biases and calls for collective efforts to overcome this issue.

Cultural Competence Training (CCT)

Smedley, Stith and Nelson (2003) indicate that some health disparities are caused by the unequal treatment given by HCPs to members of diverse populations, asserting that the quality and access to health care provided to racial and ethnic minorities is lower than Whites (Smedley et al., 2003). These scholars recommend improving the abilities of the health profession workforce to deliver quality care to diverse populations by a) proportionally increasing the number of health care professionals from diverse cultural groups; b) increasing education for patients about existing services, ways to access them, and the importance of participating in decision-making related to their health; and c) integrating cross-cultural education into training and practices provided to the future health professions workforce (Schroeder, 2016).

Consequently, health professional schools and health care and services institutions have increasingly recognized the importance of improving education to address the impact of prejudices, biases and power imbalances between HCPs and members of populations they serve.

Over the years, health professional schools have attempted to improve issues of diversity through what it has been called cultural competence training. Although the term Cultural Competence has been widely used in health and other professions, there is not a generally adopted definition. The National Center for Cultural Competence defines it as a set of behaviors, attitudes, and policies used to enable effective cross-cultural communication (Cross, Benjamin, Isaacs, Portland State University. Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their, and Center, 1989). Other scholars have defined it as a set of skills, values, and principles that allow individuals to interact in diverse settings and with diverse populations (Cross, Benjamin, Isaacs, Portland State University. Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their, and Center, 1989). Betancourt et al. (2002) and Ihara (2004) describe cultural competence as the ability of health professionals and organizations to provide services

that are culturally and linguistically appropriate to the diverse populations they serve. Cultural competence refers to the ability to understand and respect values, attitudes and beliefs across cultures. Furthermore, Luquis and Perez (2014) argue that most common definitions of cultural competence ignore the complexity of cross-cultural communication and individuals' relations from the institutional and systemic levels. These scholars indicate that cultural competence is more than a series of traits individuals and institutions can use to serve diverse populations.

When referring to cultural competence in public health care, Campinha-Bacote (2002 p.181) explains that it is “[t]he process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client” (Campinha-Bacote, 2002). To accomplish this goal, health profession students and practitioners should be provided with tools to increase their awareness and explore their attitudes about self and others; cultivate respect and empathy; develop foundational knowledge; and acquire required skills. They also need adequate support to implement appropriate policies. Models of multicultural counseling describes cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire as five of the necessary constructs to develop culturally responsive competencies (Bauer and Bai, 2018; Campinha-Bacote, 2002, 2011). Other paradigms include factors such as religious and spiritual identities, economic class background, sexual identity, psychological maturity, ethnic and racial identities, chronological development, trauma and other threats to individuals' wellbeing, family history and dynamics, unique physical characteristics, location of residence, and language differences (Purnell, 2005; Warren, 2002).

Over the years, agencies, organizations, and institutions of higher education and health facilities have developed various interventions to increase awareness about the effects of bias and discrimination in population health. Nonetheless, diverse professionals, students, faculty, and staff and populations served by HPCs continue to experience communication challenges,

impacting their general wellbeing and the wellbeing of the population they serve (IOM, 2003; Park et al., 2006; Sue et al., 2009). In a global society, health and health care professionals interact with diverse and vulnerable populations on a regular basis. The outcomes of their encounters are influenced by their cross-cultural communication and related skills, especially their ability to read culturally imprinted symbols and meanings (Eubanks et al., 2010).

Educational experiences that promote equity and support diversity in its population, program content, assessment, and pedagogy can positively impact the development of culturally responsive professionals (Banks and Banks, 2013; Booker et al., 2016; Gay, 2010a). In public health care, cultural competence training was later strengthened by federal and institutional standards and competencies. Some of these standards prompt organizations to have governance, leadership, and workforce qualified to provide culturally and linguistically appropriate services to diverse populations (OMH, 2013).

Culturally and Linguistically Appropriate Services (CLAS) Standards

In December 2000, the Office of Minority Health of the Department of Health and Human Services published the National Standards on Culturally and Linguistically Appropriate Services (CLAS) Standards in health care. These standards were updated in 2013 in an effort to improve responsiveness of the system to the needs of diverse populations, including racial, ethnic, linguistic, and other vulnerable populations. The CLAS standards have been implemented and promoted not only in the medical and public health fields but also across agencies and organizations at the global, national and local levels (OMH, 2013). Unfortunately, the CLAS standards are not a law and organizations are not required to comply unless they receive federal funds. In addition, many educational institutions do not teach about or implement the CLAS standards, preventing many HCPs from becoming familiar with this important resource. The CLAS standards and other forms of cultural competence training offer frameworks and strategies

to address individual needs of members of all populations. Health professionals can use these standards as a guidance to better understand individuals' beliefs, practices, language, communication, and traditional considerations.

Some of the health professional schools that have offered CCT to students, faculty and staff, including leadership have included information about the CLAS Standards. These trainings aim to provide participants with cultural knowledge to help them deal with issues of institutional climate and address educational, health and many other disparities. Unfortunately, these efforts have not been sufficient. Most cultural competence training has an elective or extracurricular nature and the term cultural competence implies a false sense of mastery of or proficiency in other people's cultures. In addition, regular programmatic courses do not consistently embed inclusive content, teaching, and instructional practices (Tervalon and Murray-Garcia, 1998). The dimensions of multicultural issues that need to be considered to improve health and other disparities might be better understood by exploring and integrating the principles of CCT, CLAS standards, Multicultural Education/Culturally Responsive Pedagogy, and Cultural Humility. These principles can assist medical and other health professional schools and service organizations in the provision of culturally responsive services.

Multicultural Education (MCE)

Vincent describes the work of many Multicultural Education scholars who have created conceptualizations of schooling that promote individual and social transformation, social justice, and equity in education over the past six decades (Vincent, 1992). Banks, one of these scholars, developed strategies to help educators address some of the challenges faced by students of color in educational settings. As a MCE scholar, Banks created the Elements of Multicultural Education, providing meaningful steps towards the improvement of existing teaching and

learning dynamics and academic achievement of diverse students. According to Banks (1995) content integration, the knowledge construction process, prejudice reduction, an equity pedagogy, and an empowering school culture and social structure are five dimensions of multicultural education. Each of these components explains ways in which educators can use inclusive information and data to create new knowledge. They also address the damaging effects of prejudices and discrimination by helping learners develop attitudes and values that are respectful, sensitive and ethical.

MCE promotes equity through the use of pedagogy that facilitates the academic achievement of students from diverse backgrounds by using instructional and teaching strategies responsive to their learning needs. In 1995, when Banks talked about the empowerment of a school culture and social structures, he was already addressing the challenges of institutionalized racism and other forms of oppression that impact students' learning in schools. These challenges included lack of diversity of staff, faculty and student body, school climate, and the impact of social changes such as evolution of systems of communication, political changes, and civic engagement. Banks' scholarship has increased recognition of diversity and awareness about the importance of multicultural education. It has also led the development of theories and frameworks to further this primary knowledge to humanity, contributing to the improvement of the academic achievement of diverse populations.

MCE principles and frameworks should continue to expand its reach to health profession schools to prepare HCPs for democratic citizenship, better understanding of social, economic, and political issues that impact the cultural fabric of the U.S. population, and to achieve health equity, equality, and social justice (Gay, 1975a, 1975b, 2005; Gay, 1988, 2004, 2010a, 2010b, 2018; Gay and Kirkland, 2003). A particular framework that has been used to take MCE from

theory to practice is Culturally Responsive Pedagogy (CRP). It could contribute to strengthening HCPs preparation to address increasing health disparities.

Culturally Responsive Pedagogy (CRP)

Within the realm of MCE, Gay (2018) developed theories and frameworks to take MCE principles into practice. Gay, renowned for her scholarship in MCE curriculum theory and Culturally Responsive Pedagogy (CRP) has offered a global theoretical and practical perspective to educational equity. The theoretical frameworks, constructs and tenets of MCE and CRP have evolved in efforts to incorporate a diversity of cultural contexts to the existing hegemonic views of history. Furthermore, CRP has a global theoretical perspective. By using CRP, Gay highlights the power of caring, the power of relationship building, dialectical variance, the importance of cultural congruence, and the importance of shifting paradigms of practice when teaching and caring for diverse populations.

In her work, Gay comprises personal, institutional, and instructional dimensions of the teaching and learning processes denoting their critical importance to understanding the effectiveness of culturally responsive pedagogy. Gay put principles of multicultural education into practice, stressing the fact that practice is imperative for knowledge and skills to be effective. CRP, also referred to as Culturally Responsive Teaching and Culturally Relevant Pedagogy, has five essential elements: 1) developing a knowledge base about cultural diversity; 2) including ethnic and cultural diversity content in the curriculum; 3) demonstrating caring and building learning communities, 4) communicating with ethnically diverse students; 5) and responding to ethnic diversity in the delivery of instruction (Gay, 2018).

Over more than four decades, Gay has worked on the development of the elements, theory, and practice of CRP. This theory evolved from Gay's work in 1972 and her views, to this

day, have remained steadfast. Gay exhorts educators, learners, and practitioners to understand and respect differences between individual cultures and heritages as they impact people's knowledge, beliefs, values, and attitudes. By applying the principles and elements of CRP, it is possible to achieve equity and eliminate disparities caused by exclusionary and discriminatory models. Throughout her scholarship, Gay discusses the importance of improving cognitive knowledge as it is oftentimes distorted by traditions and conventional conceptions, personal attitudes, and instructional behaviors.

The elements of CRP operate from a framework in which teaching, learning, and practice must have congruity with the needs of all cultural groups. We must understand our own history, the history of inequities, and the current disparities faced by racial, ethnic and other populations in order to promote social justice and achieve health equity. Through Gay's teaching, I learned that to promote culturally responsive pedagogy (CRP) one must explore self and individuals' identities, bridging intercultural communication, and resist resistance (Gay, 2013). By opening my understanding about myself, my views, perceptions, and experiences, my humility and understanding of the people I interact with has increased. It also increased my interdisciplinary perspectives to address some of the causes of health disparities.

Factors and elements of CRP have been used along with principles of Multicultural Education in developments of cultural competence trainings offered in health professional schools, including psychology, social work, and chiropractic medicine. Health professions scholarship such as Cultural Competence in Health Education and Health Promotion (Gay, 2018); Banks Multicultural Model: A Framework for Integrating Multiculturalism Into Nursing Curricula (Bagnardi, Bryant, and Colin, 2009); and Examining the Impact of Critical Multicultural Education Training on the Multicultural Attitudes, Awareness, and Practices of Nurse Educators (Beard, 2016) include elements of culturally responsive pedagogy. Although

many public health scholars have used principles and elements of MCE and CRP to complement their work, their main focus has been the interaction of providers and clients. MCE/CRP offers a foundation to expand and enhance learning, teaching, services, and care practices. CRP can also help strengthen the educational process by increasing HCP's cultural humility, including abilities for self-reflecting, continued identity rediscovery, understanding of the needs of diverse cultural groups, and building honest and trustworthy relationships.

Cultural Humility

Humility is the quality of being modest and humble, having a low view of one's self-importance. This is a very significant quality for all human beings to have, especially health care professionals (HCPs), educators, and individuals in leadership positions in health profession schools and healthcare and service organizations. Humility is a valuable skill to maintain in order to check power imbalances pervading local and global societies. Over many years, scholars and practitioners in various professional fields have worked to create theories and practices that can help address increasing health, educational, and other disparities between most members of the White and diverse populations. The principles and elements of Multicultural Education, culturally responsive pedagogy, and cultural competence trainings have shown positive results in the acquisition of cultural knowledge and skills to work with different cultural groups (Banks, 1999, 2014; Gallegos, 1984; Gay, 2018; Green, 1982; Rose, 2013). Nonetheless, disparities persist, prompting scholars to continue developing more effective and targeted approaches.

Across and within professional fields, many of the existing theories, frameworks, models, and strategies regularly interchange concepts or use similar definitions to describe ways in which practitioners and leaders can become culturally proficient and address issues about equity, inclusion, and diversity (Foronda, Baptiste, Reinholdt, and Ousman, n.d.; Foronda et al., 2018).

Pinderhughes (1989) presented the essence of cultural humility as an important quality and needed skill. Although the strategies proposed in Pinderhughes' work do not conceptualize the term culturally humility, scholars have indicated that this early work has helped them question their identity, cultural sensitivity, self-understanding, and self-awareness before serving diverse populations and increased their self-reflections about dynamics of power and privilege, especially as a middle-class White health care practitioner (Haeseler, 1994; Sabbath, 1991).

The term cultural humility has been used to address challenges of measuring outcomes when receiving CCT, especially HCP's abilities to elicit information and relate to members of diverse populations (Borden, 2018; Isaacson, 2014; Tervalon and Murray-Garcia, 1998). Some HCPs feel that the term *humility* does not offer practical advantage over *competence* and *proficiency*, concepts commonly used in cultural competence training (CCT) (Danso, 2018). They oftentimes dismiss the potential for stereotyping members of diverse cultural groups. Conversely, other scholars indicate that by practicing cultural humility, health care professionals (HCPs) can address existing gaps (Borden, 2018; Isaacson, 2014). Borden, Isaacson, Tervalon and Murray-Garcia indicate that cultural competence training concentrates on increasing awareness, knowledge, attitudes, and skills of policymakers, physicians, and other HCPs about culture-specific beliefs of diverse populations.

The term cultural humility has been used along with the term cross-cultural efficacy to examine the knowledge, attitudes, and skills needed by HCPs (Nunez, 2000). Similar to CCT, cross-cultural efficacy addresses practitioner-client dynamics from the practitioners' perspective and do not promote active involvement of individuals receiving care or services. Cultural humility, on the contrary, deals with HCPs' awareness, self-evaluation, and self-critique to understand the perspectives of their clients and other individuals they interact with, helping HCPs manage power imbalances (Satcher et al., 2006). The concept of cultural humility has also

been included in conceptual approaches and frameworks developed to address cross-cultural medical education, indicating that health care professionals attitudes such as empathy, respect, and sensitivity must be evaluated along with other skills, knowledge, and levels of awareness (Carnes, Handelsman, and Sheridan, 2005; Palepu et al., 1998).

Relationship of Study to Existing Theory and Research

There is a wealth of scholarship reporting increased health disparities in racial, ethnic and other diverse populations and describing the impact of discrimination, racism, and biases when presenting research findings and when providing services to diverse populations. However, studies assessing perceptions of students, faculty and staff about their readiness to interact in cross-cultural setting are limited.

Over the past several decades, there have been different studies analyzing factors influencing the lack of representation of minoritized populations in the health professions, including public health and academic medicine and practice (Carnes et al., 2005; Palepu et al., 1998). Efforts from organizations such as the National Institute of Health (NIH) and U.S. medical schools to increase diversity do not show positive impact or growth in representation of members of minoritized groups or in the elimination of health disparities (Merchant and Omary, 2010). Race, ethnicity, disability, age, and gender identification continue impacting academic medicine and public health practice (Greenwald, 2011; Moskowitz and Li, 2011; Sabin et al., 2009; Staats, 2014; Teal, Gill, Green, and Crandall, 2012; van Ryn and Saha, 2011). Guidelines and strategies for building multicultural competence and addressing multiculturalism explains the need to increase multicultural awareness in health professionals especially those who do not recognize issues such as White privilege and challenges faced by individuals from diverse ethnic and racial identities (American Psychological Association, 2003; Constantine and Sue, 2005).

The UW has increased instruction and fieldwork efforts to help professionals in different disciplines to confront ethnocentric conscious and unconscious biases. This study presents perceptions of UW SPH DGH students, faculty, and staff about their cross-cultural education preparedness, implementation of learned concepts when interacting in diverse settings and with diverse populations, and educational strengths and gaps they have identified. One of the instruments developed to collect data from the selected population is an adaptation of existing tools created to assess perceptions of health professionals in different fields. These tools mostly assess interactions during client/provider encounters and during medical training. The adapted tool is more focused on different states of the learning process, especially before HCPs enter their respective professional field.

Summary

The history of humanity shows how group differences have promoted exclusionary and barbaric behaviors between people from different groups. In the U.S., these behaviors often have been transformed in institutions and systems of discrimination and embedded in social traditions. Although the U.S. has been advertised to the world as the land of the free; a land made by and for immigrants, freedom and the American dream have been impacted by differential treatment among its population. Regardless of the search for effective solutions to improve services for members of diverse cultural groups, health disparities and healthcare inequities are longstanding and persistent problems in the U.S. and at the global level. Unfounded biological racial and ethnic categorizations and socially constructed norms related to people's gender, sexual identity, age, and (dis)abilities continue to cause oppression in educational research, policy, curriculum and health services. Scholars have been exploring educational and health inequities considering different historical, political and economic contexts that impact individuals' health. Particularly

in the U.S., there have been many advances to end segregation, including the Civil Rights Act and many other anti-discrimination laws, regulations, and policies to promote culturally responsive services. Nonetheless, diverse populations, especially people of color, continue facing unjust growing inequalities and health disparities. In higher education, including health profession schools, scholars have explored existing and developed new theoretical and conceptual frameworks to advance knowledge. These theories have been largely influenced by a plurality of concepts and perspectives such as Postmodernism, Critical Race theories (CRTs), Whiteness, White privilege, and other critically oriented thoughts. Considering that there is no emergence of widely supported paradigms or theories inclusive and relevant to culturally and linguistically diverse groups and contexts, the understanding and use of a combination of theories could be beneficial to develop and support transformational approaches to promote health equity and social justice.

Transformational approaches can guide the development of productive strategies to address discrimination and other spectrums of oppression experienced by members of diverse cultural groups at the personal, structural, and systemic levels. These strategies must also address ways to help White people understand and recognize how systems created have benefited them while undermining the wellbeing of diverse cultural groups and creating power imbalances. Theories, frameworks, principles, and elements used in MCE research and scholarship can help further explore the impact of cross-cultural communication on health inequities and other disparities. The incorporation of cultural humility in multicultural education, culturally responsive pedagogy (MCE/CRP) and other elements of cultural competence training (CCT) can contribute to expand the reach of these educational approaches because they ask for individual and institutional life-long self-reflection, self-critique, and advocacy, working in partnership with

communities to change attitudes towards diverse populations (Berger and Peerson, 2016; Geneva Gay, 2018; Pinderhughes, 1989; Tervalon and Murray-Garcia, 1998).

Educational frameworks seeking to eliminate power imbalances can help healthcare professionals understand how the intersection of race, ethnicity, religion, class, and other social, economic and political constructs impact their identities and beliefs about others (Tervalon and Murray-Garcia, 1998). Studies completed in various U.S. and international health professional schools, health care, and service organizations show the benefits of developing cultural humility of health care professionals (HCPs). Nonetheless, locally and globally, public health care must continue to work to increase HCPs awareness of and address existing power imbalances in the teaching/learning and client/practitioner relationships. These imbalances impact health outcomes of diverse populations and propel persistent health disparities and inequities.

Chapter III

Methodology

Research Site: The University of Washington (UW)

The UW declared its commitment to integrate diversity and foster inclusive classrooms across campuses by establishing system-wide policies such as the Race and Equity Initiative and the Population Health Initiative. It also created university-wide and school-specific diversity committees to identify issues, foster strategic conversations, and develop best practices for creating, sustaining, and supporting diversity. When the Race and Equity Initiative was launched in Spring 2015, President Ana Mari Cauce stated:

“that all of us--students, faculty, staff and university leadership--take personal responsibility for addressing our own biases and improving our university culture. And it began with a commitment: that together we would combat the racism and inequities, both individual and institutional, that persist here and throughout our society” (Initiative, 2015).

The university Office of the Provost and the Office of Minority Affairs and Diversity have been working to meet the 2010-2014 Diversity Blueprint goals. Goal 3 states that the university will “provide rich learning experiences and prepare students for global citizenship” (OMAD, 2017). The Provost’s office also works in partnership with the Race and Equity Initiative. In April 2017, during a public presentation, Dr. Ed Taylor, Vice Provost, Dean of Undergraduate Academic Affairs, and Chair of the Race and Equity Initiative outlined how the Diversity Blueprint and Diversity requirements seek to Cultivate an Inclusive Campus Climate; Attract, Retain, and Graduate a Diverse and Excellent Student Body; Attract and Retain a Diverse Faculty; Attract and Retain a Diverse Staff; Assess Tri-Campus Diversity Needs; and

Improve Accountability and Transparency to help set goals for change and to encourage innovation and activism (OMAD, 2017; Taylor, 2017).

Previously, the May 2017 publication *Trends and Issues in Higher Education* reports that different schools within the university have been developing strategies to reach this goal. One school highlighted in this report is the School of Public Health (SPH). In 2016, this school, following its history of activism and awareness about institutional racism, “passed a new school-wide competency specifically addressing the effects of racism on public health” (“Curriculum Transformation,” 2016 para. 7; Hagopian et al., 2018). This action supports efforts of the university to transform curriculum by encouraging instructors to create equitable learning spaces and inclusive teaching practices. In addition to adopting this competence, the SPH created a course that addresses the “effects of race, power, and privilege on public health (para. 8).

The UW School of Public Health (SPH)

The SPH has five academic departments: Biostatistics, Environmental and Occupational Health Sciences, Epidemiology, Global Health, and Health Services. It also has five Interdisciplinary programs: Health Administration, Maternal and Child Health, Nutrition Services, Pathobiology, and Public Health Genetics. During the academic year 2016-17, the SPH had 1,475 students. Of this total 940 were in graduate programs, 535 in undergraduate programs, 73% were women, 60% Washington state residents, 16% underrepresented minorities, and 10% international students. There were 1,027 faculty. From this total, 106 were primary, 109 joint, 193 adjunct, 565 clinical and affiliate, and 22 held the high honor of been elected to the National Academy of Medicine. For the academic year 2018-2019, the SPH registered 1,602 students distributed as follows: 990 in graduate programs and 612 in undergraduate programs. Of this total 74% are women, 61% are Washington state residents, 17% are underrepresented minorities,

and 10% are international students. It also had a total of 1,052 faculty members including: 146 primary/core faculty, 102 joint, 203 adjunct, 601 clinical and affiliate, and 22 elected to the National Academy of Medicine (*UW SPH Facts*, 2019). The description and numeric breakout for the SPH staff was not included in SPH fact reports, limiting access to their demographic characteristic.

In 2016, the SPH reconfirmed its commitment to increase equity by passing a school-wide competency requirement to address individual, organizational, and systemic racism and the effects of racism in public health. The SPH established a core competency recognizing “the means by which social inequities and racism, generated by power and privilege, undermine health” (UW SPH, 2019). The Diversity Blueprint for the university was developed in 2016 and published in 2017. It established as a goal to cultivate an inclusive campus climate. This goal is a step to enhance effectiveness of curriculum and educational programs with regard to diversity and inclusion and it is expected to be accomplished between 2017-2021. The Blueprint asks to “[a]ssess the impact of the recently implemented student diversity course requirement by including questions about it in the student climate survey.”

The SPH, in addition to passing the school-wide competence to address racism, has also made further steps such as hiring external consultants to examine the campus climate and to provide recommendations for the development of a successful race, equity and inclusion strategic plan. On May 25, 2017 external consultants presented to the SPH a report that showed the various power dynamics impacting the UW SPH and general UW community. Their findings delineate among others the need to create diverse, equitable, and inclusive work and learning environments for faculty, staff, and students. It also highlights the need to “train and educate faculty, staff, and students around race, equity, and inclusion” and recommends hiring an Assistant Dean for Diversity, Equity, and Inclusion (DEI) (Impact, 2017).

In February 2018, the SPH announced the hiring of the Director of Equity, Diversity and Inclusion: Dr. Victoria Gardner started working as Chief Diversity Officer at the SPH on March 1, 2018. Particularly, at the department level, the SPH Department of Global Health foment diversity, social justice, and equity as key elements for reducing health disparities.

The UW SPH Department of Global Health (DGH)

In the academic year 2016-17, 1700+ students took global health courses at the DGH and 8100 enrolled in e-learning courses. The degrees awarded included 43 MPH, two PhD Global Health, three PhD Pathobiology; 18 students received global health certificates, 53 global health minors. The diversity of students was 70% female, 5% African American, 13% Asian American, 50% White, 6% Hispanic, 2% Other, and 23% international students (48% Africans, 43 Asians, and 3% Latin American). The department did not report race and ethnicity for faculty and staff (*UW DGH Annual Report, 2017*). In 2017-2018 a total of 646 students were enrolled in programs offered by the DGH and 14,500 enrolled in e-learning courses.

In autumn 2018, of the total enrolled students in DHG programs, 127 were MPH students, 48 PHD in Metrics and Implementation Sciences, 29 PHD in Pathobiology, 134 School of Medicine Pathways, 29 Graduate certificates, 97 undergraduate global health minor. A total of 1700+ took global health courses and 14,000 were enrolled in e-learning courses (p.24). The degrees awarded by the DGH in the year 2017-2018 included 53 MPH, three PhD in Metrics and Implementation Science, two PhD and one MS in Pathobiology. A total of 43 undergraduates received Global Health minors, 13 graduate certificates, and 17 the School of Medicine Global Pathway certificate. A total of 74 students were admitted in Autumn 2018, 55 in the MPH program, 14 in Global Health PhD programs, and five in the PhD in Pathobiology. The diversity of these incoming students was 67% female, 50% Caucasian, 13% Asian American, 8% African

American, 8% Latin American or Hispanic, 2% other, and 23% international students (50% Asian, 36% African, 7% Latin American, and 7% Oceanian). There were 20% students from underrepresented minorities (*UW DGH 2018 Annual Report*, 2018, p. 25).

For the purpose of this study, the selected population excludes members of SPH departments who are not directly related to the DGH. As of December 2017, the total SPH DGH students, staff and faculty was 669, including students who completed PhD, MPH and Certificate programs during the 2016 academic year and current students in PhD, MPH and Certificate programs. Staff refers to individuals working in administrative roles for SPH DGH programs. Faculty include core, adjunct, clinical, and affiliate faculty working in the DGH program as of December 2017. Two DGH listservs included 432 faculty, one had 87 core faculty and the other 345 adjunct, clinical and affiliate faculty members. The listserv for GH staff had 28 members. The total student sample was 237. A total of four listservs reached 140 master's students including 54 First year, 48 Second year, and 20 Continuing MPH-GH students, respectively. There was also a list for 18 MPH-GH 2017 graduates. The PhD listservs had 62 students, of which, 11 were in GH Metrics, 24 in GH Implementation Science, and 27 in Pathobiology. The Graduate Certificate program listserv included six students in Global Health, one in HIV and STIs, and 28 Global Health of Women, Children, and Adolescents, for a total of 35.

The DGH “encourages and supports the multiple identities of staff, faculty and students including, but not limited to, socioeconomic status, race, ethnicity, language, nationality, sex, sexual orientation, gender identity and expression, culture, spiritual practice, geography, mental and physical disability and age”. One way in which the DGH is taking action to increase the diversity of its students is by creating opportunities for underrepresented minoritized students (URM). In May 2018, Dr. Carey Farquhar explained how the Endowed Fellowship for Global Health Excellence, Equity and Impact supports the recruitment and retention of a few URM

students. Without this fellowship, some of these students would not have been able to participate and complete a graduate degree and others would be facing additional challenges.

The Fellowship for Global Health Excellence, Equity and Impact empowers its awardees to share their diverse perspectives and enrich the overall learning experience of all students in their programs. Dr. Farquhar asserts that increasing diversity and promoting inclusion is a collective responsibility. She highlighted the importance of balancing the burden of the few current UW DGH URM faculty to promote diversity and mentor URM students (*Advancing access, opportunity, and justice for all: UW'S endowed fellowship for global health excellence, equity, and impact.*, 2018).

A Graduate School Diversity-Report completed in 2013 indicates that quality mentorship is more than a match between faculty and students who have similar cultural backgrounds. It must be a sustained investment of all faculty and school leadership (UW Graduate School, 2013). Some of the findings of this report are consistent with recommendations provided by Bezruchka, (2010), Boardman (2015), Boysen (2012), Doorenbos, Schim, Benkert, and Borse (2005), Endicott, Bock, and Narvaez (2003), Greenwald (2011), IOM (2003), Lu (2017), Moskowitz and Li (2011), Narvaez and Hill (2010), Park et al. (2006), Sabin et al. (2009), Smedley et al. (2003). Staats (2014), Stone and Moskowitz (2011), Sue (2010a, 2010b), Sue et al. (2009), Sukhera and Watling (2018), Teal et al. (2012), and van Ryn and Saha (2011). Consequently, in addition to increasing the number of URM faculty, this report emphasizes the importance of embedding and actively discussing diversity content in the curriculum. Furthermore, faculty must use culturally responsive pedagogies and evaluation strategies to create a positive learning experience for all students. When students acquire knowledge about and understand the importance of valuing diversity, they also increase their cross-cultural communication skills and ability to provide culturally responsive services after graduation.

In an effort to address students concerns about gaps in the existing curriculum, in January 2017, the DGH supported the work of the DGH Curriculum Development Caucus (Caucus), a student group that led efforts to share their perspectives on the strengthening of the MPH GH curriculum to increase equity. In partnership with faculty and staff, these students created and proposed a new curricular model, promoting the inclusion of relevant knowledge and practical skills to provide culturally responsive services to diverse local and global populations.

Caucus members advocated for inclusion of relevant stakeholders in decision-making processes impacting students' learning and demanded that current and incoming students receive world-class global health education in an inclusive, diverse, and safe environment. In 2018, the SPH began a process to develop a new MPH curriculum. The model presented by the Caucus was used, along with many other resources to inform the creation of the new MPH curriculum. During the first phase of the MPH Re-envisioning work, Caucus members engaged students and graduates from other SPH MPH programs. Participants representing different MPH departments provided feedback and shared experiences with their respective programs, contributing to the development of the new MPH Core Curriculum.

In the DGH, SPH and UW as a whole, the strategies used to increase equity and improve campus climate have gone further than improving required curriculum. The UW has increased extracurricular activities. Over the years and across the different UW schools, several workshops, courses, and seminars have been offered to faculty, staff, and students with the goal of improving campus climate, increasing teaching and learning outcomes, and developing high quality professionals able to address persistent health disparities. In 2019, the DGH supported efforts of students to create a Global Health Students Association. Over the school year, students had the opportunity to attend weekly meetings to increase cross-cultural interactions, organize and participate in activities and workshops supporting curriculum development and supporting

diversity, equity, and inclusion. At the end of the year, the department approved financial support to continue supporting Global Health Students Association activities during the year 2019-2020.

No empirical studies assessing how well-prepared the SPH DGH students, staff, and faculty feel to interact in cross-cultural settings within and outside campus have been published. Although each program might offer a variety of courses that directly or indirectly address issues of cross-cultural communication, race, equity, and inclusion, most of these courses are not required. In addition, the SPH currently does not have a process in place to complete comprehensive assessments of the readiness of students, staff, and faculty to address cross-cultural issues within the institution, during students' practical experiences, and ultimately when getting incorporated into their respective fields of work after graduation. Furthermore, diversity values and cross-cultural communication among health care professionals have been specific to medical, pharmacy, counseling, and other related health fields (Bezruchka, 2010; Boardman, 2015; Boysen, 2012; Doorenbos et al., 2005; Endicott et al., 2003; Greenwald, 2011; IOM, 2003; Lu, 2017; Moskowitz and Li, 2011; Narvaez and Hill, 2010; Park et al., 2006; Sabin et al., 2009; Smedley et al., 2003; Staats, 2014; Stone and Moskowitz, 2011; Sue, 2010a, 2010b; Sue et al., 2009; Sukhera and Watling, 2018; Teal et al., 2012; van Ryn and Saha, 2011).

This study focusses on the experience of public health students, faculty and staff at the SPH Department of Global Health. The rationale used to select this department as a research community is that global health professionals are an important part of the School of Public Health and the health care professions workforce. Global health graduates provide services to diverse populations at the national and international levels. Understanding their perceptions and identifying and addressing existing gaps in their cross-cultural communication skills are directly related and relevant to the elimination of health disparities and the promotion of health equity in the U.S. and the world.

Research Questions

Power and privilege imbalances impact learning, teaching, and practical experiences of the current and future health professions workforce. The levels of multicultural education training and interactions with members of diverse cultural groups can influence the ability of HCPs to address inequities on health and the growing disparities experienced by racial, ethnic, and other vulnerable populations. This study focuses on the primary question:

How do students, staff, and faculty in the UW SPH DGH program describe their preparation, skills, and readiness to work in cross-cultural settings?

It uses a subset of questions to unravel participants responses, including:

- 1) What training pertinent to cultural diversity and cross-cultural communication are offered by this university, specific department, and program being assessed?
- 2) How training received, or the lack of it, impacts the knowledge, awareness, skills, and attitudes of students, staff, and faculty towards populations with backgrounds different than their own?
- 3) How the respective programs and department prepare their members to effectively and responsively work in culturally diverse settings?
- 4) From the perspective of participants, what are the perceived training and practical gaps?

Research Design

This study has a cross-sectional exploratory, sequential, and inductive design developed with a mixed methods approach, including data collected from a survey, interviews, and observations. In the quantitative portion, participants responded to a survey that gathered general demographic and educational information; cross-cultural responsive communication skills,

knowledge, awareness, and attitudes to serve diverse populations; and perceived quality of interactions during different stages of pre-and in-service preparation. In addition to completing the survey, selected participants were invited to share additional information through individual interviews. The qualitative portion of the study was designed to gain in-depth insights into the educational experiences of participants, sense of readiness before and after completing voluntary or required practices, and while studying and working in cross-cultural settings.

The interpretivist approach used was appropriate to answer the research questions of this study because it looked to create understanding instead of predicting, making the research inductive and exploratory by nature. It allowed for the use of descriptions to explain a phenomenon as they naturally occurred. This research shows how perceptions, knowledge, awareness, skills, and attitudes about diverse populations in healthcare can be related to each other and how they affect intended outcomes. The knowledge generated is relative to the time and context in which the study was conducted, and to the cultural perceptions of each participant. Elements of cultural humility and culturally responsive pedagogy were used to help participants explore their beliefs about cultures different than their own.

Data Collection

In the quantitative portion of this study participants respond to a survey designed to gather demographic and educational information. It explored their perceptions about necessary and acquired cross-cultural communication skills, knowledge, awareness, and attitudes to serve diverse populations. The domains included in the survey allowed accessing a broader number of individual perspectives, helping obtain an overview of the training and experiences of participants. Participants also included short comments by answering a few open-ended questions. Survey findings informed the development of interview questionnaires used to collect

qualitative data. Qualitative data of the study was collected through interviews. It was used to explain and expand on data collected in the initial survey. While quantitative data collected allowed for understanding of numerical variations between domains and their relationships, the qualitative data emphasized the value of discovering and understanding individuals' perspectives. Both approaches have interest in improving practices.

The qualitative data was collected using a philosophical lens necessary to provide in-depth descriptions (Decuir-Gunby, 2017; Rubin, 2012). Similar to Hutchison-Green, Follman, and Bodner (2008), the qualitative data included describes the perceptions of students, faculty, and staff about the impact of training on their levels of cultural humility and readiness to interact with members of culturally diverse populations and cross-cultural settings. It narrates some of the tensions and successful outcomes experienced or observed by participants while confronting biases, linguistic, cross-cultural, ethnoracial, and other challenges as well as individual, systemic, and structural discrimination (Hutchison-Green, Follman, and Bodner, 2008). The examples and stories shared by participants helped provide detailed, rich, and thick descriptions to complement the initial background information. They revealed their perceived sense of cross-cultural readiness before and after completing voluntary or required training and practical work (Corbin, 2015).

The assigned meaning to activities and social experiences explained by participants helped uncover and construct knowledge (Corbin, 2015). All data was gathered, coded, and classified through a reflexive process that helped identify issues (Glesne, 1992, 2016; Merriam, 2009). This method allowed for presenting in-depth perspectives of individual experiences, perceptions, knowledge and attitudes. It also offered the opportunity to identify gaps and provide practical recommendations for improvement and promotion of social change (Creswell, 2011, 2018; Decuir-Gunby, 2017; Glesne, 2016; Merriam, 2009; Zheng, 2015). The data collected was

appropriate to answer the research questions of this study. It allowed the development of initial findings, triangulation of information, complementation of findings, and expansion of information (Decuir-Gunby, 2017). Particularly the qualitative data collected increased understanding of the consequences of biases towards ethnic/racial and other minoritized populations (Delgado and Stefancic, 2013; Klassen, Creswell, Plano Clark, Smith, and Meissner, 2012). It described how individuals who do not explicitly recognize their bias can implicitly be biased against other individuals (Banaji, 2016). The experiences shared by students, staff, and faculty, can help health profession schools raise awareness about and address the effect of implicit and explicit biases on health disparities, develop strategies to increase participation and understanding of URM in health profession schools, and develop a workforce that can provide quality health services health and other services to diverse populations.

A theory of action is presented in Figure 3.1. It is a design for a Humble and Culturally Responsive Path for Equity in Health Professional Schools developed by the investigator. It illustrates different steps and components needed to create and maintain a continuous flow of elements relevant to the elimination of health disparities. The model proposes the exploration of perceived preparedness of students, staff, and faculty to interact in cross-cultural settings. It starts by gathering demographic, educational and practical information relevant to participants' cross-cultural preparation. It explores how perceptions might impact individuals' understandings and experiences with members of diverse cultural groups. It describes self-reported knowledge, awareness, skills, and attitudes to interact with members of diverse populations and explores how the perceptions of students, staff, and faculty might impact their experiences with members of different cultural groups.

Data collected and analyzed allows the identification of strengths and gaps on levels of preparation of participants. As a next step, there is the creation of a culturally responsive

teaching and learning model. This model must include periodic evaluations, identifying gaps and gathering recommendations to continue strengthening the participating program. This framework uses an interdisciplinary lens addressing the intersectionality of culturally responsive teaching, cultural competence, cultural humility, and cross-cultural communication. It seeks to achieve health equity and reduce health disparities through the preparation of a humble and cross-culturally responsive health professions workforce.

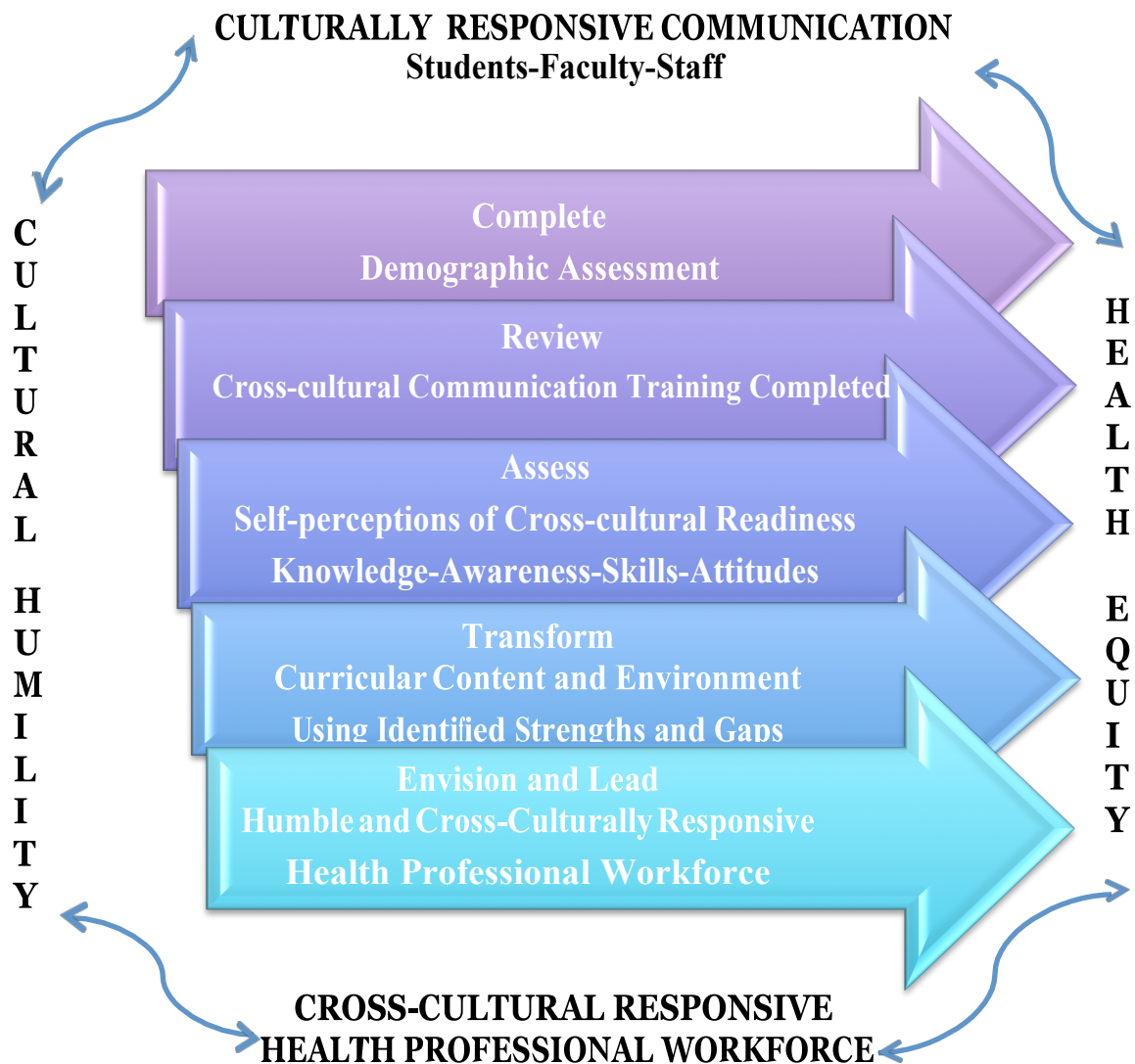


Figure 3.1. Theory of action: Humble and Cross-Culturally Responsive Equity Path for Health Professional Schools

Participants

Participants in this study include students in the Department of Global Health PhD, MPH, and Graduate Certificate programs, staff and faculty, as of December 2017 and March 2019. In December 2017, a total of 115 DGH members agreed to participate. There was a total of 49 students. Total students included fourteen PhD students (three in Metrics, four in Implementation Science, and seven in Pathobiology), 32 MPH students (13 first year, 11 second year, two continuing, three Graduate Certificate in GH, and three Graduate Certificate in Women, Adolescent, and Children health), and there were four MPH 2017 graduates. The total faculty responding was 39. It included 13 core, 13 adjunct, four clinical, and nine affiliate faculty. Lastly, the total number of staff members consenting to participate was 27. Staff programs or position levels were not identified. A total of 14 DGH members participated in interviews. Four faculty, four staff, and six students.

Quantitative Data Collection and Analysis

The Cultural Competence Questionnaire Demographic, Knowledge Awareness, Skills, and Attitudes (CCQ-DKASA) was created and assessed for use in this study. This instrument, relevant to public health, medical, and other health services students, faculty and staff was developed after reviewing scholarship examining professional counseling, medical self-reported multicultural knowledge, and medical curriculum (Boardman, 2015; Narvaez and Hill, 2010; Ponterotto and Potere, 2003; Wetzel, 2013).

The CCQ-DKASA was created by the investigator using, as a foundation, the Clinical Cultural Competency Questionnaire (CCCQ) and some identical and modified items from the Multicultural Experiences Questionnaire (MEQ) and the Tool for Assessing Cultural Competence Training (TACCT). These instruments have been used to assess populations in the

medical, pharmacy, counseling, and other related health fields. In the public health field, there is not a specific instrument to assess students, staff or faculty perceptions about cross-cultural communication. Therefore, the CCQ-DKASA was developed to be relevant to both public health and medical services, and to include students, faculty and staff in both fields. The instrument was sent to the sample population including a five-item statement section that was used as a preliminary evaluation of the tool. The evaluation gathered feedback from survey takers with regards to the clarity, relevance, language, and timing of the survey. It measured the overall quality of the instrument in relation to the project goals.

For this study, participants were asked to discuss their experiences in the DGH at the SPH, even if they were also part of a program at the School of Medicine (SoM). The investigator completed an in-depth literature review and through assessment of the items included in the CCQ-DKASA. The instruments reviewed included the Multicultural Counseling Knowledge and Awareness Scale (MCKAS); a revised MCKAS (MCKAS-R); the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS); Tool for Assessing Cultural Competence Training (TACCT); the Multicultural Experiences Questionnaire (MEQ); and the Clinical Cultural Competence Questionnaire (CCCQ) (Like, 2011). The CCQ-DKASA uses as a base the Clinical Cultural Competency Questionnaire (CCCQ), developed by Robert C. Like, (2001) (Appendix A permission of adaptation). The instrument also includes some items of the Multicultural Experiences Questionnaire (MEQ) For College Students and Adults developed by Darcia Narvaez (Endicott et al., 2003; Narvaez and Hill, 2010). (See Appendix B permissions for adaptation). General aspects similar to the Tool for Assessing Cultural Competence Training (TACCT) also are reflected in this tool. Some of the factors considered during this revision were increased awareness and insights about the concepts, language used, domains, items, scales

included, and strategies to validate, define reliability, and establish internal consistency of the instrument.

The CCQ-DKASA is an electronic survey instrument that includes 32 items distributed in five domains. Attachment D presents a copy of the CCQ-DKASA electronic survey sample. The domains are composed as follow:

- Section A. Items 1 to 16 comprise Demographic Data, pertaining to the status of participants in their respective programs, including education outside of the U.S.; languages spoken; cultural groups and environments with which participants have interacted; received training in cultural diversity, cross-cultural communication and biases; and their age, gender, sexual identity, and racial and ethnic background.
- Section B. Items 17 to 19 discuss perceptions of participants about their knowledge of health-related issues impacted by race, ethnicity, age, gender, sexual orientation, laws and regulations, discrimination, and biases.
- Section C. Items 20 to 25 discusses participants' awareness of their own identity and the identity of the people they interact with; the impact of biases and prejudices during cross-cultural interactions; and organizational commitment to equity, diversity and inclusion.
- Section D. Items 26 to 27 inquire about skills needed to interact with people from diverse cultural backgrounds and deal with challenges faced during cross-cultural interactions.
- Section E. Items 28 to 32 describes participants' attitudes toward issues impacting health disparities; the importance of understanding cultural differences when interacting with people with diverse cultural backgrounds; training opportunities to

eliminate biases and discrimination and caring for individuals from diverse cultural backgrounds.

Some of the items within each category have multiple questions or statements. Response options included in this instrument are a combination of simple selection, multiple-choice, Yes/No, checkbox responses, Likert type scale items, and open-ended invitations. Items addressed the role of participants in the institution; studies outside of the U.S.; cultural groups most encountered; and aspects of race, ethnicity, gender, sex, socio-economic status, and disability. The instrument also includes questions related to living and working environments, languages spoken and levels of language proficiency, training, and individual identity.

Likert-type rating scales were used to determine how knowledgeable and aware students, faculty, and staff feel about the subject assessed and their perceptions of their skills and attitudes necessary to address cross-cultural situations. It also includes some evaluation questions that use a variety of scales with options between three and seven points and a Likert-type scale with five response choices. The responses to these items have assigned values from one to five, ranging from Strongly Disagree, Disagree, Somewhat Agree, Agree, and Strongly Agree. The descriptive survey data will be presented as preliminary evidence of the context in which SPH DGH students, staff, and faculty perceive their preparedness to interact in cross-cultural settings considering the impact of the training they have received on changes in their beliefs, knowledge, attitudes, and behaviors when addressing issues related to a) linguistic, cross-cultural, and racial diversity, b) individual, systemic and structural discrimination and c) social justice and equity.

Email invitations to participate in the survey included an introduction to the researcher, description of the topic and the project goals, and words of encouragement. It explained how the data would be analyzed and protected. All data collected was analyzed in aggregate for each category of participants. Individual responses were kept anonymous, strictly confidential, and

saved in a password-protected computer. Furthermore, no students, faculty or staff member of the SPH, DGH, and any other university school or department had access to any data that could possibly be used to identify an individual. The University of Washington Institutional Review Board (IRB) approved all aspects of this study (See Appendix C). The potential participants were informed through email about the approximate time needed to complete the survey and the voluntary nature of their participation. The invitation email also contained a link to the CCQ-DKASA. By accessing the link participants agreed to the inclusion of their responses as a part of the study.

The CCQ-DKASA included five-item evaluation statements: 1) The questions provided appropriate response scales; 2) The questions were relevant to cross-cultural communication; 3) The time taken to complete the survey was reasonable; 4) The questions in each section were clear and easy to understand; and 5) content was relevant to my communication at school or work. Responses to these evaluation statements were used to determine the internal consistency, reliability, and validity of the CCQ-DKASA as an appropriate instrument to assess SPH students, staff, and faculty perceptions of readiness to work in cross-cultural settings. A total of 115 participants completed the CCQ-DKASA. Of these, 105 answered the first evaluation statement; 107 answered the second and third evaluation statements; 106 answered the fourth statement; and 107 answered the fifth statement.

The IBM SPSS Statistics package (version 25) was used to organize and manage the CCQ-DKASA quantitative data and to analyze responses to the CCQ-DKASA evaluation statements. **SPSS Statistics** is the most recent version of the SPSS Statistics traditional software license. This software, originally developed for the Social Sciences, has also been used in other fields including health sciences (Blanksby, 2006). SPSS Statistics is used by social, education, and health researchers, survey companies, government agencies, and other organizations. In

addition to statistical analysis and data management, it is used for case selection, file reshaping, and creating derived data. This software allows data documentation including a dictionary of the data in the data file. SPSS degenerated response frequencies for CCQ-DKASA items and descriptive statistics including item means, standard deviations, medians, and ranges.

During the preliminary evaluation of the survey, inferential statistics were used to make statistical comparisons between groups and included analysis of variance (ANOVA) and t-tests. Chi-square tests were used to examine relationships between categorical variables (Aljandali, 2016; Stehlik-Barry, 2017). The only significant difference in answers by category of participants was to question five in which the Staff mean of 3.09 was significantly lower ($p = 0.007$) compared to faculty mean 3.49 and students mean 3.87. The Cronbach Alpha estimates of the evaluation of these statements showed internal consistency for all participants and with each group. Alpha values ranged between 0.75 and 0.79. This is a normal range based on participants' responses. Data analysis showed no significant differences by gender, sexual identity, and racial background of the participants. There were no significant relationships (all $ps > 0.05$) between age and the survey items.

The assessment of internal consistency of the five-item evaluation demonstrated evidence of reliability. The integrated evaluative judgment of the CCQ-DKASA's reliability and validity provided preliminary evidence that inferences can be made for the different respondent groups completing the questions. The combination of responses to the CCQ-DKASA evaluation shows the overall quality of the instrument to achieve the project goals. The analysis of participants' responses confirmed the CCQ-DKASA's reliability, internal consistency, and construct validity to assess participants' perceptions of their readiness to interact with individuals from diverse populations in cross-cultural settings. Results of the study validating the tools were included in the report "CCQ-DKASA: A Tool to Assess Cross-Cultural Communication in the Health

Professions”. A summary of findings “Cross-Cultural Communication in Health Profession Schools: Assessment Tool Validation” is presented in Appendix D. Copy of the electronic CCQ-DKASA is included in Appendix E.

SPSS was used to conduct all subsequent descriptive statistical analyses for responses to the CCQ-DKASA. The quantitative standard data collected with the CCQ-DKASA items helped provide descriptive statistics including sample size, response rate, response frequencies, means, standard deviations, medians, and range statistics as appropriate. The analysis of data collected with the CCQ-DKASA presents descriptive information. The descriptive statistics present separate analysis for faculty’s, staff’s, and students’ responses. The open-ended questions included in the CCQ-DKASA were explored using content analysis by themes. The analysis of responses to the CCQ-DKASA items helped corroborate the reliability of the instrument and explore in depth the significant difference in the staff’s responses (Messick, 1993, 1995; Teo, 2013).

In addition to capturing formal training, the data collected in the CCQ-DKASA includes information about extracurricular training attended by participants before and during their programs. In the case of the faculty and staff, the study discusses their cross-cultural preparation before and after joining the SPH DGH program. The study includes data analysis examining students’ cross-cultural preparation before the program, after their coursework, and after their practicum and also explores staff and faculty preparation before working on the selected program and receiving any relevant cultural training. This approach helped capture changes in the knowledge, awareness, attitudes and skills of students during milestone stages of their program and examine changes on faculty and staff cross-cultural knowledge, awareness, attitudes and skills while serving in this program.

Participants provided consent for the gathering, analysis and use of information before the completion of the CCQ-DKASA (see Appendix F). Name, phone numbers, email addresses, and additional information provided to the study investigator through the CCQ-DKASA and interviews have been stored in a password-protected computer. Before individual interviews, selected participants were asked to confirm consent to participate in the study. The project investigator reviewed with each participant the objectives of the study to validate understanding and to ensure the information provided is clear. The investigator informed participants about their rights to withdraw from the study at any time and ensured that the consent process was ongoing from the initial interaction throughout the development and completion of the study. Participants had the opportunity to determine their anonymity or express desire of recognition in the report narrative when appropriate.

Qualitative Data Collection and Analysis

In addition to the CCQ-DKASA, the investigator developed instruments to gather qualitative data, capture qualities of participants, and explore their level of awareness about how training received and experiences in their respective programs influenced their knowledge, skills, awareness, and attitudes towards diverse populations (White, 2011). These tools helped examine the awareness of participants about additional education and training needs and their perceptions of existing gaps (Appendix G, H, I include Interview questionnaires). After completing the analysis of participants' responses to the CCQ-DKASA, the results were used as a foundation for the development of the interview protocol and the questions used for in-depth individual interview (Bernard, Wutich, and Ryan, 2017). Data collected helped with the development of recommendations for further research and actions to address training needs of selected populations during the final stage of the study.

The CCQ-DKASA results provided context to guide the development of questions for conducting in-depth individual interviews. Selected themes helped answer questions such as:

- What is the level of knowledge regarding diverse population demographics, sociocultural characteristics, stereotypes, health risk and health disparities reported in each participants' category (students, staff, and faculty)?
- How well-prepared do members of each participant category feel to meet required competencies in their respective fields of work?
- How well-prepared do participants feel to interact and serve their target audience?
- How knowledgeable are members of each participant category about the U.S. and global history of discrimination and the laws and policies created to increase equity?
- What is the level of awareness that members of each participant category report about self and others individual identities?
- How aware are members of each category about institutional efforts to increase equity, diversity, and inclusion?
- How well-prepared participants of each category feel to maintain cross-cultural interactions and solve conflict related to those interactions?
- What is the percentage of members of each participant category that report attitudes related to cultural humility?
- Which participant category reports having received the most diversity training in their current program?
- Where (in the institution or outside the institution) and in which modality (curricular, extracurricular) do each participant category report having received their diversity training?

The online CCQ-DKASA invitation and instrument sent to participants included an invitation to participate in individual interviews. A total of 24 respondents indicated interest in participating in individual interviews. Of the total respondents five were current second year MPH, four MPH graduates, and one Graduate certificate, and two PhD students. Faculty volunteers included three core faculty, two clinical faculty, and one affiliate faculty. The total staff volunteering for interviews was three. The selection criteria for interviews was as follows: Six students, including two PhD, two second year MPH, and two recent MPH graduates; four faculty members, including two core, one adjunct and one affiliate, and four staff. Randomly selected volunteers received an invitation email to participate in individual interviews. The investigator participated in diversity committee meetings in the institution and observed admission processes in a different health profession school. During these limited observations, the investigator was able to capture some of their cross-cultural communication dynamics. In diversity committees, some participants, particularly individuals from minoritized groups were often silent. At least in two occasions, committee members clarified to the investigator that this silence is oftentimes caused by continued disregard of their comments by other members who happen to be from dominant groups. Regardless of their silence during meetings, these committee members reviewed documents such as a checklist to guide search and hiring committees in the recruiting, interviewing, and hiring processes. They provided written suggestions asking for the use of this checklist by all search committees in their school and discussed the organization of brown bag sessions to discuss diversity topics. The investigator witnessed some of the strategies used by an admissions team. They worked along with interviewing faculty to ensure that the applicants from all backgrounds are treated fairly by their interviewers and have equal admission opportunity to their program. These observations were used to triangulate data provided by participants in the survey and interviews.

The qualitative analysis focuses on understanding behaviors, thoughts, and emotional and environmental conditions that have impacted the way participants behave, think, and feel (Bernard, Wutich, and Ryan, 2017). The dynamic, free-flowing process used for this study allows the researcher and participants to become part of research as much as the data collected. It is a holistic and comprehensive approach developed to humanize the research by exploring social conditions that can lead to findings to increase social justice (Corbin, 2015). The analysis of qualitative data collected required deep thinking and profound awareness of environmental factors surrounding the information collected, as well as the research questions the investigator tried to answer (Creswell, 2011, 2018; Miles, Huberman, and Saldana, 2014). Close attention was given to emerging patterns. These patterns were used to identify codes, categories, and themes.

Particularly, coding was used as a tool for reflection, thorough analysis, and interpretation of the meaning contained in the collected data. Considering that codes alone do not provide the full story, the narrative reflects the reasoning and presents a synthesis of information embedded in the raw data (Creswell, 2011, 2018; Miles et al., 2014). Most interviews were video, and audio recorded. Each interview took approximately one hour (60 minutes). Interviews were recorded using an Olympus digital voice recorder. All interviews, with exception of one made using telecommunication, Skype, an application that specializes in providing video chat and voice calls through computers, were also video recorded using Apple Photobooth a software application for taking photos and videos with an iSight camera. This allowed the investigator to avoid getting distracted taking notes during the interview.

Data collected were transcribed the same or within the following two days of the interview. The investigator used transcription protocols established by research methodology scholars to ensure the appropriate and adequate preparation of transcripts from digital video and

audio recordings and to track and store audiotaped materials, ensuring its confidentiality, reliability, and validity (McLellan, Macqueen, and Neidig, 2003). During the process of transcriptions, the transcriber a) Protected the morphologic naturalness of transcriptions by retaining word forms, commentaries, and punctuation as close as possible to speech presentation and ensured they were consistent with what is typically acceptable in written text; b) Preserved the natural structure of the interview; c) Made the reproduction, avoiding to correct mispronunciations, jargons, and non-verbal sounds d) then, adjusted it to everyday language rather than academic jargon and prepared transcripts appropriate for human and computer use; and e) Used transcription rules, ensuring sensitivity to participants, other researchers, and stakeholders (McLellan et al., 2003).

Steps to complete data analysis included 1) Collect data; 2) Code data; 3) Organize concepts; 4) Elaborate patterns 5) Link categories; 6) Create an explanatory model. The repetition and constant comparison of evidence and theory helped draw conclusions. After the completion of transcripts, data provided by each interviewee was classified using themes. These themes were selected combining common areas discussed in the interview questionnaire and additional information shared by participants. Data was organized in seven themes saved in a separate sheets of an Excel document created for each group of participants. These themes included responses to all questions, demographics, training, skills, DEO policies, impact of diversity on learning, and successful strategies to address tensions and issues of power and privilege in the educational and working environments. This information was then separated by domain and responses used to provide rich descriptions to findings identified in the CCQ-DKASA and additional experiences shared by participants that were related to each domain.

The presentation of findings went beyond simple interpretation, including sociolinguistic and cultural aspect included in the spoken, and unspoken discourses (Bernard, Wutich, and

Ryan, 2017; McLellan et al., 2003). To accomplish this, the unspoken language used by participants during the interviews was embedded in the respective transcription being careful to differentiate them from verbal content of the interviews. For example, these would include non-verbal responses, such as nodding, shaking head, raising eyebrows, expressions of surprise, disapproval, and disappointment as well as nuances of non-verbal sounds (N. J. Gordon and Fleisher, 2006; Meenakshi and Sangeeta, 2015). After transcribing and organizing each document for first stage analysis, the investigator selected material to be included in the findings of the study. Participants were asked to review selected information for accuracy, authenticity, and comfort. Chapter IV, V, VI, and VII present analysis and summaries of data collected with the CCQ-DKASA and during interviews. These identify key findings and recommendations presented by participants. Chapter VIII establishes relationships between some of the findings and existing scholarship reviewed. It presents recommendations for further studies and actions.

The investigator designed the survey and interview questionnaires which were the instruments for data collection and analysis. According to (Merriam, 2009), the interpretations of the realities studied through observation and interviews strengthen the internal validity of qualitative research. Potential threats were identified and addressed. For example, the investigator's communication may have impacted responses of participants. For this reason, she made conscious efforts to monitor her biases and subjectivities during the development of tools, data collection, and interpretation of the data collected. These efforts included review and feedback from scholars who have interdisciplinary perspectives, other college students in the respective fields, and individuals with limited understanding of the topic explored. Reviewers had diverse cultural backgrounds. This process aimed to prevent prompting specific responses from and ensuring questions could be equally interpreted by participants. Furthermore, the investigator presented the context of the study including the characteristics of participants, the

nature of their interactions, and the environment in which the study took place (Tolley, Ulin, Mack, Robinson, and Succop, 2016; Ulin, 2005).

Researcher Positionality

In research, particularly in qualitative research, the researcher is one of the instruments of data collection and analysis. It increases the importance for researchers to clearly establish their positionality and how they attempt to keep their own biases and possible power imbalances in check. According to Creswell (2018) reviewing positionality is a measure of validity and quality control of the research. As a part of the framework of this study, the investigator encourages increased awareness about individual knowledge of, skills, and attitudes towards the topic and subjects of investigation. This self-reflection seeks to increase transparency about the experiences and background of the researcher.

The investigator of this study is a native Spanish speaking woman from Venezuela and a U.S. citizen with English proficiency. She has basic knowledge of French language and European culture, and moderate knowledge of Latin American and Caribbean cultures. She has high levels of awareness of U.S. culture, including discrimination against people based on ethnicity and foreign accent. After years of work in the health field, she believes that one way to address existing disparities is by understanding and addressing educational disparities of health professionals. Health professions and other schools must continue to work diligently to prepare all students, staff, faculty, and active health professionals to address biases, discrimination, and social and health inequities.

The researcher uses different methods such as participants' feedback and self-reflection to increase awareness of her own biases. She is also aware of different frameworks in which societies classify individuals, and how members of dominant populations have been taught to

consciously and unconsciously stereotype and make group distinctions at an early age. The researcher has learned to interact with diverse populations, value differences, and respect diverse points of views. Her educational and personal experiences and her work with members and leaders of communities, public health, and other health care organizations have enriched her perspectives. She recognized the effects of power and privilege on health and educational outcomes and the importance of ensuring that the voices of historically marginalized populations are heard. The investigator supports social justice, equal treatment, diversity, inclusion, and equity.

Ethical Considerations

The principal investigator of this study followed respective protocols to obtain Individual Review Board (IRB) approval; consent from participants, department and schools; maintain confidentiality; and develop an atmosphere of mutual trust, dignity and respect with participants and the community involved. As a human instrument for this research, the investigator minimized and kept in check biases and possible misinterpretations of data gathered. This was achieved following Glesne's (2016) triangulation approach and corroborating the interpretation of data with participants. Furthermore, the investigator regularly acknowledged that personal biases could limit her views. She kept in mind her personal identity and perspectives, especially when interviewing and analyzing data collected for the study. This should have allowed for maintaining high levels of objectivity to present findings and recommendations.

Expected Outcomes

This cross-cultural and intercultural communication study seeks the advancement of interdisciplinary and diverse perspectives to achieve equity; inform practical interventions; and enhance curriculum, content, and the written and unwritten policies dominating the environment

in health profession schools. It may contribute to understanding student, staff and faculty views about acquired training, perceived gaps, and effects of their ability to learn, teach, and provide quality services in cross-cultural settings to culturally diverse clientele. This study uses evidence from individuals' experiences to provide recommendations necessary for the development of further interventions. It may help improve institutional climate, quality, and professional development by fostering intercultural learning, respect, ethical work, and mutual understanding.

Summary

Race, ethnicity, disability, age, gender and religious identification are among the factors directly related to increasing health disparities and other inequities in minoritized populations. Unfortunately, health services and practices have been influenced by health care professionals' (HCPs) discrimination, biases, and prejudices against members of diverse cultural groups. HCP's lack of humility and cross-cultural communication knowledge, awareness, skills and attitudes to serve diverse populations play a relevant role in the promotion of health equity. For this reason, it is important to understand and increase efforts to develop a HCPs workforce that is aware, activated, and poised for dismantling systems of oppression, reduce health disparities, and lifting up members of all the communities served by UW graduates, especially those in health profession schools.

In health professional schools, most studies addressing issues of cross-cultural communication have been focused on medicine, pharmacy, counseling, social work, and other students and professionals. This study explores the perceptions of members of a Public Health school, including students, staff, and faculty with regards to their readiness to interact in cross-cultural settings. A mixed-methods approach is used to gather quantitative and basic qualitative data important to guide the collection of in-depth perspectives from participants through

individual interviews. A solid view of the steps to complete the study included the selection of and outreach to the sample population as well as the clear description of the data collection and analysis plan.

Chapter IV

Demographic Domain Results

Before examining the CCQ-DKASA and interview data, statistical analysis of the internal consistency of the CCQ-DKASA was completed to determine its reliability. These results are presented as an introduction to and framework for interpreting the responses provided by participants. The outcomes of information shared by participants in the Demographic domain are presented in this chapter, including basic characteristics of types of participants, ranks, and respective programs. It is followed with information about their race, ethnicity, gender, sexual identity, age, and experiences with cultural groups encountered most frequently. The chapter concludes with training factors reported by participants on the CCQ-DKASA and in interviews.

The data in this chapter facilitates understanding the analysis presented in Chapter V Knowledge Domain, Chapter VI Awareness Domain, Chapter VII Skills and Attitudes Domains, and Chapter VIII Summary, discussion, and recommendations. Each chapter presents a table with the items contained in respective domains, descriptive statistics for the means by participants responses on the CCQ-DKASA, analysis of reported scores, figures showing the median response by participating group, and descriptions of level of knowledge, awareness, skills, and attitudes derived from interviews.

CCQ-DKASA Domains, internal consistency and reliability

The Cross-Cultural Communication Questionnaire Demographic, Knowledge, Awareness Skills, and Attitudes (CCQ-DKASA) contained 32 questions distributed among the domains of Demographics, Knowledge, Awareness, Skills, and Attitudes. A description summary of aspects explored within each of the five domains of this survey are presented in Table 4.1. The entire

CCQ-DKASA is included in Appendix I. The IBM SPSS Statistics package (version 25) was used to organize, manage, and analyze responses of 115 participants who completed statements included in the electronic CCQ-DKASA.

Table 4.1

CCQ-DKASA Domains

Domains	Descriptions
Domain I	Basic demographic data such education, age, gender, sexual identity, and racial and ethnic background.
Domain II	Knowledge about health-related issues impacted by race, ethnicity, age, gender, sexual orientation, laws and regulations, discrimination, and biases.
Domain III	Awareness about identity, biases, prejudices, equity, diversity and inclusion.
Domain IV	Skills to interact with people from diverse cultural backgrounds.
Domain V	Attitudes toward issues impacting health disparities, and cultural differences across diverse cultural backgrounds.

To establish internal consistency and reliability of the scales used in the CCQ-DKASA, Cronbach Alphas were calculated for each of the domains. The data in Table 4.2 indicate that the items included in each domain were internally consistent for respondents by both total and separate groups. For each group, Cronbach Alpha values were within generally acceptable levels (Cronbach's Alpha >0.70). These results show how closely related the items were collectively. The levels ranged between 0.73 to 0.97 for all respondents. Only in responses provided by faculty in the awareness domain did the Cronbach Alpha level reveal that the scale might not be sufficiently reliable to use.

Table 4.2

Cronbach's Alpha Internal Consistency Estimates for All Respondents

Cronbach's Alpha by Respondents Type					
Domain	Items	Total	Students	Faculty	Staff
Knowledge	20	0.97	0.97	0.98	0.97
Awareness	21	0.72	0.76	0.62	0.79
Skills	20	0.93	0.91	0.94	0.93
Attitudes	33	0.89	0.87	0.91	0.89

Calculation of One-way ANOVA (Analysis of Variance) provided differences between means for scale values used in each domain, and for categorical variables such as gender, sexual identity, age, race and ethnicity. These analyses did not reveal significant differences across groups. This can be interpreted to mean that all groups responded similarly to the level of perceived awareness, skills and attitudes. There were some minor differences for the knowledge scale scores for the participants by groups, age, gender, sexual identities, race, and ethnicity. They are presented in Table 4.3 ONEWAY ANOVA by respondent type, gender, sexual identity, age, and race and ethnicity.

Basic Demographic Analysis of Variance

For the purpose of this study demographic factors were limited to the rank or program, age, gender, sexual identity, race, and ethnicity, gender pronouns, and training factors reported by participants within groups for the DKASA and interviews. The basic demographic results include subgroups of student and faculty respondents. These subgroups were identified and the percentage and frequency per respondent subgroups included. Subgroup sizes by some age ranges were too small and not representative of the whole DGH population for the results to be

Table 4.3

ONEWAY ANOVA by Respondent Type, gender, sexual identity, age, and race and ethnicity

Respondent		Type: Student Staff, Faculty					Gender Identity					Sexual Identity				
ONEWAY ANOVA		Sum2	df	Mean2	F	Sig.	Sum2	df	Mean2	F	Sig.	Sum2	df	Mean2	F	Sig.
Knowledge groups	Between	6.03	2	3.02	5.18	0.007	0.19	1	0.19	0.30	0.59	0.73	1	0.73	1.16	0.28
	Within	65.18	112	0.58			70.78	111	0.64			69.16	110	0.63		
	Total	71.23	114				70.98	112				69.89	111			
Awareness	Between	0.12	2	0.06	0.40	0.672	0.16	1	0.16	1.10	0.30	0.01	1	0.01	0.09	0.77
	Within	16.32	112	0.15			15.98	111	0.14			16.24	110	0.15		
	Total	16.44	114				16.14	112				16.26	111			
Skills	Between	6.20	2	3.10	3.97	0.022	0.27	1	0.27	0.32	0.57	0.21	1	0.21	0.26	0.61
	Within	84.96	109	0.78			89.94	108	0.83			86.72	107	0.81		
	Total	91.15	111				90.21	109				86.93	108			
Attitudes	Between	0.79	2	0.40	2.35	0.101	0.86	1	0.86	5.14	0.03	0.03	1	0.03	0.15	0.70
	Within	18.27	108	0.17			17.96	107	0.17			17.58	106	0.17		
	Total	19.07	110				18.82	108				17.60	107			
Respondent		Age					Race and Ethnicity									
ONEWAY ANOVA		Sum2	df	Mean2	F	Sig.	Sum2	df	Mean2	F	Sig.					
Knowledge groups	Between	0.92	1	0.92	1.45	0.23	0.92	1	0.92	1.45	0.23					
	Within	65.28	103	0.63			65.28	103	0.63							
	Total	66.20	104				66.20	104								
Awareness	Between	0.0	1	0.01	0.07	0.79	0.01	1	0.011	0.07	0.79					
	Within	15.39	103	0.15			15.39	103	0.15							
	Total	15.40	104				15.40	104								
Skills	Between	1.81	1	1.81	2.17	0.14	1.81	1	1.81	2.17	0.14					
	Within	83.45	100	0.83			83.45	100	0.83							
	Total	85.26	101				85.26	101								
Attitudes	Between	0.19	1	0.19	1.10	0.30	0.19	1	0.19	1.10	0.30					
	Within	16.56	99	0.17			16.57	99	0.17							
	Total	16.75	100				16.75	100								

reliable. The analysis of groups by race and ethnicity was (U.S. Census Bureau, 2010a) established using two groups, European Ancestry and non-European ancestry, to ensure reliability. In addition, some individual items had too little variance—everyone answered the questions in a highly similar way. The assessment of internal consistency of scales for the different domains shows evidence of reliability and supports the claim that inferences can be made for the different participants who completed the survey. The combination of responses to the CCQ-DKASA evaluation shows the overall quality of the instrument to achieve the project goals. The analysis of the responses provided by participants confirmed the internal consistency and reliability of the CCQ-DKASA to assess the perceptions of participants about their readiness to interact with individuals from diverse populations in cross-cultural settings.

SPSS was used to conduct all subsequent descriptive statistical analyses for responses to the CCQ-DKASA. Quantitative data collected helped provide descriptive statistics including sample size, response rate, standard deviations, medians, and ranges as appropriate. Separate descriptive analyses were conducted for responses from faculty, staff, and students. The open-ended questions included in the CCQ-DKASA were examined using content analysis by themes. These procedures helped corroborate reliability of the instrument and explore the consistencies between test responses and the content relevance and representativeness.

Distribution of participants by respondent type

A total of 115 members of the DGH completed the CCQ-DKASA. The distribution by participant groups was 42.6 percent students, 33.9 percent faculty, and 23.5 percent staff. All respondents to the CCQ-DKASA were invited to participate in interviews. Only 21 registered to participate in interviews. Faculty were of different ranks, and students were enrolled in different programs within the DGH. Staff did not identify their position or program. Of these 21

volunteers, only nine accepted the invitation to be interviewed. Additional recruitment using snowball referral and interacting with members of the DGH produced five additional interviews. A summary of the total distribution is presented in Table 4.4.

Table 4.4

CCQ-DKASA and interview participants by respondent type

CCQ-DKASA	Frequency	Percentage	INTERVIEWS
Total Respondents	115	100	14
Total Faculty	39	33.9	4
Core	13	33.33	
Adjunct	13	33.33	
Affiliate	9	23.07	
Clinic	4	10.25	
Total staff	27	23.5	4
Total Students	49	42.6	6
MPH	30	61.22	
PhD	14	28.57	
GC	5	10.22	

Respondent by age, gender, sexual identity, race, and ethnicity

The survey results show predominant cultural groups in the DGH and within the different subgroups. The total distribution of survey respondents by age, gender, sexual identity, and racial and ethnic backgrounds is presented in Table 4.5. It is not surprising that no faculty members were within the 18-30 age category and the number of participants was greater in higher age categories. Likewise, there was no representation of students in the >60 age range, and the number of students is larger within the lower age ranges. Across groups, there were more straight or heterosexual respondents with European ancestry.

The representation of participants with non-European ancestry varied in frequency across groups between two and 16 percent. This means that the individual representation of non-European respondents was minimal. There was no representation of AIAN, NHPI, or individuals with African ancestry among staff. Only African and European American ancestry individuals were included in the group of students. According to DGH (2017), the race and ethnicity of students enrolled in the MPH and PhD programs in 2016-2017 was five percent African American, 12 percent Asian American, six percent Hispanic American/Latin American, and 23 percent international students mainly from Asia, Africa, and Latin America (DGH 2017, p. 23). In this report, the racial and ethnic backgrounds of staff and faculty were not included. There was a very small representation of male staff in the CCQ-DKASA.

The seven faculty members who initially volunteered to be interviewed were all of European ancestry, but diverse in ranks, gender, age, and sexual orientation. All volunteers received an email invitation to participate in the interviews. Four faculty responded to this invitation, but only two accepted it. Two additional were identified using snowball sampling. The faculty interviewees were of varied ranks, from junior to midlevel. They were straight: two were females and two males. There was one African faculty member and one was of European Ancestry and Hispanic background. Three DGH staff members volunteered to participate in interviews when completing the CCQ-DKASA. They worked in different positions and programs. They were of European ancestry; two were straight females and one was LGBTQ. Volunteers received an email invitation to participate in interviews, but only one agreed.

Table 4.5

CCQ-DKASA participants by age, gender, sexual identity, and race and ethnicity

Category	Rank Program	fq	%	Age Range	fq	%	Gender	fq	%	Sexual Identity	fq	%	Ancestry Race Ethnicity	fq	%	
Faculty	Core	13	33.33	>60	14	35.90	Male	21	53.85	Straight	31	79.49	European	32	82.05	
	Adjunct	13	33.33	51-60	11	28.21	Female	18	46.15	G/L	5	12.82	Asian	2	5.13	
	Affiliate	9	23.07	41-50	8	20.51				PND	2	5.13	African	2	5.13	
	Clinic	4	10.25	31-40	6	15.38				Diff. Ident.	1	2.56	Hispanic	2	5.13	
				18-30	0	0							AIAN	1	2.56	
													NHPI	1	2.56	
													DNI	1	2.56	
Staff				31-40	9	33.33	Female	24	88.89	Straight	22	81.48	European	24	88.89	
				41-50	8	29.63	Male	2	7.41	Bisexual	2	7.41	Asian	2	7.41	
				51-60	5	18.52	Queer	1	3.7	queer	2	7.41	Hispanic	1	3.70	
				18-30	4	14.81				G/L	1	3.70	AIAN	0	0	
				>60	1	3.7							African	0	0	
Students	MPH	30	61.22	18-30	24	48.97	Female	33	67.35	Straight	37	75.51	European	22	44.89	
	PhD	14	28.57	31-40	22	44.89	Male	15	30.61	G/L	6	12.24	Asian	8	16.32	
	GC	5	10.22	41-50	2	4.08	DNI	1	2.04	Bisexual	4	8.16	African	7	14.28	
				51-60	1	2.04				Queer	1	2.04	Hispanic	3	6.12	
				>60	0	0							Mixed R	3	6.12	
														Other Eth	3	6.12
														AIAN	0	0
													Mixed-eth	1	2.04	
													DNI	1	2.04	
													NHPI	0	0	
													Other race	1	2.04	

DNI. Did not identify; G/L: Gay or Lesbian; GC: Graduate Certificate; Different Identity: Diff. Ident.; Other ethnicity: Other Eth.; PDN: Preferred not to disclose

Additional recruitments were completed using snowball sampling with referrals from previous interviewees and through interactions at the DHG. A total of four staff members working for different programs in different capacities, and with different years of service were scheduled for interviews. These interviewees included female, male, straight, and LGBTQ. Two of them were of European ancestry, one was of European ancestry and had African background (raised in Africa), one was of Asian ancestry, and one had disabilities. Ten students showed initial interest in participating in interviews. These volunteers had diverse racial and ethnic backgrounds, genders, and sexual orientations. Email invitations were sent and students from each program—MPH, PHD, and Graduate Certificate program who confirmed their interviews were scheduled. Participants were assigned pseudonyms to protect their actual identities and the confidentiality of their responses. This information is included in Table 4.6.

Table 4.6

Interviewees pseudonyms and demographic data

Type	Pseudonym	Race, ethnicity, Cultural background*	Gender Pronouns*
Faculty	Lindsay	White American European descend	She, her, hers
	Charlene	White rural	She, her, hers
	Peter	African ancestry	He, his, him
	Rodrigo	Hispanic European	He, his, him
Staff	Alexis	Caucasian	He, his, him
	Jessica	Asian American	She, her, hers
	Roxy	White American	She, her, hers
	Donna	American European	She, her, hers
Students	Francis	White	She, her, hers
	Fatima	Black African ancestry	She, her, hers
	Sarah	White American	She, her, hers
	Anthony	White European	He, his, him
	Hakim	Middle Eastern, White	He, his, him
	Pablo	White Hispanic	He, his, him

- As described by participants

Student interviewees included three from the MPH program, one Graduate Certificate student, and two PhD candidates. They were predominantly White and straight; two females of European ancestry, one male of European ancestry; one female of African ancestry; one male of Arab ancestry; and one male of European Ancestry and Hispanic background. One student identified as Muslim, but others did not include religion when describing their identity. Interviewees also indicated the gender pronoun they preferred in self-referencing. Participants used various nouns and adjectives to describe their racial, ethnic, and cultural backgrounds. No students with Asian or African American background participated in interviews. Interviews with volunteer faculty, staff, and students were recorded, and most transcriptions were completed within two days of the interview.

Cultural groups most frequently encountered by participants within groups

Respondents to the CCQ-DKASA reported cultural groups they most frequently encountered during their educational and professional interactions. The results, summarized in Table 4.7, include groups from a wide range of ethnic, cultural, and economic backgrounds, individuals with disabilities, and individuals with different gender and sexual orientations. Participants had the option to add cultural groups they most frequently encounter if not included on the list provided in the CCQ-DKASA. Students added Veterans, South Asian, Middle Eastern Arabic, people from Eastern Mediterranean region (Iraqi, Iranian, Egyptian Pakistani); faculty reported multiple African groups such as Somalian, Ethiopian, and Kenyan, adding also Filipinos; and staff did not report encountering additional cultural groups.

During interviews, participating faculty, staff, and students further explained the cultural, racial, and social groups they encountered most frequently in their respective programs, department, schools, and the university at large. They indicated that composition had not

changed substantially since they joined the DGH and the university. Some faculty and staff had

Table 4.7

Groups most frequently encountered by CCQ-DKASA participants

Faculty	fq	m	Staff	fq	m	Students	fq	m
Female	102	88.70	European Anc.	24	88.89	European anc.	44	89.80
European anc.	97	84.35	Middle SES	24	88.89	Female	44	89.80
Male	92	80.00	High SES	23	85.19	Straight	44	89.80
Straight	90	78.26	Asian anc.	23	85.19	Male	40	81.63
Middle SES	89	77.39	Gay	21	77.78	Middle SES	40	81.63
African anc.	88	76.52	Mixed ethnicity	21	77.78	High SES	38	77.55
High SES	82	71.30	Genderqueer	21	77.78	Asian anc.	37	75.51
Asian Ancestry	77	66.96	Hispanic	18	66.67	African anc.	35	71.43
Gay	73	63.48	Straight	15	55.56	Hispanic	32	65.31
Hispanic/Latino	70	60.87	Low SES	15	55.56	Low SES	30	61.22
Low SES	66	57.39	NHPI Anc.	15	55.56	Mixed race	27	55.10
Mixed race	61	53.04	People with disabilities	14	51.85	Gay	27	55.10
Mixed ethnicity	45	39.13	Mixed race	13	48.15	Mixed ethnic	24	48.98
Bisexual	34	29.57	Bisexual	10	37.04	Bisexual	13	26.53
People with disabilities	32	27.83	Male	8	29.63	People with disabilities	13	26.53
NHPI anc.	23	20.00	Other race	6	22.22	NHPI anc.	10	20.41
AIAN anc.	21	18.26	Transgender	5	18.52	AIAN anc.	9	18.37
Transsexual	21	18.26	Other ethnicity	5	18.52	Transgender	9	18.37
Genderqueer	17	14.78	Female	4	14.81	Other ethnicity	7	14.29
Other race	16	13.91	African anc..	3	11.11	Genderqueer	7	14.29
Other ethnicity	15	13.04	AIAN	3	11.11	Other race	2	4.08

SES: Socio-Economic Status Anc: ancestry

been in the DGH since its creation in 2007 (twelve years) and others for slightly less, about ten years. Students indicated the duration of their respective programs. Interviewees also identified the cultural groups they encountered most frequently. These groups are shown in Table 4.8. The groups encountered by interviewees closely align with those identified by general participants in the CCQ-DKASA. However, the survey list is more comprehensive considering the larger number of respondents.

Charlene, who has been in the university for more than 20 years said:

The predominant cultural groups among faculty are Caucasian, upper class... Students, we have a much better mix. In global health, we always have at least a third of the group

from other countries... Africans, Asians, Latin-Americans. [The composition of] those cultural groups vary linguistically. Also, in terms of religion, [the students' group] is quite varied. Staff has been about 90 percent White. ...[The composition of] staff has actually improved lately. We have a range of ethnic groups--African Americans, Asian Americans, and Caucasian Americans. For sure, the Caucasian group is dominant. Students, in terms of numbers, I think there are more Caucasians. It might be close to half.

Table 4.8

Groups encountered most frequently by interviewees

Faculty	Staff	Students
White European ancestry High SES African Americans Asian Americans Asians	White European ancestry Asian <ul style="list-style-type: none"> • Chinese • Koreans • Japanese • Vietnamese • Filipinos • Samoan • Tongans Asian Americans African Latin Americans Latinos African Americans Heterosexual LGBTQ	White European ancestry Africans Asians Koreans Chinese Japanese LGBTQ Latin Americans Black Americans

Alexis shares similar perspectives in noting that

I would say probably ten percent of the population [is diverse groups]. Anybody who is White Anglo-Saxon or straight is probably 90 percent of the population. Then, all the rest, the groups aggregated are probably ten percent of the population. It includes... Asian Americans as a secondary group...Chinese Americans, Chinese nationals,

Japanese Americans, Koreans, some Vietnamese, and Filipinos. And to a little lesser extent, Samoans and Tongans. Then, I would say the next groups are split between African American/Africans and Latinos, whether they're from the US or from abroad. In terms of the number of employees and [sexual identity, these groups are] predominantly heterosexual... [there are some] LGBTQ folks as well and some trans folks... in the school and in the department.

On the CCQ-DKASA responses, faculty and students identified encountering the same five groups at the top of their list. Contrarily, staff recognized females as their least frequently encountered groups even though females were the dominant gender for DGH staff and students who completed the survey. In general, only some CCQ-DKASA participants had few encounters with people with disabilities, transsexual, transgender, AIAN, NHPI, and genderqueer identities. The reported cultural groups encountered by participants on the survey and in interviews varied, depending on the program in which they studied or worked. Lynsey identified some of the predominant groups she encountered as “African in Africa. In America, some representation of all groups, Africans, Asian, Latin Americans. She added, LGBTQ is a group I work with often.”

Some of the cultural groups faculty, students, and staff encountered have been consistent. Charlene, Alexis, Roxy, Pablo, Anthony, and Francis agreed that in addition to people of White European ancestry, most of the diversity on campus is achieved through significant numbers of international students from African, Asian, and Latin American countries. It is rare to see non-international students such as African Americans and Native American students in health sciences programs, according to Charlene, Anthony, Jessica, and Alexis. Hakim said “I have not seen anyone from my cultural background teaching. I have not even seen a guest speaker with my cultural background since I started this program. Only once an African American faculty was

invited.” When referring to the diversity of individuals by sexual identity Alexis concluded, “oftentimes I am the only [LGBTQ] in the room.” In Antony’s experience:

On campus, there is a good representation of the Asian community, I have a lot of colleagues and roommates from Korea, China and Japan, ...I have interacted with the LGBTQ community. People who identify themselves as gay, ...[and] I would say that on campus, there is an underrepresentation of Black Americans.

Only Alexis, Anthony, and Frances encountered Native Americans on campus. Alexis indicated that some Native students and one Native staff who are part of the School of Medicine (SoM) occasionally come to collaborate with DGH staff and students. Anthony said, “I met one Native American towards the end of my program.”

Faculty and staff reported that within the DGH, each program has some variations in the representation of diversity of cultural groups. For example, Donna indicated “over time some diversity on faculty has increased. Leadership has changed from White male only to include White females and White LGBTQ... We [also] have more female faculty and faculty of color.” Rodrigo, who has worked for the DGH for more years than Donna, indicated that

Before coming [to this university], I used to work...[overseas]. There, [the population] is not very diverse. Rather, it is more color-blinded. [Racial and ethnic] diversity is not a big issue there so there was not a big training on that. There were some issues on gender, but not that much on [racial] diversity. ... We [had] less faculty when I entered [the DGH], but pretty much it has been the same level of diversity. You find people from all over the place, both in the faculty and among the students... there are people from India, China, and Iran. There are also people from Lebanon and Greece. [The cultural groups I most frequently encounter are] very diverse... most of the students, in the Health Metric track and MPH are U.S. students, but in the Implementation Science track..., there are

many coming from Africa... [The composition] ...is very diverse... [The program] is pretty much balanced.

In contrast, Peter noticed that “the [university] is predominantly White and then everyone else is minoritized.” Most faculty identified minor representation of Asian, Hispanic or Latino, and LGBTQ in their regular interactions with students, staff, and community partners.

Cultural Diversity and cross-cultural communication training

Faculty, staff, and students who participated in the CCQ-DKASA and interviews received “none”, “some”, and “limited” cultural diversity specific training, respectively before joining the DGH and the university. After joining the institution and individual programs, their cultural diversity training has been mostly workshops elective in nature and short in duration. Students had none or very limited courses with content specific to cultural diversity. In some programs, courses or workshops have, to a degree, included issues about cultural diversity and cross-cultural communication, if or when they arise as a part of class discussion. Some participants acquired their training and knowledge outside of their program, school, or university. Data collected by the CCQ-DKASA examined cross-cultural preparation through formal, elective curricular and extracurricular training of faculty, students, and staff. These quantitative data are presented in Table 4.9.

Staff and faculty training scores were higher for the options of “some” and “none.” Most students did not respond to this question. Those who responded to it gave their highest rating to “A Little Training.” The cultural diversity training that did occur happened most often in the department or school. The frequency of training for faculty was higher than the total number of faculty participating. This happened because they reported receiving training inside and outside

Table 4.9

Cultural diversity training factors reported by DKASA participants within groups

Category	Training	fq	%	Character	fq	%	Location	fq	%	Practical Training	fq	%
Faculty 39	None	9	23.08	NR	25	64.10	Current program/school	16	41.03	Urban	28	71.79
	Some	9	23.08	Elective	8	20.51	Outside of the UW	15	38.46	Rural	21	53.85
	A Little	8	20.51	Required	6	15.38	UW outside prog/school	11	28.21	Underserved	20	51.28
	Moderate	6	15.38				Other	4	10.26	Suburban	15	38.46
	Lots	6	15.38				None			Other	9	23.08
	N/A	1	2.56									
Staff 27	None	9	33.33	Elective	13	48.15	Current program/school	6	22.22	Urban	15	38.46
	Some	8	29.63	NR	10	37.04	UW outside prog/school	3	11.11	Underserved	13	33.33
	A Little	5	18.52	Required	4	14.81	Outside of the UW	7	25.93	Other	11	28.21
	Moderate	3	11.11				Other	4	14.81	Rural	10	25.64
	Lots	2	7.41				None	1	3.704	Suburban	6	15.38
							NR	6	22.22	Other	1	2.04
Students 49	N/R	12	24.48	NR	19	38.78	Current school/program	17	34.69	Urban	35	71.42
	A Little	10	20.40	Elective	17	34.69	Outside of the UW	6	12.24	Underserved	25	51.02
	Some	9	18.36	Required	13	26.53	UW outside prog/school	1	2.04	Rural	22	44.89
	N/A	6	12.24				Other:	3	6.12	Suburban	14	28.57
	None	5	10.2				NR	22	44.9	N/A	1	2.04
	Moderate	5	10.2							Other	1	2.04
Lots	2	4.08										

N/R: No response N/A: Not apply

of the university. Other learning occurred through studying and living abroad. All faculty interviewed did not receive any cultural diversity, cross-cultural communication training before coming to the university. Lindsay was the only one who received information about cultural diversity before joining the institution. However, she emphasized that this information did not have a good connotation or effect on students, staff, or faculty. Lindsay said,

As a university student, diversity was a big watch word. At the time, the type of training you were getting about diversity was basically that diversity is good because it enriches our experiences. It was a very selfish definition of diversity. You will have a richer experience at the university if the university has diversity in here. It was not specifically addressing any cultural wrongs. It was very much like it enhances our university to have diversity so that is why it is a good thing. Diversity was taught as something to value and we should all be for diversity. I feel that it was the vocabulary I was taught years ago when I was a college student... The information was imbedded..., I do not remember attending any cultural diversity training. It was like diversity is good, ice cream is good.

In spite of the fact that most faculty members had not taken any formal cultural diversity training, those from dominant groups rated their cultural knowledge and skills higher than those who reported having diverse cultural backgrounds. In contrast to faculty responses, most staff members had some formal or informal training in cultural diversity before being employed by the university.

Most members of staff received cultural diversity training as part of their formal and informal education. They were followed by students who received some theoretical and practical cultural diversity training before joining their respective programs. The results summarized in Table 4.10 show the character and location of their trainings. When describing his training,

Alexis stated that he had substantial cultural diversity training and participated in several workshops

Table 4.10

Cultural diversity training factors reported by interviewees

Faculty	Staff	Students
No training before DGH	ME training before DGH	Limited CD training before DGH
After joining the DGH	Personal experience	After joining the DGH
Information tokenizing	Family education	Outside of the program
diversity during meetings	After joining the DGH	Elective
Elective workshops	Elective	Workshops
		Courses no specific but with some content

on diversity, multiculturalism, and multicultural health. At the time he took these trainings, the word “cross-cultural communication” was not part of the language used. but the concept of multiculturalism addressed communication barriers and issues of racial ethnic, and gender discrimination. Alexis recalled,

When I was in college, I took a lot of workshops in diversity and multiculturalism... [I also did] a lot of peer health education about sexuality. I was part of the speakers’ bureau for LGBTQ students, and I went and talked to medical students and other people about my experiences... People of many cultural backgrounds... would regularly talk about race and sexuality and there were LBGTQ, too... and some of them were straight people... At the time, [training on diversity] ... was elective ... They didn’t use the words cross-cultural communication back then, but they did talk about multiculturalism, they talked about racism.... In college, [I went] to these lectures. ... [I had] a diverse group of friends who I would sit with and listen to their conversations... and I had a friend who was kind of a mentor to me, who helped me. He was a Black gay man who was about six years

older than me...He made sure that I went to talks, lectures, and book readings, and gave me things to read.

Roxy indicated that her training was basic and presented under the rubric of cultural competence. “[When] I went to school...we learned the basics of cultural competency...be humble, ask questions... It was generally the tone...” The remaining staff said their cross-cultural communication training was informal, such as readings and family conversations. In this respect, Donna said,

My cultural diversity training and cultural sensitivity come from growing up as expatriates in a different country than either of my parent’s home countries... When we had classes that included 20th century history, my parents often shared personal stories about their own experiences within the context of the history we were learning. These real stories created an awareness for me that history is about the human story, bad or good. I was [educated] in an international school, and my history classes included accounts of the biohazard warfare tactics and racial genocides used to conquer the Americas, as well as civic lessons in European and American politics. But, when I came to the U.S., I met a lot of people who didn’t understand or know about American history or their own connection to it much beyond the popular Fourth of July and Thanksgiving stories. ...For most Americans, media sources and entertainment filter and alter history, creating drama instead of accuracy. The way that history is presented often separates the story from the context of family generational accounts and makes people feel as if history is unconnected to their personal family stories.

Jessica’s experiences were similar to Donna’s. She said her training was the outcome of living in and visiting diverse environments, interacting with members of diverse populations and volunteering in underserved communities. She explained further that,

For me just having been raised in a very culturally diverse area... was integral to my cultural training, and just being minorit[tized]. I think that helps one to have perspectives where you don't necessarily view things from a position of power all of the time. ...I [also] volunteered outside of the U.S. a lot. As a part of that training, we as students and as people from privileged backgrounds, were... constantly aware of our position of power and we had discussions and trainings about how to approach certain situations. It really was a good point of exposure... being in a different context and having to learn how to work in that environment was really beneficial. That was primarily it. I was never in any formal diversity training program.

Before joining the DGH, students in this study had very limited formal cultural diversity and cross-cultural communication training, but at the moment of the study, some were participating in elective trainings and have had practical opportunities, such as living and studying in other countries, online searches, and addressing homelessness and mental health stigma of underserved populations, particularly through AmeriCorps. Fatima's online communication class illustrated these options. She explained,

I found it very difficult to communicate with people. Not that they can't listen and understand what I'm saying but it's different so I might express things a certain way and I'll come up as offensive to some people, and I just didn't like any of that happening....

Hakim and Pablo had mostly practical training. Sarah's cultural diversity training was both theoretical and practical. It was part of a research course and practicum.

I have had my fair bit of training... on qualitative data collection. There were subtle elements of cultural awareness and sensitivity embedded in that training, [such as] talking to respondents, and listening to their stories, and meeting them in the places that they are.

[It was] around good qualitative data practices. I think that was more of an incidental piece.

Anthony indicated that most of his practical training was in different parts of Africa while working for a non-governmental organization. He described the settings and highlighted the importance of mentorships and talking with members of the communities he wanted to investigate to ensure that he was aware of their perspectives. However, he

only had one specific training on cultural diversity--a one-day seminar provided by a consultant to the team I went to Africa with. During my first year, I had mentorship from my bosses.... There was not a formal training, but they explained how to be open when talking to members of the communities.

Sarah acknowledged the importance of personal initiative in learning about diverse cultures through interacting with people and visiting places where one is not part of the demographic majority. She did

an AmeriCorps term of service for 2 years. [It] was largely around hunger and homelessness... [I did] a lot of training around underserved populations, mental health, and mental health stigma. A lot of that just comes up with different cultures and different populations... I've always tried to find different training and travel....

Faculty, staff, and students, using a scale 1 to 10, rated their levels of cultural diversity knowledge and skills before and after joining the DGH. The knowledge and skills of all participants improved after receiving limited training. Changes on the levels of improvement can be observed in Table 4.11. After recalling the training taken and providing examples, some participants lowered their initial ratings. Through those trainings, they recognized the need to learn more. For instance, Donna explained that after reviewing her training she felt more aware of her limitations and need to engage in continued training. She downgraded herself from eight

to five because she realized that she did not know much about American popular culture, and by extension she realized that she knew less than she had thought she knew about cross-cultural communication in general. She also began to realize that “there were many social tensions that limit [cross-cultural communication].”

Most of the faculty interviewed participated in short cultural diversity workshops. These limited experiences were reflected in their self-assessed levels of knowledge and skills about cultural diversity. Lindsay, who had not had any diversity training before coming to the DGH, was very conservative when scoring her knowledge and skills. After joining the DGH she only added one point to her scores because, “the only diversity training, I went to was here at the

Table 4.11

Interviewees self-reported rating of cultural knowledge and skills

Cultural Knowledge and Skills	Faculty	Staff	Students
Before joining the UW and the DGH	6.20	6.00	5.25
After joining the UW and the DGH	7.40	6.00*	6.25
Variation	1.2	0	1.00

*Some staff increased awareness while others lowered their initial scores.

SPH. I went to one workshop about a year ago.” Although this training was elective, Lindsay was strongly encouraged to attend. After completing the training, her knowledge marginally increased. In contrast, Rodrigo claimed high levels of cultural diversity knowledge, even though he did not have any prior formal training. He started taking training after joining the department, declaring that “actually, it was here. [at the DGH] when I started to get exposed to some of the [cultural diversity] trainings. In the last years, there has been more [of this training] in my program.” After receiving training, Rodrigo’s knowledge increased “It has been interesting. It

really makes you think. It's not just like you learn many new things, but it forces you to do some reflections. It has been useful. I have enjoyed [the trainings]."

Similar to Lindsay and Rodrigo, Peter attended some short-term cultural diversity workshops over the years. They were sponsored by the department in response to racial tensions. Feeling that these workshops inadequate he declared,

I said I'm learning. If there were other trainings, I'd be the first one to sign up because I'm very aware of my ignorance in this context. Every time I have new knowledge, I try to apply it. I think everyone would improve with one-on-one mentoring, teaching in the classroom, and just the general environment by being culturally aware. It would be a good thing and it could help on a day-to-day basis.

Some of the faculty and staff interviewed focused their comments about cultural diversity training on its benefits to others. For example, in describing his training Alexis explained that they were

mostly around cross cultural in terms of students going abroad and figuring out... what happens when a student experiences culture shock. Also, about experiences of students coming [to the U.S.] and what kinds of culture shock they have in our country. I took them and then I led them, ... I organized them. Then, I listened, and I learned.

Roxy indicated that over a period of time the DGH offered workshops regularly on topics related to cultural and communication knowledge to address issues such as diversity. As to their focus and effects, she recalled:

The department began to offer sort of quarterly workshops. There were a couple of different people that came in that did pretty basic cultural competency [training], tackling difficult conversations. It was surprising to me that a lot of people in the room had never had any of that type of training. They never had thoughts about implicit bias.... I felt like

what they offered didn't completely hit the mark. I think for a lot of people it wasn't enough.... The [trainings] that I went to were not required... it would be great if they would require them.

Neither the staff nor the students interviewed indicated cultural diversity training was required in their employment and/or programs at the DGH. If interested students had to acquire this training mostly outside of their programs. A few students did identify one course and a few seminars offered by the DGH. The course did not properly address the impact of cultural factors such as race, ethnicity, and gender on diverse population and in the seminars only some topics related to cultural issues were discussed.

Roxy recalled one class that was required for undoing racism for a cohort but then they cancelled it." Fatima, who was able to take the class, remembered it as

mostly focused on telling the history of how even the world race began, how segregation is and all of that... Then, in the Friday workshops, I found like that made a huge impact... The other specific class, [that included some cultural content was] our leadership class... The Undoing Racism class, it's required for everyone in the SPH before they can graduate ...it is like one credit. The workshop is also required for me as a global health student. But the leadership and management class is not required for me...I took it anyway....

In reviewing his cultural diversity formal learning after joining the DGH, Hakim said, The only aspects that have been taught in my program has been equity in global health problems and diseases... I already had good cultural diversity knowledge, but the only things [we have learned] is more about the topics that we are discussing. For example, the course problems in GH with Steve Gloyd was mind broadening by discussing problems in-low-to-middle income countries... We took other courses too outside of the program

such as Undoing Racism. [However,] no one course was specific to cultural diversity or cross-cultural communication.

According to Pablo, the DGH does not offer enough training opportunities to improve understanding of cultural diversity and develop skills in cross-cultural communication because That specific topic is not addressed in any of the core classes. If you want to really go and learn or be trained about cultural differences and cultural communication, you have to go on and look in other departments... In the DGH, ...the vast majority of students of color have discussed this issue with my colleagues [who] come from other countries... [in] Africa, Asia, and Latin America. We started to discuss how this [type of training] is absent and it has created a lot of conflict when organizations from the U.S. or Europe go to countries... [in] Africa, Latin America and Asia... to bring the perspective from the institution they are representing without really understanding the context of the countries or specific regions. That was something problematic that I found. That training is missing...

Sarah shared similar feelings as she explained that her program does not address cultural diversity and cross-cultural communication with incoming students. She recalled them being occasional topics of discussion in class but not focused trainings. “[It comes] more off as a topic for conversation or prompt for reflection. Nothing stands out for me as a student.”

Anthony was an exception because he had participated in cultural diversity training sessions, but they were not part of his program. Like other students, cultural diversity training within his respective program was minimal. He said.

I was in two cultural diversity and communication trainings organized by the DGH. They were open to all students, but they were not required to attend. As part of my classes

there was very little content [on cultural diversity and cross-cultural communication]. It is one of the criticisms I have for the program. I am doing mostly statistics and we didn't get any cultural diversity or cross-cultural specific training. I didn't get any cross-cultural specific training for my TAship either.

In contrast to other students who focused on on-campus preparation for cultural diversity, Francis concentrated on experiences she had as part of her program, but outside of the DGH. She was appreciative of her study abroad in non-majority settings. Francis reported going on these trips, one with another school within the health field and one with a school outside of her field of study. Working with these diverse populations made her experience the feeling of not being a majority, yet

It was just really, really, uncomfortable for me not to know anything, but to still be there learning.... I [also] got... to be at a federally qualified health center... Their population is largely immigrants, refugees, and diverse populations... The three of those [experiences] just were like tons and tons of different populations and working and never being the majority and so it was just more exposure and cultural humility, lots of cultural humility.

Summary

The research domains, demographic information of the CCQ-DKASA and interviews were presented in this chapter. The responses of participants on the survey were used to establish the internal consistency and reliability of the scales provided. The Cronbach estimates for the domains of knowledge, awareness, skills, and attitudes were all within the generally acceptable levels. One-way ANOVA was used to identify differences between means for scale values used in each domain, and for the categorical values. These differences among groups were not statistically significant. In the basic demographics presented on the survey and in interviews,

participants of White European Ancestry prevailed. There was no representation of AIAN and NHPI among students and staff on the CCQ-DKASA and interviews.

On the CCQ-DKASA, faculty of different teaching ranks, students participating in different programs, and staff in unidentified positions rated the level of cultural diversity, and cross-cultural communication training received after joining the DGH. The highest frequency on responses from staff and faculty were for the options “some” and “none,” while students’ highest frequency was for the option “a little training.” The participants interviewed described their cultural diversity training before and after joining their respective programs. In general, participants indicated that some of their cultural diversity and cross-cultural communication training was taken outside of the university. Some participants have studied and lived abroad. Some of the White European and non-European participants described their cultural diversity training as part of being members of minoritized groups, and their interactions with members of diverse populations. On the CCQ-DKASA most participants indicated that cultural diversity and cross-cultural communication training were elective. In interviews participants reported benefiting from the limited training they received, even though the improvement was minimal.

Chapter V

Knowledge Domain Results

For the purpose of this study, knowledge was defined as information about cultural diversity and cross-cultural communication acquired by faculty, staff, and students before and after joining the DGH through curricular and extracurricular theoretical and practical trainings. Participants in the CCQ-DKASASA rated their knowledge of how health-related issues are impacted by race, ethnicity, age, gender, sexual orientation, discrimination laws, and biases. They also estimated their levels of their comprehension about cross-cultural issues impacting the health of members of diverse population. Their responses described perceptions about historical and contemporary challenges faced by members of diverse cultural groups. Faculty, staff, and students rated their understanding about the impact of systematic and institutionalized discrimination, biases, and prejudices on health and access to services. They also examined their familiarity with and experiences implementing policies, initiatives and competencies promoted by the department, school, and institution to improve DEI.

Items included in the CCQ-DKASA knowledge domain are listed in Table 5.1. Descriptive statistics, including the frequencies, means, and confidence intervals for the three participant groups (faculty, staff and students) and comparative distribution of scores by group are presented in Table 5.2. The variation and consistency of scores are depicted in Figure 5.1. Survey results are followed by narratives of responses provided by interviewees.

Among the groups, faculty rated only one of 20 items in the “very much” knowledge range. Most scores across groups were in the “moderate” and “somewhat” knowledge range. The overall means for faculty responses were a little higher than for students and staff. Items rated with the lowest and highest scores by faculty and staff were consistent, while the patterns of responses from students were gradual, lowering their scores between the mid “moderate” to

“somewhat” and “a little” knowledge ranges. Results show a conservative variation of scores per group on items included in this domain. Interestingly, when looking at group scores provided in Table 5.1 and reviewing narratives of interviewees the results are sometimes contradictory.

Table 5.1

CCQ-DKASA Knowledge domain items

KNOWLEDGE DOMAIN	
17a	Health Promotion/Disease Prevention
17b	Reproductive Health/Pregnancy
17c	Child Health
17d	Adolescent Health
17e	Adult Health
17f	Geriatrics Health
17g	Women’s Health
18a	Demographics of culturally diverse populations you most frequently encounter
18b	Social characteristics of culturally diverse populations you most frequently encounter
18c	Stereotypes of culturally diverse populations you most frequently encounter
18d	Health risks experienced by diverse populations you most frequently encounter
18e	Challenges experienced by diverse populations to receive preferred services
18f	Historical and contemporary impacts of racism, bias, prejudice and discrimination in health care experienced by culturally diverse groups in the U.S.
18g	Different cultural healing traditions (e.g., Ayurvedic Medicine, Chinese Medicine)
18h	Ethnopharmacology (i.e., racial and ethnic health practices of and medicines)
18i	Potential challenges to integrating CCC training in health care services and practice
19a	Civil rights policy prohibiting discrimination against individuals based on race, color, religion, sex, and national origin including those with limited English proficiency
19b	Federal requirements to provide CLAS services in health services and health care
19c	Council on Education for Public Health (CEPH) Competencies
19d	U.S. DSHS Initiative to Eliminate Racial and Ethnic Disparities in Health

The rich descriptions provided by interviewees and the “moderate” knowledge rating on the survey indicate that much more needs to be done to reach cultural diversity goals established by the DGH, the SPH, and the university. Interviewees discussed the need for offering cultural diversity and cross-cultural communication specific training, increase and strengthen diversity

content shared in non-specific courses and workshops, and develop clear action steps and accountability for leaders and members of hiring and admission committees.

Cross-cultural factors impacting the health of members of diverse population

Participants assess their knowledge about particular health factors impacting members of diverse populations by age, and gender by rating items 17a to 17g, 18d, 18g, and 18h. Staff and students rated item 18g, cultural healing traditions, within the “somewhat” knowledge range while faculty responses to this item were marginally higher. Faculty and staff rated items 17f, Women’s Health and 18h, Ethnic Health Practices within the “somewhat” knowledge range, the lowest for faculty, while students rated this item in the “a little” knowledge range. In general, responses of participants denote limited knowledge about these particular issues. The remaining items, exploring health issues impacted by race, ethnicity, age, gender, sexual orientation, and biases in the CCQ-DKASA, were rated within the “moderate” to “somewhat” knowledge ranges by all groups.

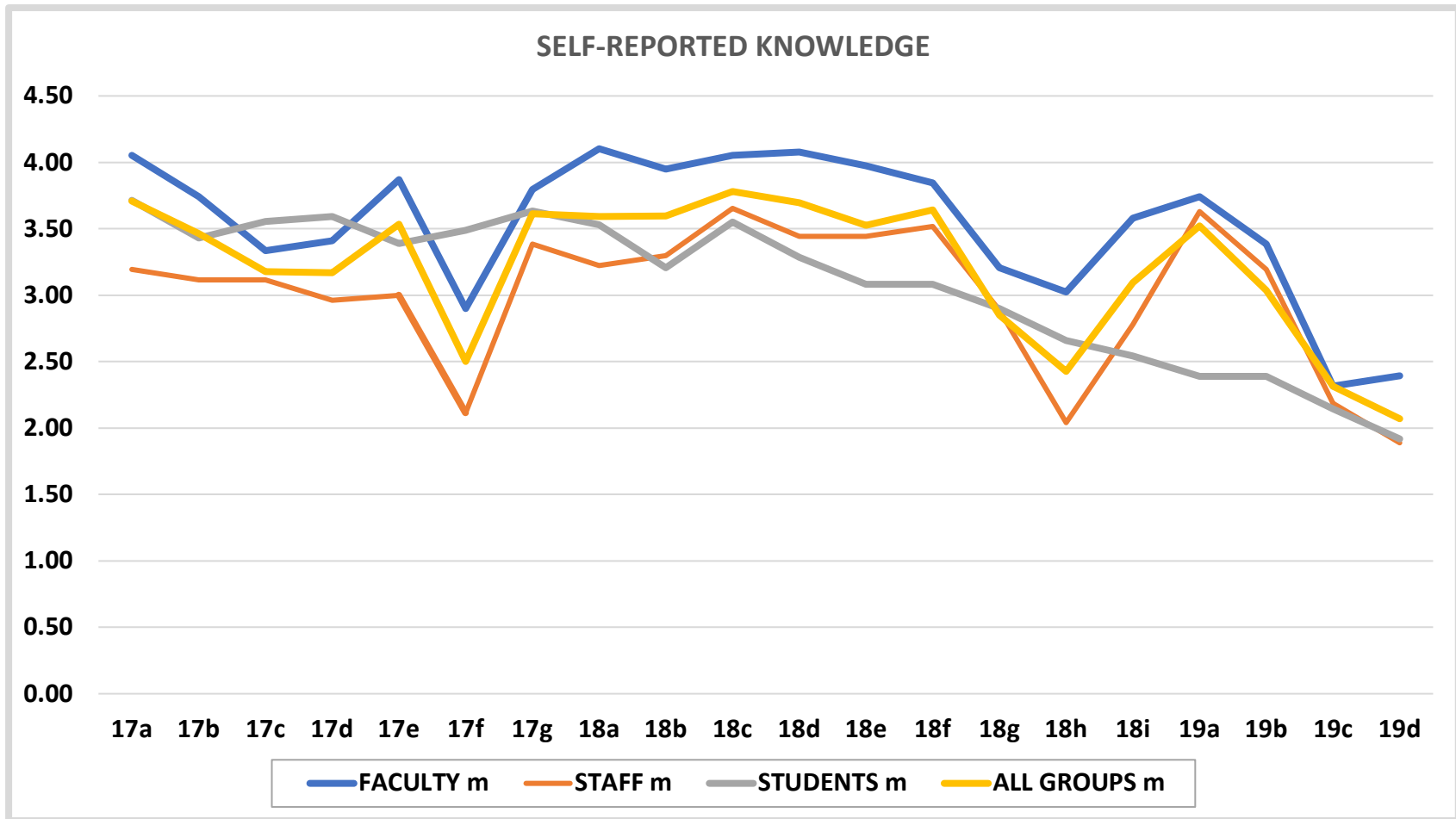
Participants also explored their perceptions about demographic, social characteristics, stereotypes, and histories impacting the health of members of diverse cultural groups. Related items, 18a, 18b, 18c, and 18f, were rated within the “moderate” knowledge range by all participants. The only exception was on item 18a which was rated by faculty within the “very much” knowledge range. Interviewees did not explore specific issues contained in the first three items. However, they discuss item 18f, historical and contemporary impact of racism, in the health of diverse populations, and rate their knowledge about anti-discrimination laws and initiatives to promote DEI in the university.

Table 5.2

Knowledge Domain frequencies, means and confidence intervals by participant type

TOTAL RESPONDENTS						FACULTY					STAFF					STUDENTS							
#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R
			LB	UB					LB	UB					LB	UB					LB	UB	
18c	114	3.78	3.60	3.96	M	18a	39	4.10	3.77	4.43	V	18c	26	3.65	3.29	4.01	M	17a	49	3.71	3.45	3.98	M
17a	114	3.71	3.52	3.91		18d	39	4.08	3.73	4.42	M	19a	27	3.63	3.16	4.10		18c	49	3.63	3.34	3.92	
18d	115	3.70	3.50	3.89		17a	39	4.05	3.68	4.42		18f	27	3.52	3.12	3.92		17g	49	3.59	3.33	3.85	
18f	115	3.64	3.44	3.85		18c	39	4.05	3.75	3.92		18d	27	3.44	2.99	3.90		17e	47	3.55	3.25	3.85	
17g	114	3.61	3.41	3.81		18e	39	3.97	3.63	4.32		18e	27	3.44	3.00	3.89		18f	49	3.55	3.23	3.87	
18b	114	3.60	3.42	3.78		18b	38	3.95	3.66	4.23		17g	26	3.38	2.94	3.81		18d	49	3.53	3.26	3.80	
18a	115	3.59	3.39	3.79		17e	39	3.87	3.49	4.25		18b	27	3.30	2.92	3.67		18b	49	3.49	3.21	3.77	
17e	112	3.54	3.33	3.74		18f	39	3.85	3.49	4.21		18a	27	3.22	2.77	3.68		17b	49	3.43	3.17	3.68	
18e	114	3.53	3.32	3.73		17g	39	3.79	3.39	4.20		17a	26	3.19	2.62	3.76		18a	49	3.39	3.11	3.67	
19a	115	3.52	3.32	3.72		17b	39	3.74	3.35	4.14		19b	26	3.19	2.80	3.59		19a	49	3.29	2.99	3.58	
17b	114	3.46	3.27	3.66		19a	39	3.74	3.40	4.09		17b	26	3.12	2.7	3.58		18e	48	3.21	2.91	3.51	
17c	114	3.18	2.95	3.40		18i	38	3.58	3.19	3.97		17c	26	3.12	2.7	3.50		17d	48	3.08	2.80	3.36	S
17d	113	3.17	2.96	3.37		17d	39	3.41	3.03	3.79		17e	26	3.00	2.60	3.40	S	17c	49	3.08	2.76	3.40	
18i	114	3.10	2.89	3.31		19b	39	3.38	2.89	3.88		17d	26	2.96	2.50	3.43		18i	49	2.90	2.61	3.19	
19b	112	3.04	2.77	3.30	S	17c	39	3.33	2.90	3.76		18g	27	2.89	2.45	3.33		19b	47	2.66	2.31	3.01	
18g	114	2.85	2.63	3.07		18g	39	3.21	2.84	3.57		18i	27	2.78	2.33	3.22		18g	48	2.54	2.18	2.91	
17f	114	2.50	2.27	2.73		18h	39	3.03	2.67	3.38	S	19c	27	2.19	1.65	2.72		17f	49	2.39	2.07	2.71	
18h	112	2.43	2.22	2.64		17f	39	2.90	2.43	3.36		17f	26	2.12	1.73	2.50		19c	49	2.39	1.99	2.79	
19c	114	2.32	2.06	2.57		19d	38	2.39	1.97	2.82		18h	25	2.04	1.62	2.46	L	18h	48	2.15	1.86	2.43	
19d	114	2.07	1.86	2.28	L	19c	38	2.32	1.86	2.77		19d	27	1.89	1.49	2.29		19d	49	1.92	1.61	2.23	L

Scale: Very Much (V) 4.1-5.0 Moderate (M) 3.1-4.0 Somewhat (S) 2.1-3.0 A Little (L) 1.1-2.0 Not at All (N) 0.0-1.0
 #: Item number n: number of participants m: median score CI: confidence interval LB: Lower Bound UB: Upper bound



Not at all 0-1- A Little 1.1-2- Somewhat 2.1-3- Moderately 3.1-4- Very Much 4.1-5

Figure 5.1. Median by participant group and reported knowledge

Historical and contemporary challenges faced by members of diverse cultural groups

Faculty, staff, and students scored item 18f within the middle level of the “moderate” knowledge range. The interviewees discussed how knowledgeable they were about historical and contemporary events impacting racism, bias, prejudice and discrimination in health care experienced by culturally diverse groups in the U.S. Scores on the survey suggest that participants were aware of these issues. However, the connection between these factors and persistent health disparities might or might not be part of their knowledge. Interviewees indicated that histories of diverse cultural groups were not included in their trainings and when historical events were discussed, no connections to contemporary challenges faced by diverse populations were made. Table 5.3 summarizes the perceptions of the interviewees.

Table 5.3

Interviewees knowledge about histories of diverse cultural groups

Diverse cultural groups-Historical and contemporary challenges	
Faculty	Information not included in most diversity trainings received When history was included it had no connection to contemporary issues impacting DCG
Staff	Staff members mentioned the gravity of historical events impacting diverse populations, indicating that people very rarely make connections with current living experiences of the same groups
Students	Not included in their training programs but one student attended, outside of his program, a lecture that connected the history of slavery to current mass incarceration

The lack of connection to history and contemporary health disparities experienced by members of diverse populations can influence the way health professionals provide their services. Interviewees indicate that discussions about the impact of these behaviors on health and educational disparities should be an integral part of trainings provided in the university and specific health related programs.

The analysis of information provided in interviews enriches the information shared by survey participants. For example, Lindsay described her experience taking cultural diversity and cross-cultural communication training in her program.

I haven't seen any of that content about history of different people and different cultures in my recent trainings. I think this information was compartmentalized. It was like today we think that diversity is good. Then, in the class it was like look at the horrible things that happened a long time ago, and so you could pat our backs, saying things like, 'long time ago things were bad for African Americans, but today we have diversity and we are doing better.' We can give ourselves a pat on the back because we are being more inclusive. ... [The trainings I had] felt like this is a historical thing that is good to be aware of. It didn't feel like this is something that is happening right now.

Rodrigo's recollections of his training were similar to Lindsay's.

I don't think they try to go into history beyond specific examples. For example, one of the trainings had the history of Japanese incarceration in the states, early in the last century. When they put the Japanese into detention... Another one is ...about how Native Americans essentially had their land stolen... In our training, all you can do is bring out one example of something that happened that was discriminating, unfair, or is the basis for modern discrimination.

Hakim and Donna had not received any training that connected the histories of diverse populations and their influences on health and other disparities they face. Donna said, "not really. I don't think people understood the gravity of [many] years of slavery. ... people would maybe say it [was grave]. They might throw it out there, but I don't think it gets fully addressed." Consciously engaging with the histories and the stories of people and connecting

that history to current living experiences and interactions with members of those same groups, “I think happens rarely,” Donna concluded. Hakim also said,

The closest I got to that was in my first or second year in a lecture about the book *The New Jim Crow*. It was an eye opener in the part of the U.S. history. That is the closet I got as far as the historical background of diverse communities.

Alexis thought these connections are “tremendously important because knowing where somebody’s past stem from, their historical trauma and pain, and why people think the way they do allow [us to] see the strengths people bring with them as well.”

Historical discrimination impacts the health of members of diverse cultural groups. Conscious and systemic efforts to exclude them from most aspect of social advancement have contributed to increased health and other disparities among these groups. Regardless of their long struggle for freedom and equity of services, diverse populations continue to receive unequal services. Oftentimes, mistreatment and disrespect caused by biases and stereotypes prevent them from improving health outcomes. In effort to improve health and other services for members of diverse populations, the U.S. government and professional organizations have developed policies, initiatives, and competencies. Participants in the CCQ-DKASA and in interviews discussed institutional support to inform and implement these changes. They also explained how health and education professionals oftentimes do not receive training to develop the necessary knowledge and skills to reduce health disparities.

Policies, initiatives and competencies to improve DEI

Participants, both on the CCQ-DKASA and during interviews, scored and discussed current federal and public health initiatives and competencies guiding efforts and education to improve services for members of diverse populations. When rating item 19a, Civil rights policy

prohibiting discrimination against individuals based on race, color, religion, sex, and national origin including those with limited English proficiency there were some differences in responses by participating groups.

Faculty rated this item in the middle to low moderate range, staff in their lowest within the moderate range, and students in the high levels of the moderate range. For students, this was one of the items with the highest scores. Item 19b, Federal requirements to provide Culturally and Linguistically Appropriate Services (CLAS) in health services and health care, was rated by faculty and staff in the low moderate knowledge range and students rated it within the somewhat knowledge range. Item 19c, Council on Education for Public Health (CEPH) Competencies, was rated by all CDQ-DSASA participants the lowest within the “somewhat” knowledge range. Students and staff had a little knowledge about item 19d, U.S. DSHS initiatives to eliminate disparities. This item was scored by faculty in the low “somewhat” knowledge range and it had the lowest score for students and staff who rated it in the “a little” knowledge range.

During interviews, faculty, staff, and students discussed their knowledge about federal requirements and initiatives to eliminate racial and ethnic disparities, such as the CLAS standards, CEPH competencies, and institutional, school and department policies to improve DEI. Participants described how, if at all, they received this information and shared their perspectives regarding the relevance of what was taught. This information is summarized in Table 5.4. Extended discussions about how relevant DEI is to their work and learning experiences, and how these policies and initiatives could help improve actions addressing inequities in their programs, schools, and communities at large are included following this table.

Table 5.4

Interviewees knowledge about policies, initiatives and competencies to improve DEI

	Faculty	Staff	Students
Federal initiatives and policies, including CLAS standards	Lindsay: never heard Rodrigo: Work within his program Peter: heard at meetings Charlene: do not know specifics	Alexis: heard about it Donna: have not exposure Jessica: have not heard about it Roxy: heard at diversity committee meetings	Fatima: have not heard about it Hakim: have not heard about it Pablo: heard at extracurricular activity Sarah: have not heard about it Anthony: heard at meetings Francis: have not heard about it
CEPH Competencies	Lindsay: never heard Rodrigo: Work with in his program Peter: heard at meetings Charlene: do not know specifics	Alexis: heard about it Donna: have not exposure Jessica: have not heard about it Roxy: heard at diversity committee meetings	Fatima: have not heard about it Hakim: have not heard about it Pablo: heard at extracurricular activity Sarah: have not heard about it Anthony: heard at meetings Francis: have not heard about it
Institutional DEI efforts	Lindsay: Heard at diversity meetings Rodrigo: Work with in his program Peter: heard at meetings Charlene: do not know specifics	Alexis: heard about it Donna: Heard at diversity committee meetings Jessica: heard some info Roxy: heard at diversity meetings and workshops	Fatima: heard by talking to faculty who participates in diversity committee meetings Hakim: heard through email Pablo: heard at extracurricular activity Sarah: heard through email Anthony: heard at meetings Francis: have not heard about it
Relevance	Lindsay: They are good frameworks, necessary first step. Rodrigo: They are important to have. They key is to implement action to meet requirements. Peter: they all exist in this framework of box ticking Charlene: if they have been used, they have been ineffective	Alexis: can be used as frameworks Donna: DEI efforts are currently under a framework of checking boxes Jessica: not been a priority Roxy: They are necessary but not everyone is informed. DEI has been used as a disclaimer.	Fatima: they are relevant but not informing about them makes them irrelevant. Hakim: very relevant. Should be included in training. Should include action. Pablo: very important. Should be included in curriculum and be part of the institution. Sarah: very important but efforts are insufficient Anthony: They are very important, and people should be required to comply Francis: very important

During interviews, about 50 percent of participants indicated not hearing about these policies, mandates, and competencies while the other 50 percent have heard of or had more knowledge about them. When asked if they believe that most students, faculty, and staff in their departments have received sufficient knowledge about and guidance to follow these initiatives, competencies, and policies, most faculty indicated that they think they did not. Below are some of the perspectives shared by interviewees regarding policies at the university to increase DEI and other federal efforts to reduce health disparities. Donna indicated “I do not have exposure to these initiatives,” and Hakim said “I have not heard about any initiative as a part of my training. Only a few days ago, I received an email that talked about [DEI] issues.” Charlene, Francis, Sarah, and Jessica were not aware of specifics about these initiatives while Lindsay had never heard anything about the CLAS Standards and CEPH competencies. Anthony and Roxy learned about these initiatives during diversity committee meetings. Fatima learned about them by interacting with a faculty member who participated in a diversity committee meeting. Lindsay learned about DEI initiatives during department meetings. She said,

Each organization needs to consider what they can do but it helps to have policy frameworks. If we don't know where to begin, at least, we can go there and say, ok what are the requirements and how are we meeting and how are we not meeting them. [This is] a necessary first step, but it is only the first step.

Alexis said, “Well I think they serve as guidelines and [something] inspirational... [They] give people... who don't have a way forward a framework to follow or at least some targets for them to try to reach.”

In Rodrigo's department, these initiatives are known. He explained that having them is important, but policies alone are not enough to achieve DEI.

It is good to have them. I'm not saying that we don't need them. It is important to have them, but they don't solve the situation by themselves. One thing is to have a document that you say students should have to handle these competencies... The key is to implement actions to get there.

Peter was very familiar with all the initiatives and policies mentioned. However, in his experience and the experiences of most participants, they exist within this framework of box ticking. It did not seem that proper discussions and actions to address DEI occurred in meetings attended by participants, including those who have been members of hiring, admissions, and diversity committees. In this respect Lindsay indicated that her interest in participating in DEI committees and efforts increased when the issues impacting the institution have been more openly discussed during her department meetings. She said, "in department meetings, we talk about that. Like I said, they have become a little more interested in it after getting open to issues. Although Lindsay seemed hopeful, Charlene's perception was discouraging. She said,

I don't think I know specifics about any of those [initiatives]... What I really know about it is how when we do admissions to the MPH program, we're not allowed to say... we're going to advantage them because they are African American. We can't do that. We have to use the whole diversity thing... That's what... affected me most...

Faculty, staff, and students who served in diversity committees reported more awareness about the CLAS standards, CEPH, and institutional, school and department policies to improve DEI. However, most students were not aware of these initiatives. As stated by Anthony, information about these initiatives is not available to students who are not members of diversity committees. Anthony "learned about some of these terms" during discussions with members of the DGH committees. They talked about some "initiatives and policies, but it was not something that was available for anyone that was not in that committee." Fatima said that she only has

heard about institutional efforts through email "... it's like all I see is annoying emails from them all the time ... I don't feel that they are impactful." Pablo indicated that he has heard about institutional initiatives but because he and his peer looked for it.

Yes, I heard the SPH and I know the SPH and DGH are trying to work towards a more inclusive curriculum and student body, I don't know about ... trying to get faculty body... I feel that in some sense in certain areas, it has been taken as if diversity is something to sprinkle around. I did not learn about these factors as a part of the MPH curriculum. It was extracurricular. I learned about it because [students] started asking questions. Within my own colleagues, we started digging and doing some research until we found that there have been some initiatives and things that are changing around the country... This is not embedded in our curriculum. It is kind of an elective if anybody can find it or really look for it...

In Hakim's opinion, these policies should be included in formal training, be permanent in the institution at all levels, include action steps, leadership should be held accountable, and results of their implementation be made public. He said,

These policies are relevant and should be included in the training of the students. These policies also should include action. If they do not include action nothing will change. If there is not an implementation plan that is monitored and evaluated throughout its process, we [will not] see changes. It needs to start since day one and continue over the years. For example, they can say they will hire diverse faculty members and they do, but temporarily. A contract for one year ... [or] three years, and then go back to do not hire diverse faculty. There should be an evaluation plan over the long run as to how to in an X number of years from now, [what] the composition [of faculty] looks like, who are the decision makers, and what are decision made in each program.

Understanding systematic and institutionalized discrimination, biases, and prejudices

Participants on both CCQ-DKASA and in the interviews described how their respective programs prepared them to understand and address systematic and institutionalized discrimination; conscious and unconscious biases; prejudices against members of diverse cultural groups; and diversity, equity, and inclusion. CCQ-DKASA respondents rated related items 18c, and 18e, within the “moderate” knowledge range. The perspectives of interviewees are summarized in Table 5.5 and some explanatory comments provided by some interviewees are included to illustrate how training taken at the DGH helped them to increase their knowledge. On the CCQ-DKASA, participants also scored item 18i, potential challenges to integrating CCC training in health care services and practice. The faculty ratings were in the low “moderate” knowledge range, and staff and students in the “somewhat” knowledge range.”

Faculty discussed their preparation to address systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices. Rodrigo was the only participant who received conscious and unconscious biases training. When asked about the benefits of his training he said,

That’s a good point. I mean in the trainings that we have received ...unconscious biases are something that has been deeply addressed because sometimes we are not aware. Now, the DGH also has a big emphasis on social justice, so students get exposed to these issues.

Table 5.5

Impact of institutional effort to address systematic and institutionalized discrimination, biases, and prejudices and increase DEI

	Faculty	Staff	Students
Systematic and institutionalized discrimination, biases, and prejudices	<p>Biases have been addressed in some programs that have increased emphasis on social justice</p> <p>In some programs no bias training is provided</p> <p>SES, race, and ethnicity should be considered during admissions</p> <p>Dominant groups would benefit of bias trainings</p> <p>DCG should be provided with resources for mitigation.</p>	<p>No staff or students receive this type of training.</p> <p>Information has been introductory</p>	<p>Some course content has been helpful</p> <p>Program did not prepare students to understand bias and discrimination</p> <p>Structural issues have been discussed but not how to change them</p> <p>DEI is not a required component in any structural way</p> <p>DEI training help professionals explore equitable services.</p>
Diversity, Equity and Inclusion (DEI)	<p>Diversity of faculty is minimal</p> <p>DEI discussions aimed at ticking boxes</p> <p>Basic DEI problems is the pipeline</p> <p>Committees hire people who look like them</p> <p>DEI is a continuous process, supervisors should be in continuous training</p> <p>Senior faculty and staff must model humility and show the importance of learning and listening</p> <p>Diversity can be mostly seen in lower administrative ranks</p>	<p>DEI training help committee members ask:</p> <p>Why to choose a person? Is this application equitable?</p> <p>Trainings offered have been punctual</p>	<p>No solid efforts to increase DEI</p> <p>DEI is not part of curriculum, teaching, mentoring, or educational experience.</p> <p>DEI should be part of the institution and its structure</p>

Some of the faculty interviewed indicated that the DGH has not provided them with training on these issues. The closest to this type of training Charlene had were conversations within admission committees. Members were encouraged to consider socio-economic status in addition to race and ethnicity during admissions. When referring to training to address systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices, Lindsay thought,

The dominant group needs the training, other people need the mitigation. If you are students of color it doesn't seem like you are getting a fair share in the institution. I do not know how much training you need. For the dominant group that is where the training is helpful.

Participating staff indicated that their program has not prepared them to understand and address issues of systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices against members of DCG. Alexis said,

...[Although] it has been a part of all of my training since I was an undergraduate and graduate student... I feel like this [training] does not exist here... I do not think our students get that kind of base [either].....

Roxy, who earlier mentioned her role as an advocate for inclusion, felt that most of the skills she had before joining the program have somewhat developed during efforts to engage others and improve issues in the department. She recalled,

It's hard to say because I came, I think I came into it with a lot more than I have gained... what I have experienced in the few years [I have been in the DGH]... was introductory.

Students shared their perceptions about how their respective programs prepared them to understand and address issues of discrimination, biases, and other prejudices against members of diverse cultural groups. Some courses have helped Fatima increase

awareness of these issues. She praised her department for, “bringing out health inequities.” However, in Hakim’s opinion the program outlines them but “doesn’t really prepare students to understand these issues.” It seems evident that depending on the courses provided the department might or might not offer students the knowledge and skills needed to address issues of systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices against members of diverse cultural groups. Hakim described how biases impact research and services. He elaborated,

We do not do research from the perspective of the community. We do it from the perspective of the department. In the department there are aims and we need to achieve those aims. What [the department] might be doing might not be respectful for other countries. Especially if you are trying to implement specific projects and that work might not suit the population because of their culture. You think you are trying to help there. It might not be bad intentions but maybe [it is] a bad approach... When we talk about public health, we do not talk about the U.S. We do not talk about Europe. We do not talk about the developed countries.

We talk about the developing countries. When you ask a question concerning the U.S., [this] type of content or subjects... are out of the scope of the lectures. We keep talking about problems in Africa, problems in Asia, problems in Latin America, but we do not really go after how we cause these problems. ... For example, we do not explain how after discovering and eradicating malaria in the U.S., even that we go to other countries to do research, we do not provide the medication for the population....Although we are spending money and doing a lot of research that is interesting and frustrating to know...

most of the money you get from donors and funders is spent on U.S. faculty. It is not spent... training people from these countries...

Pablo also explained that students are not adequately prepared to actively address issues of discrimination, biases, and other prejudices against members of DCG. She said,

...in [my] program there was a lot of discussion about structural issues, but not really about how we can change them. We talked a little about how we can navigate through them, which makes it sound a little bit sad, but that is how it is. It is basically saying the system is a wreck and you have to do what you can.

Francis was interested in comparing care and learning how to leverage resources. In her Graduate Certificate program she acquired knowledge “[to look at]... discrepancies in care, both here in the U.S. and on a global level... [and] to address them ...anytime that [she serves members of] a vulnerable population such as women, adolescents, and children.” She believes that “resources... have to be diverted to them in order to provide equitable services.

Pablo, Hakim, Francis, and Anthony agreed that no courses addressing discrimination, bias, and prejudices were offered in their respective programs. In discussing the lack of cultural knowledge and diversity of communities in his program, Francis explained,

[Addressing systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices are] not a component of my PhD program in any sort of required or structural way. It’s not something that has come up in course work. Almost all of my coursework has been technical, about how to process data. Actually, one of the best [trainings] I’ve seen on unconscious bias was given when I got called for jury duty in King County.

Anthony added,

I would not say [that my training in the university] contributed to my understanding of cultural diversity and cultural knowledge. ...Now, I have more understanding specifically of U.S. culture. More understanding of some cultures that I had not interacted with before, but I would not say that I learned a lot as far as skills or methods. It was definitely not part of the curriculum or my training. ...Most of my training and work... in Seattle...was...not [reflective] of the very diverse community [it has].

Finally, Pablo suggested that people should question themselves when addressing discrimination, bias, and prejudices against members of diverse cultural groups.

We come from different perspectives and we have our own biases. Our own implicit biases. I think that to change our own biases and to realize that we have some, I mean, we all have them. It requires [to ensure we ask ourselves] ... how can I, a White male, understand the perspectives of other people from around the world? [How can I] at least open the doors and opportunities to challenge my own views because I do not have all the answers.”

Faculty, staff, and students, in different programs acquired some surface introductions while attending trainings and meetings promoting diversity, equity, and inclusion. They had a wide range of perceptions. In their comments some of the issues impacting DEI were clearly stated while others seem to continue the status quo as the accepted norm. In their comments, most interviewees concluded that in the university there is limited diversity, including students. Some of the interviewees indicated that there is no representation of African Americans, and most other cultural groups are represented by international students. Sometimes, faculty is diversified by inviting guest speakers.

Lindsay highlighted the need for more faculty diversity because “Diversity of faculty is just minimal, minimal in the whole university, I mean the whole university is pathetic.” Charlene was frustrated when trying to bring perspectives of faculty members from different cultural groups to her classes. As she explained:

There have been times when I had a class that I was teaching... I was always looking for speakers... more diverse... speakers to come in. Then, you get to realize very soon that there aren't that many faculty that are not just good old middle class White. [There is] limited ability to involve diverse faculty in a classroom.

Lindsay's and Charlene's observations are eye openers about the lack of diversity in the institution. It is often a direct outcome of whom the institutional leaders and powerbrokers are. Their attitudes toward and lack of assertive engagement in increasing diversity, promoting inclusion, and achieving equity are consequential. Peter described how some of the behaviors he has observed in these meetings denote the need to increase diversity of faculty.

The discussions about DEI are sort of discussions aimed at [checking] boxes...there's all this diversity this, diversity that, this effort, this climate, and this climate that. But... at the end of the day, you wake up, you come back, and nothing has really changed... One of the ways that things can change is to put money where people's boxes are being ticked. For example, you can do all of the diversity training you want, but still only three professors in the DGH are Black. It doesn't matter how many diversity trainings you do, we are still sitting in a faculty meeting and we are still two out of seventy faculty members, we are still two Black people... The same thing is with students. It doesn't matter if you bring all the experts in the world and you have one Black student... It doesn't matter how many trainings, how many consultants, [how many] boxes you [check], and the pictures you put on your website with one Black face, a Hispanic, and a

couple of White students. All that doesn't matter. As long as you don't diversify the faculty. You still remain like three Hispanics, two Blacks [of] 70 faculty members... White men and White women [faculty].

Diversifying faculty was a very important action that many participants in the study recommended to improve DEI in the DGH and the university as a whole. Charlene indicated that in some committee meetings the lack of diversity due to pipeline and lack of tenure of faculty of color has been discussed. She recalled,

I was on the search committee... Obviously, there was a lot of discussion... about diversity and ...the basic problem of the pipeline... Even grade school, high school children of diverse backgrounds are disadvantaged... How do you get to be on the faculty?... How are you going to find [diverse faculty] and what was exactly the issue with the search committee?... One of the key issues that came up is that it had to be a tenured position because... [no faculty] is going to move to a new place without some guarantee of a tenure track... if they're going to move, ... they've got to have a lot of motivation for it.

Lindsay also pointed out the importance of increasing efforts to hire more members of diverse cultural groups and help everyone navigate cultural differences. These needs are evident in her comments that

In all of my jobs [as faculty], the staff are more diverse than my colleagues. ... At the university, the administrative staff is more diverse than the [teaching] staff... Everyone, I think, tries to be respectful, but there are so many ways in which relationships could be challenging because of the power dynamics differential as to whatever the cultural differences there are... Every time you are working as a supervisor you want... [employees] to be happy in their jobs. ...When you do not share cultural backgrounds

there is more opportunity for misunderstandings. ...Sometimes the way people have solved that is by hiring people who look like them. [People] they feel comfortable with. But I don't think it is a good solution. We are at a point now...we should be trying to hire diverse people. ...It will create more cultural differences in the office. That [will also] need to be navigated.

Some search committees have been more successful than others at embracing practices to eliminate biases in hiring processes. Donna described how some of the tools used in her trainings have been of great help while the same tools have not been effective for other participants. She explained,

I have been involved in a number of faculty searches and there are a lot of resources available, ...[including] videos documenting best practices. Certainly, every time I have been asked to be part of a committee, I find them to be very useful resources... All members of committees are expected to review these materials... Some committees have been more engaged with the diversity aspect of a search than others – those who referenced and used the tools more intensively seemed to become more engaged overall. One group was very exceptional and took that particular aspect of the search very seriously. Everyone took the course. There was verification and constant discussion throughout the process, [such as] “Why choose this person? Is it an equitable choice?”

In addition to training individuals who participate on search committees, some programs are taking steps to ensure that current faculty, students, and staff are equipped to interact with members of diverse cultural group. Their efforts could help retain the few members of diverse cultural groups who are already on campus. They could also help improve the environment by attracting and successfully engaging more members of diverse populations. In this respect, Anthony said that the institution should become more representative of the populations that

inhabit the city and country. Rodrigo mentioned strategies used in his program to improve DEI. One of these was the provision of cultural diversity and related training, specially to individuals holding positions of power. The approach of his program addressed some of the concerns shared by Lindsay. Rodrigo declared,

We are having everyone who is supervising someone to have continuous training and we are covering different topics. It has been really helpful to learn not only better tools to handle situations that may arise but also learning more about the inclusion process at the University and ...[my] program.

The strategy used by Rodrigo's program seems to be successful. However, not all programs use similar approaches. Most trainings offered at the department are related to specific health conditions or health processes. When cultural diversity and cross-cultural communication trainings are offered, they seem to be isolated events. As Alexis recalled,

Rarely. Rarely, rarely. Most of the trainings offered are around specific disease or processes or science, but we don't have a lot of [cultural diversity, equity and inclusion] talks. We've only had a handful and that's only been in response to an event. It wasn't like it's a constant series.

The insights shared by Roxy could be a useful response to Alexis' concerns. She suggested training on "Implicit bias and difficult conversations [should be] mandatory for faculty." Yet, when the diversity committee has requested that such training be required, "leadership ...said 'No. People are going to complain. We can't make it mandatory.'" Roxy concluded, "If you don't want to go to the cultural competency training, if you object to it for some reason, maybe you shouldn't be a teacher in the department." Her comments aligned with Rodrigo's views. He thought that people, if they have not learned yet, must change and learn to respect others.

When exploring ways to increase DEI, the most frequently used word by the participants was training. Nonetheless, some faculty, staff and students indicated that to improve DEI, actions needs to be deeper and richer than they have been. For example, Roxy felt the imminent need of action to address issues impacting DEI. Lindsay described some of the issues she has encountered while attending DEI training that need to change:

I have been into workshops where right at the beginning some senior person would say ‘I don’t need to be here. I don’t know why I am here. This is stupid.’ I know we were not going to get anywhere with that attitude, but I have also been inspired by a lot of people much older than me who model humility and show how important it is to continually learn and listen.

Students also thought that more needed to be done. Hakim said, “we see people talking about DEI but it has not been part of our program. It is just words, nothing solid. We have not seen anything that shows that people really care about these issues.” When asked how issues of DEI were incorporated in her training, Fatima said, “I would say no [training has been incorporated]. There is nothing like that. She continued by expressing skepticism she and other students have about continued surveys students are asked to complete. ‘[The school] only tries to take surveys... Then show us the results... [saying] this is what graduate students are thinking..., but there is no formal training,” Fatima concluded. Anthony thought that DEI has not been seriously embraced because

Other than the two workshops that were organized by the department, [DEI] is not something that was included in the curriculum or was part of the values of the program. It was not part of the teaching or even in the mentoring or educational experience.

Pablo, in particular, talked about the need to change the institutional culture in its structures and perspectives:

In the DGH, the core classes [did not have] anything in [them] that addressed diversity in the content. We had some sort of discussion very vaguely on some courses but [it was] because some of my peers and I brought up the topics. It would be great if this knowledge could be part of the institution... basically [it] has been lacking the understanding of what institutionalized racism is. This goes on in the structural level. If we are looking to eliminate these disparities, we must address [issues] at the structural level. The structure of the university.

Summary

The Knowledge domain, in this study, explored the perceptions of participants about the levels of information formally provided by their programs. Specifically, about health-related issues impacted by race, ethnicity, age, gender, sexual orientation, discrimination laws, and biases. Faculty, staff, and students identified efforts to increase diversity, equity, and inclusion (DEI) in the university, a predominantly White institution. Rich descriptions provided by interviewees complemented participants responses on the CCQ-DKASA which rated a large number of items in the “moderate” knowledge range. This denotes that there is a need to increase efforts to reach cultural diversity goals. Interviewees discussed the urgency to offer cultural diversity and cross-cultural communication specific training; increase and strengthen diversity content in non-specific courses and workshops; and develop clear action steps and accountability for leaders and members of hiring and admission committees. When discussing cross-cultural issues impacting the health of members of diverse population, in general, the responses of participants indicated they have limited knowledge about these particular issues.

Participants in both the CCQ-DKASA and interviews discussed historical and contemporary challenges faced by members of diverse cultural groups. Responses on the survey

suggested that participants were aware of the histories of these groups. However, during interviews, participants indicated that histories of members of diverse cultures were not included in their trainings and when historical events were discussed no connections were made to contemporary challenges faced by diverse populations. Most of the faculty and staff indicated that the department has not provided them with systematic and sustained training on issues of discrimination, biases, cultural diversity, cross-cultural communication, and cultural humility. Students said that when those issues arise within their respective programs, they are not taught how to address them. Participants also discussed current federal and public health initiatives and competencies guiding efforts and education to improve services for members of diverse populations. Initiatives included Civil Rights policy, CLAS standards, CEPH competencies, and U.S. DSHS Initiative to eliminate racial and ethnic disparities. The first three initiatives were rated within the low “moderate” and “somewhat” knowledge ranges by faculty, staff, and students. However, the initiative to eliminate racial and ethnic disparities was rated in the “a little” knowledge range by staff and students. About half of participants interviewed indicated not hearing about these policies, mandates, and competencies and the other half had some knowledge about them. Faculty indicated that most students, faculty and staff have not received sufficient knowledge about and guidance to follow these initiatives, competencies, and policies.

Chapter VI

Awareness Domain Results

As used in this study, “awareness” referred to the ability of faculty, staff, and students to perceive and focus attention on issues influencing cultural diversity and cross-cultural communication. This included recognizing different aspects related to professional preparation (or the lack of) for working with racially and culturally diverse clients in health care settings. The participants rated their awareness about their own and other people’s identities; how their identities and cultural backgrounds influenced their experiences and abilities to effectively communicate in a predominantly White institution; and how institutional discrimination negatively impacted members of diverse cultural groups.

Participants also identified institutional efforts to improve DEI, including their levels of consciousness about stereotypes, biases, and prejudices; institutional structures to achieve DEI’s organizational mission, vision, and goals; commitment from leadership to increase diversity and address controversial issues related to diversity; development and use of diverse curricula; levels of diversity in leadership, faculty, staff, and student bodies; existence of representative advisory committees; and identification of the impact of racism and oppression on their own and the behavior of others with whom they interacted.

Part I: Identity Awareness

Items on the CCQ-DKASA that comprised the Awareness domain are listed in Table 6.1. Descriptive statistics, including frequencies, means, and confidence intervals for faculty, staff and students and total distribution of scores are presented in Table 6.2. All three groups of participants were strongly aware of their own racial, ethnic, and cultural identities, stereotypes, biases and prejudices; and how systematic and institutionalized racism, poverty,

Table 6.1

CCQ-DKASA Awareness domain items

AWARENESS DOMAIN	
20a	How AWARE: My own racial, ethnic, and cultural identity
20b	How AWARE: My own racial, ethnic, and cultural stereotypes
20c	How AWARE I am about: My own biases and prejudices
21a	agree/disagree: Prejudices and biases impact my interactions with people who have professional and/or cultural-backgrounds different than my own
21b	Discussing issues of discrimination, racism and oppression makes me uncomfortable
21c	My cultural background (CB) or orientation can influence my ability to effectively communicate with people who have CB or orientations different from my own
21d	Systematic and institutionalized racism, poverty, and prejudice negatively impact members of minorities, racial and ethnic populations
22a	observed/aware: Biases or prejudices of a member(s) of my program towards other member(s) or client(s) who have CB or orientations different from their own
22b	observed or aware: The way in which a member(s) of my program believe that their cultural backgrounds or orientations may influence their effectiveness
22c	observed or aware: Discomfort experienced by a member(s) of my program when discussing issues of discrimination, racism, or oppression
23	Include issues the you have observed or been made aware of that are not included in the CCQ-DKASA*
24a	My current program has: Mission, vision, and goals committed to promote diversity, cultural diversity and cross-culturally responsive educational services
24b	My current program has: An advisory committee composed of faculty, students, and staff to addresses issues of biases, cultural diversity, and cross-cultural communication (CCC)
24c	My current program has: Instructional materials (e.g. lectures, films/videos, books, etc) representing DCG you most frequently encounter
24d	My current program has: Racially and ethnically diverse staff
24e	My program has: Racially / ethnically diverse student body
24f	My current program has: Racially and ethnically diverse faculty body
24g	My current program has: Curriculum that prepares students with sufficient knowledge to interact in cross-cultural settings
24h	My current program has: Curriculum that prepares students with sufficient practical experiences to work in cross-cultural settings
24i	My current program has: Curriculum that prepares students, faculty and staff to provide high quality culturally responsive education and other services
25a	My current program has: Appointed directors to address issues of CCC, and biases
25b	My current program has: Strategic plan implementing clear diversity, cultural competency, cross-cultural communication strategies promoting appropriate services to all populations

*Results and analysis of item are included along with responses provided by interview participants.

Table 6.2

Awareness Domain Frequencies, Means, and Confidence Intervals by Participant Type

TOTAL RESPONDENTS						FACULTY					STAFF					STUDENTS							
#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R
			LB	UB					LB	UB					LB	UB					LB	UB	
21d	115	4.61	4.46	4.76	T	20a	39	4.49	4.24	4.73	V	21d	27	4.63	4.36	4.90	T	21d	49	4.78	4.62	4.93	V
20a	115	4.40	4.24	4.56	V	21b	39	4.49	4.24	4.73		20b	27	4.33	4.02	4.64	V	20b	49	4.45	4.21	4.69	
20b	115	4.39	4.25	4.54		21d	39	4.38	4.03	4.74	T	24a	26	4.23	3.92	4.54	T	20a	49	4.43	4.17	4.68	
20c	115	4.19	4.06	4.32		20b	39	4.36	4.12	4.60		20a	27	4.22	3.84	4.61	V	20c	49	4.20	3.98	4.42	
24a	110	4.06	3.90	4.22	M	20c	39	4.21	3.98	4.43		20c	27	4.15	3.91	4.39	V	21a	49	3.43	3.10	3.76	
24b	111	3.83	3.65	4.00		24a	36	4.14	3.83	4.44		24b	27	4.11	3.79	4.43		21c	49	3.69	3.41	3.98	A
22c	113	3.58	3.36	3.79		24b	36	3.94	3.61	4.28	M	24e	27	3.48	3.10	3.87	M	22a	48	3.73	3.32	4.14	M
24e	111	3.51	3.32	3.71		24e	35	3.63	3.30	3.95		21c	27	3.44	3.03	3.86		22b	48	3.58	3.26	3.90	
21c	27	3.44	3.08	3.81		22c	38	3.39	3.03	3.76		22c	27	3.44	3.08	3.81		22c	48	3.79	3.44	4.14	A
22b	112	3.40	3.20	3.60		22b	38	3.32	2.98	3.65		25a	23	3.26	2.87	3.66		24a	48	3.92	3.67	4.16	A
22a	27	3.15	2.65	3.65		25a	36	3.31	2.94	3.67		22b	26	3.19	2.75	3.64		24b	48	3.58	3.32	3.85	
25a	107	3.14	2.94	3.34		21c	39	3.31	2.94	3.67		22a	27	3.15	2.65	3.65		24e	49	3.45	3.13	3.77	
21a	115	3.11	2.90	3.76		25b	36	3.31	2.94	3.67		25b	27	3.14	2.87	3.66		25a	48	2.96	2.64	3.28	
25b	107	3.06	2.87	3.25	S	24c	35	3.29	2.94	3.63		24d	27	3.07	2.68	3.47	S	25b	48	2.96	2.64	3.28	S
24d	111	3.03	2.83	3.22		24h	34	3.26	2.92	3.61		24c	27	3.00	2.56	3.44		24d	49	2.92	2.60	3.24	
24c	110	2.98	2.79	3.18		22a	38	3.21	2.78	3.64		21a	27	2.96	2.56	3.37		24f	49	2.76	2.44	3.07	
24h	107	2.85	2.66	3.04		24i	34	3.21	2.85	3.56		24h	24	2.88	2.54	3.21		24c	48	2.75	2.47	3.03	
24g	107	2.85	2.67	3.03		24g	34	3.18	2.86	3.49		24g	24	2.83	2.54	3.13		24i	48	2.65	2.35	2.94	
24i	106	2.82	2.63	3.01		24d	35	3.14	2.82	3.47		24i	24	2.63	2.30	2.95		24g	49	2.63	2.35	2.91	
24f	111	2.75	2.56	2.93		24f	35	2.86	2.54	3.17	S	21b	27	2.59	2.28	2.91		24h	49	2.55	2.26	2.84	
21b	115	2.32	2.14	2.50		21a	39	2.82	2.44	3.21		24f	27	2.59	2.28	2.91		21b	49	2.45	2.16	2.74	

Scale: Strongly Agree (V) 4.1-5.0 Agree (M) 1.1-4.0 Somewhat (S) 2.1-3.0 Disagree (L) 1.1-2.0 Strongly Disagree (N) 0.0-1.0

#: Item number n: number of participants m: median score CI: confidence interval LB: Lower Bound UB: Upper bound

and prejudice negatively impact members of racial and ethnic minoritized populations. They gave items 20a, 20b, 20c, and 21d their highest scores, rating them within the “strongly” aware range.

Faculty and staff were “strongly” aware and students “moderately” aware that their departments have a mission, vision, and goals to promote diversity, cross-cultural communication, and culturally responsive education (item 24a). Only staff “strongly” agreed that the programs have advisory committees composed of faculty, students, and staff to address issues of biases, cross-cultural competency and cross-cultural communication (Item 24b). Students and faculty were “moderately” aware of the existence of these committees. Furthermore, on the CCQ-DKASA and interviews all groups of participants were aware of the levels of cross-cultural preparation provided by their programs. Faculty “moderately” agreed while staff and students “somewhat” agreed that their programs have curricula that prepare students with sufficient knowledge to interact in cross-cultural settings; with sufficient practical experiences to work in cross-cultural settings; and provide high quality culturally responsive education and other services (items 24g, 24h, and 24i).

Moreover, faculty placed item 21b in their highest range, indicating that they were “very aware” that discussing issues of discrimination, racism, and oppression makes them uncomfortable. It was surprising that staff did not score this item in the same range as faculty, since the racial composition of these two groups of research participants was similar. Staff who participated in the CCQ-DKASA was 88.89% of White European ancestry and faculty was 82.05%. In addition, the percentage of faculty who reported receiving moderate cultural diversity training was higher than the percentage of staff. All participants by group agreed that in their programs and institution, there is lack of diversity in the faculty body. They rated item 24f within the lowest range reported. Staff and students almost split even the remaining items of this

domain within the ranges of “agree” and “somewhat.” These results denote that staff and students who participated in the survey were less aware of the impact of biases and prejudices on cross-cultural interactions, and about the level of commitment to equity, diversity and inclusion of the DGH and the university. This was not the case for the participants interviewed who tended to be quite aware of these issues.

The variation and consistency of scores provided by individual groups and overall respondents are depicted in Figure 6.1. This figure demonstrates remarkable differences between responses provided to item 21b by faculty, students, and staff. It also shows that scores provided by students to items within the moderate range were little higher than those provided by faculty and staff, but lower than items within the “somewhat” aware range.

The CCQ-DKASA Awareness domain included a qualitative question that allowed participants to describe issues they had observed or been made aware of but not addressed in the survey. A summary of responses to item 23 by participating group is included in Table 6.3. Some of the responses to this item were complemented by responses from interviewees. For example, faculty and students were aware of the importance of including religion in cross-cultural communications. Fatima was aware of the lack of inclusion of religion in conversations about culturally responsive education. Staff were also aware of lack of respect and tolerance for religious diversity, indicating that more dialogue is needed to achieve acceptance of diverse of views. Staff elaborated,

In the laudable effort to be aware of, and sensitive to, religious/cultural diversity of the holidays season, the discussion of the problem of cultural expression of diversity has become a binary argument; a) enforcing a majority, one-tradition-only approach, or b) forbidding any expression of seasonal goodwill that might possibly be linked to an actual

tradition, whether religious or secular either of which is equally dysfunctional and equally a suppression of diversity.

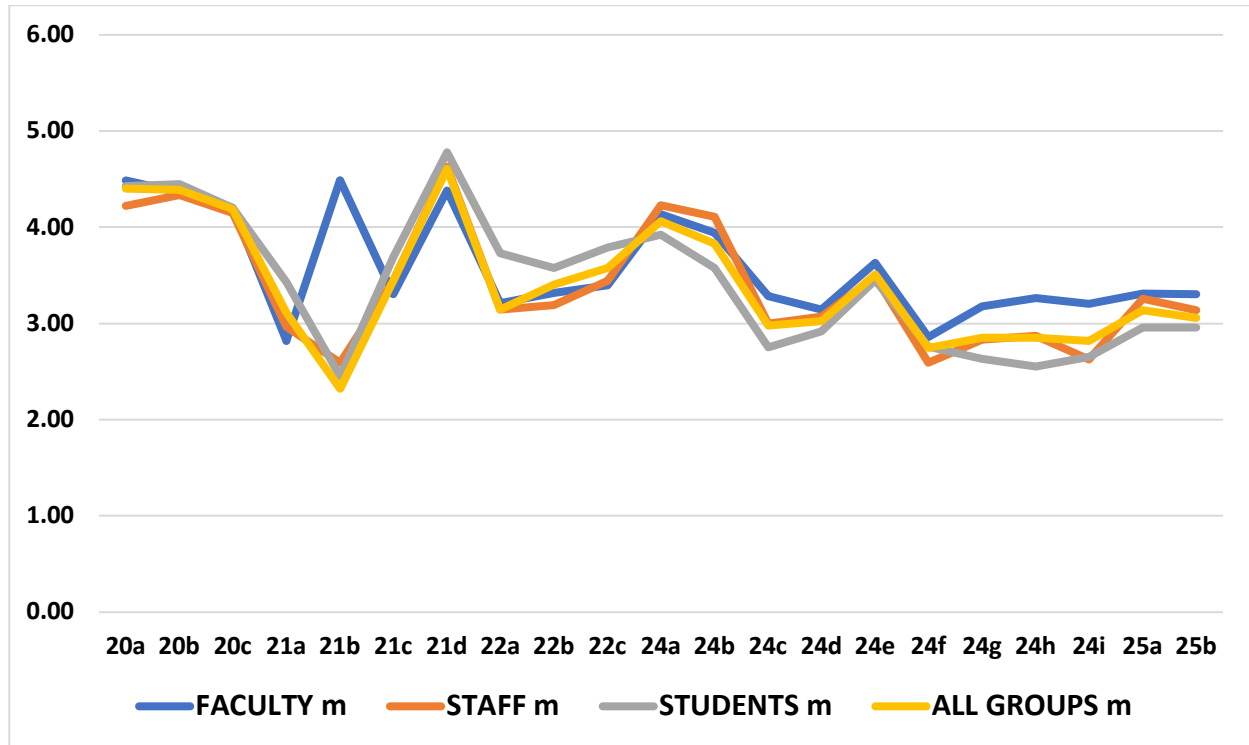


Figure 6.1. Median by participant group and reported self-awareness

In responses to item 23, faculty were aware of other issues. One remembered “a disturbing incident with a staff member ... who experienced racial profiling...” The individual affected “felt he was treated unfairly [and the issue] affected our whole program.” This faculty also expressed awareness of how “...students experienced discomfort in a course by their lecturer who reinforced racial stereotypes.” Another faculty member indicated, “I am most sensitized to issues in the faculty hiring process and in the process of accepting students that reveal biases in those making those decisions.”

Staff were aware of a more comprehensive list of challenges. One acknowledged that part of the discomfort expressed by their colleagues when having discussions about

discrimination, racism, and oppression was due to lack of dialog. A different staff member indicated that having the ability to recognize these issues is important because

Table 6.3

CCQ-DKASA Item 23 cross-cultural issues observed or made aware of

Cross-cultural issues observed or been made aware of	
Faculty	<ul style="list-style-type: none"> Religion must be included in discussion about cultural diversity and cross-cultural communication Racial profiling increases unfair treatment to underrepresented minorities Racial stereotypes reinforced by faculty increases discomfort of students Biases in hiring process and admission of students who express biases
Staff	<ul style="list-style-type: none"> Dialog about issues of discrimination, racism, or oppression must increase Need to identify own biases and recognize historical and institutional forces impacting them and minorities populations Question, interrupt and change discriminatory behaviors Long-term impact of social and institutional discrimination Individuals must recognize mistakes, be willing to get feedback, learn, and grow Being uncomfortable is part of the process to make changes Socio-economic and educational elitism Need to increase awareness, sensitivity, and respect for non-binary traditions Sexist comments
Students	<ul style="list-style-type: none"> White privileges Implicit bias against students of color Harassment and microaggressions Biases and positionality role in interdisciplinary work Racist faculty Inappropriate facilitation of difficult conversations Racist/sexist faculty and microaggressions impact on students' learning Identity of faculty and interaction with members of culturally diverse groups

...part of being aware and trying to act for change is identifying your biases and acknowledging the historical and institutional forces that ...shaped [them] ... [and] negatively impact so many underrepresented peoples in this country. ... Being uncomfortable but challenging yourself to engage in these issues regardless of that is part of the process in changing these dynamics.

Participating staff were also aware of the impact of sexist comments in the educational environment and on cross-cultural communication and cultural diversity. Staff recounted how gender, racial and ethnic disparities directly influence access of members of diverse cultural groups to spaces intentionally reserved for members of the dominant population and increase social and economic disparities. They indicated that “relatively little weight seems to be given to the forces of socio-economic disparities and even more, educational elitism in the university system.” Students were aware of similar issues such as microaggressions based on racial profiles and the impact of their identity on their privileges. One also added “...biases and positionality and how [these factors] affect ... [individuals’] role[s] and interactions with others in the program.” These were considered important because awareness impacts identity, teaching experiences, and interactions with culturally diverse groups. Recognizing the ways in which “White folks tend to be bad at acknowledging their own privileges” was also among the needed area of analysis identified by students.

Influences of identity on working experiences and interactions with diverse cultural groups

Faculty, students, and staff described how their racial and ethnic backgrounds; gender and sexual orientations; language skills, religion, and disabilities affected their experiences in the DGH, SPH, and the university. They also described how environmental settings such as places where they were born, raised, and have lived, studied and worked influenced those experiences. Some challenges and advantages encountered are summarized in Tables 6.4, 6.5, and 6.6. Explanatory comments follow the tables. These narratives illustrate some of the demographics and training experiences identified by faculty, staff, and students on the survey. For example, during interviews various students highlighted the limited opportunities they had to interact with populations that actually comprise the U.S.

The previous observation can also be made by looking at Chapter IV Demographic Domain Results, Table 4.4 (p.73) which shows that among CDQ- DKASA respondents there were no staff of AIAN, NHPI, or African ancestry, no students of NHPI or AIAN backgrounds, and a very small number of diverse identities on the faculty body. In general, participants described in the survey and interviews the representation of diverse students in the institution, indicating that it is very small, and it is achieved through the admission of international students. Interviewees indicated that most students they encountered are African natives and that there is an underrepresentation of African American students and lack of diversity of faculty on campus.

Faculty, staff, and students said that individual's racial and ethnic backgrounds were some of the most impactful factors on their experiences and the experiences of some of their colleagues. For example, Peter and Charlene were very aware of how race and ethnicity affected the work of faculty. Peter agreed with colleagues who have expressed that

If you are Black, Hispanic, or [member of other] minorit[ized group], as a professor, it is different and more difficult. You can't work at the same rate and expect the same results if you are a minority.... Yeah, being a minority is tough. Everything from interactions with students, classroom teachings, evaluations. Everything is a little bit more difficult than one would expect.

Charlene's awareness of similar experiences and effects were evident in this situation with an African-American colleague:

I was very peripherally involved, with an African American friend who is faculty. [She had] ... some really major problems with other university faculty. I got very involved...trying to [help], working with others to show support for what she was going through. It really taught me a lot about it. I mean, I just learned a lot about what African Americans go through in academic settings. The big message that

came through is the isolation. The fact that there are so few African American faculty and certainly very few African American students in our graduate programs. There are Africans, but not so many African Americans. How isolating that feels? But even for international students, they feel on their own.

Charlene provided other examples of the impact of racial identity in the life of African Americans. She acknowledged the importance of being aware of challenges experienced by African Americans, indicating that awareness alone is not enough. Charlene asserts that change actions need to accompany this awareness. Charlene recalled the following situation that illustrates this need:

[We] were having a small group of friends at home, one of them was African American and one of my other friends was talking about Obama. This other friend said, ‘Obama is not really Black you know. He grew up privileged and all that.’ And this African American friend just jumped on her and said... ‘as a Black person... you don’t grow up in America as anything but a Black person. That is... You look like that, you are African American, that's all there is to it...’

Just hearing what people have to say and recognizing their experiences, what they have gone through, is critical in understanding where they are at... For example, [data trends on] African American faculty over the years have gotten worse... It’s really astounding because there’s awareness, but somehow, we just haven’t been able to move past that awareness stage.

In explaining how race and ethnicity can influence the identities of faculty, students, and staff in different ways, Lindsay shared how she became aware of her privileges while working abroad. She was taken aback by the levels of respect and special treatment she received. Lindsay indicated that when she learned the term White Privilege, she thought

about how she felt when recognizing that she had not earned that respect and associated benefits. Lindsay stressed the importance of checking power imbalances and the need for health professionals to increase their awareness and examine their attitudes about self and others when interacting with members of diverse marginalized cultural groups. This awareness should be present in working both locally and abroad. As she explained,

Every time I go [abroad], I receive a lot of respect and deference. It is often out of proportion of what you deserve. You might visit someone in their house, and they want to give you their only chair. They move their elderly mother so you can sit in that chair. Obviously, I do not deserve that chair, but people show a lot of respect. Sometimes, this happens a lot and in different formats, personally and also professionally. When I finally learned the term White Privilege, It was the term that I have been looking for all these years to express how uncomfortable I was with being given automatic privilege that I did not merit. That is something that when you work in another country you have to be well aware of your own privileges and check them It is one of the challenges of cross-cultural working.

Donna recommended similar cautions regarding discrimination by race and ethnicity, microaggressions, and awareness of racial privileges and challenges. She added that differentials on compensation for services can be experienced by faculty and staff:

We have more female faculty and faculty of color, but do the salaries match? I don't know. Definitely, White males and females earn more than Blacks and other people of color in the USA. ...In this country, social justice has to increase. There is this pervasive perception about race [and gender] in terms of who has the ability to earn and succeed in our environment, culture, economics...

Table 6.4

Racial and ethnic background impact on identity, learning and working experiences of faculty, staff, and students

	Faculty	Staff	Students
Race and Ethnicity	<p>Faculty of color reported being ignored or questioned when sharing expertise.</p> <p>Faculty were often placed in stereotypical racial and ethnic roles.</p> <p>White faculty recognized White privilege when doing international work.</p> <p>White faculty recommend countering power imbalances.</p> <p>White faculty identified isolation as one of the issues impacting members of diverse populations, especially African Americans.</p>	<p>Staff and faculty of color have increased somewhat in numbers, but the salary might not be a match with that of White European ancestry employees.</p> <p>An exception might be found for individuals of Asian ancestry. Racially, they seem to succeed in a White environment.</p> <p>The way individuals from different racial and ethnic groups relate to individuals in positions of power impact their experiences.</p>	<p>Stereotypes of students with diverse cultural backgrounds affect their identity regardless of their gender.</p> <p>White males feel less challenged in their learning because of assumptions that they know how to do things right.</p> <p>Research is mostly focused on the experience of White people. When it refers to diverse populations, it does not include the voice of the researched population or their academics.</p>

Donna indicated that some public figures of color and other non-White racial groups such as Asians have been stereotyped as successful. However, she also indicated that

“these “successful” individuals and groups are unevenly cited as “proof” that society is an even playing field for all, and that racial/gender inequality is not a barrier to success in our environment. Worse, sometimes these non-White success stories are held up as somehow decreasing the opportunities for White (male) citizens. This seems to perpetuate the fabricated justification for uneven distribution of resources and opportunities across gender and racial divides.”

Other factors such as cultural values related race and ethnicity also impact the opportunities of individuals from diverse groups to succeed in the institution and life in general. Jessica shared these perceptions as an Asian American, from a culture characterized by respect for elders and authorities:

I think in Asian American culture, it's more like there's definitely figures of authority whereas American culture is a lot about self-advocacy. Interacting with people in positions of power is definitely different for me, just based on my background... I would say that's like a lifelong thing. It's not necessarily something that's specific to this program or the department. It's more of just learning how to be more of a self-advocate in our meritocracy.

Both male and female students from diverse cultural backgrounds were aware that faculty stereotypes affected their identities. Pablo described how the use of negative stereotypes in the classroom disrupted learning experiences:

In the DGH, I think there are very good mentors, but a lot of the professors are White [who] come from a specific mind set. I experienced a very bad situation with one professor making huge stereotypes. That is something that kind of

impacted ... my identity... When I was sitting there in that class and everybody heard what that individual stereotyping Black people, male specifically.

Everybody looked at each other... one friend of mine right next to me... was really upset... White and Black people were just looking at each other like—I cannot believe that he said that.

Hakim also was aware of how racial stereotypes in the classroom disturbed his learning experiences as evident from these comments:

Another faculty last year, in one of the classes... said something and got a lot of people offended. He said something that sounded really racist against African Americans and lots of people stood up and didn't let go. The professor tried to explain that he didn't really mean it, but it was really bad. The good thing is that that faculty doesn't teach that course anymore.

Fatima made an observation that suggested that she was aware that diverse faculty can have positive effects on students learning:

...there's one instructor, ...every time she comes around, I feel good because I can identify with her. I can see this Black African woman... impacting knowledge instead of being on my side of the aisle, and sitting, and listening to White people tell her what to do.... So yeah, every time I see a [member of a] minori[tized group] teaching, I am happy.

There were other ways in which the student participants were cognizant of race and ethnicity impacting the learning environment. Both White and students of color noted that research tended to focus on the experiences of Whites, and when diverse populations are studied the research does not include the voices of the researched. These observations were explained by Pablo as follows:

... We have a lot of conversation with my peers from other regions and we definitely observed that the vast majority of faculty are White American that come with a specific perspective... There is nobody from other regions of the world bringing perspectives from other countries. Even though it is global health, it is known as unidirectional from the U.S. to the world but not from the world to everybody.

Francis recognized her limited knowledge about racial minorities. She believes health professionals need to learn more about these groups to improve their abilities to provide quality services. Speaking from her perspective as a White student she explained:

I'm used to being ...majority. I'm always wanting more information on the minority and how to care for the minority because I generally serve ...underserved and minorit[ized] populations... I want more information... our research is largely on White populations and so that's frustrating when you're looking at data... I want to hear more of what the minority has to say. But data [are] usually more on the majority's view.

Hakim also considered it is important to have faculty members from diverse ethnic minoritized groups. He explained,

Every department should have a page including statistics of the diversity of their students, faculty, and staff. This way students can know before they apply and accept opportunities to study in a particular program and the institution. Applicants should know what the diversity of the program is as well as what is the knowledge and skills faculty have to interact with diverse populations. Applicants should know if the institutions have faculty who are natives from countries where research will take place. They should know if they

will be learning from faculty who might go to many countries but want to do there what they think they know, but do not consider the local perspective.

Lindsay shared some personal thoughts from the perspective of a faculty member that suggested that she was aware of the tendency to focus on negative conditions and experiences of members of minoritized groups, and she expressed the need to include some of their assets and strengths as well.

One of my personal challenges is to try to describe health disparities but also talk about the strengths of the different groups. For example, sometimes people think that right now African Americans in the US have tremendous health disparities compared to White Americans. But just giving a talk about how much worse it is... is demeaning... just spew out a bunch of negative statistics and say you are more likely to die, you are going to be a drug addict, going to jail, I do not feel good about that. Often people think that talking about health disparities is the same thing as having a culturally appropriate curriculum. We talk about how bad it is to be a Native American, how bad it is to be a Latino, how terrible is to be African American... That it is not the way we want to approach health disparities. This approach leaves people feeling very alienated and also reinforces the wrong message... We get to decide what to do... Then, all these other communities are out there to be decided upon.

... In GH, I think most [faculty] have some sensitivity to [how to] talk about African Americans. But some do not incorporate the community perspective. ... I hope people [will question] if they are the person to give a talk, do I need to be more careful? But in GH, you can go to many lectures where people talk about a health problem in a country far away totally objectifying the situation or talking about how bad it is even without paying attention to their audience. What can we do about this?

Table 6.5

Awareness of gender and sexual orientation effects on identity, learning, and work experiences

	Faculty	Staff	Students
Gender	Parity of salaries and opportunities to reach leadership positions continue to be a challenge for women in all fields. Women are frequently categorized into stereotypical gender roles.	Women continue to be the most oppressed group. It is harder for women to obtain promotions	Some students have never had a Black female Muslim TA. Female students feel that outspoken women make some colleagues uncomfortable. Female students feel that having female faculty encourages them to ask questions. Male students also have expressed benefits of having female faculty
Sexual Orientation	Faculty did not mention sexual orientation as an identity factor impacting their experiences. No LGBTQ faculty participated in interviews, but one faculty reported working with members of the LGBTQ community often.	LGBTQ staff felt unsupported in their professional growth by leadership. LGBTQ staff felt stigmatized by other members of the department. LGBTQ members struggle with general understanding from others, especially when you work in a department that is focused, on large part, on HIV/STD research. [People need to know that] we are not just the center for AIDS research which is where we are siloed. LGBTQ felt that the university had active resistance for inclusion. LGBTQ members felt dismissed and discouraged from sharing their perspectives.	Students did not sexual orientation as a factor impacting their experiences. A straight student reported interacting with members of the LGTBQ community as individuals rather than as a group.

This could be approached by ...first [having] people from those communities leading the discussion, sharing their challenges, the strengths in their communities. Because there are tremendous strengths and resilience... emphasize ways to move forward... hear voices from groups, see them set their own agendas.

All three groups demonstrated how their gender and sexual orientations affected different issues and experiences, along with race, ethnicity, and economic status. While they might not have acted upon their observations, this did not mean that they were not seeing and listening to the dynamics. A case in point is Roxy who was very aware of the gender disproportionality with favored females among staff. She did acknowledge that some changes were occurring. She said, "mostly women are employees, ...[they] are staffers... On faculty, ...most of them were White Americans... men. [It is] starting to change as people... [are] wanting to diversify [them]."

Donna and Lindsay pointed to racial and gender disparities in salaries with White females and racial minorities being paid less than their White male colleagues. Lindsay and Rodrigo added disparities in leadership positions as well. Males dominate even in programs that are populated mostly by females. As Lindsay explained, "women get paid less, often get passed over for leadership positions, and they have to deal with people" stereotyping them in roles with less ranks.

Alexis awareness of inequities and disparities he observed in the DGH was a consequence of his personal sexual identity as LGBTQ. He pointed out the general misunderstanding from others, prejudices, and resistance as well as the negative effects these behaviors have on his identity and feelings of self-worth.

My [awareness about my] identity, as a Caucasian gay man and as a member of the LGBTQ community, [has been impacted by] a department that is focused, in big part, on HIV/STD research... I see a visible ... need to reframe how [the department have seen]

sexuality and... LGBTQ people. [Academics need to know that LGBTQ individuals] are not just part of the center for AIDS research, which is where we are siloed... there [has been] active resistance to me expressing [these ideas] ... Sometimes, [I am] the only gay man in the room... [similar to] the experience of a person of color ... Sometimes, I feel like an alien there.

Isolation based on racial identity and sexual orientation was frequently referenced by the participants as they characterized their awareness about various types of diversity. Students were aware of isolation experienced by their LGBTQ peers. For example, Antony was conscious and indicated, “[on campus] I encounter [LGBTQ] more as individuals than as a constituted group.” Alexis also provided compelling examples of how this awareness is personally affecting his feelings and responsive behaviors:

[They] make me question my approaches, my work style, my voice, my perspectives. The way I talk, my emotions, gesticulations, all kinds of things I question. It’s hard seeing people don’t get you. They don’t get the culture references. They don’t get your experiences. They don’t understand where you’re coming from... That’s how I feel most of the time. Then, I do gravitate toward other people who feel the same way...[Where] I find ...community connection I connect. Unfortunately, people graduate every year. I lose a lot of people every year who I make connections with, who have similar experiences as well. [Among] the students ... is mostly where I find that [connection], not with my colleagues. [With them], I feel very isolated.

Sarah associated her awareness of gender disparities to her work place. She indicated:

I work on a project [in places with extreme male dominance], I have to be very aware of my unique role and also the assumptions I bring, especially as an outspoken woman, that can make some colleagues uncomfortable... I’m respectful and reflective of what is

appropriate and professional for them and vice versa. They're doing the same for me. It's a very different set of cultures.

Francis was aware of a somewhat different gender dynamic, in her education and work setting, than Sarah. She explained that,

I'm always excited when I have a woman that's a teacher. [Particularly] when I'm in a field for women and community. So, I feel more comfortable going up and speaking with a woman than if [the teacher] is a man, especially about women's issues.

Anthony also expressed awareness about how having a female teacher made a difference in his learning:

For some reason, having [classes] taught by women was a very different of experience and [way of] interacting with students. Students [were] much less tense. I would say that [these female professors] had a different teaching style than most of the statistics professors, male statistics professors. This was something that was very good. They were very enlightening for understanding the matter being taught. Very, very good classes I had. They were very [instructive and enriched the learning experience] for me in many aspects ... I would say that the students were asking questions... in a more gentle way... There were much better at explanations than was usually the case in a lot of the classes. It was one thing that I wasn't expecting. You know, having very methodic classes than that of the typical male statistician professor made a difference. The classes were more relaxed and there was more opportunity to communicate with the teachers.

Identity factors recognized by participants that influenced their experiences were interconnected and overlapping. As the data in Table 6.6 show, religion was a key one. For example, Fatima associated religious prejudices with insensitivity and rather rude curiosity of

Table 6.6

Awareness of the effects of language skills, religion, disability, and environmental settings on identity, learning and work

	Faculty	Staff	Students
Religion	No mention of religion as an identity factor impacting experiences	No mention of religion as an identity factor impacting experiences	Stereotypes can impact the learning experiences of individuals whose religious affiliations are easily distinguished by their clothing and practices
Language Skills	Knowing other languages and cultures are assets to serve diverse populations in the U.S. and other countries. Language skills made the speaker feel appreciated and respected at work	No explanation of the impact of linguistic identity on interactions with members of other cultural groups	Learning and understanding body language can help improve cross-cultural communication In addition to language skills there is need to understand local context and histories
Disabilities	No mention of disability as an identity factor impacting experiences	Individuals with disabilities routinely experience microaggressions, feel marginalized, withdrawn from processes, and ignored	No mention of disability as an identity factor impacting experiences
Environment	Rural upbringing created a sense of community that is shared by people in other countries. Families live in a very closed knit, care for each other, and there is not anonymity, creating real community support.	Non-U.S. born members report themselves as privileged minority who become invisible after others are aware that they do not know the local culture	The opportunity to learning in cohorts that are diverse in cultures and perspectives is highly valued

students about her being Muslim. She expressed frustration with others questioning her about the way she dresses as part of her religious practices. Her comments point to the intersectionality of race, gender, privilege, and religion:

This quarter, I had a student tell me, 'I've never seen a Muslim TA before.' She asked me that and then the following week another person came up to me and asked me, 'Are you a Muslim?' I don't know what the stereotype is like over here, but I've been in situations where people feel like I'm less of who I am, or I'm not as intelligent, or I'm not as capable because of the way I dress, my identity, and how I come across culturally before even interacting with me.

Fatima was also aware of how both verbal and nonverbal communication nuances affected her self-presentation and how others' reaction to hers due to cultural differences. She found puzzling how intonation, and the use of all upper-case letters when writing an email message could have contradictory meanings. Hakim knew it was important it is to understand the cultural values embedded in different languages, and that knowing how to speak a language is not enough to maintain good communication with individuals from different cultural backgrounds. As he explained,

Languages help people come closer... it is really nice if a person can speak the language [of the people] where he is going to practice... I [also] need to have an understanding of how to interact with what I see; not even [just] speaking but having an understanding of the local language, the culture, the history.

Rodrigo understand that language skills and Latino identity were assets to his career as a health care professional. He described how his language skills and Hispanic identity have contributed to his working experiences. This insight was apparent in his comments.

I came to work here because of a project that was only in Central America. The department needed someone not only who speaks Spanish but who also knows the culture. I think I have been appreciated and the people respect the work that I do there.

Disability as an identity factor that impacts the experiences of participants is also included in Table 6.6. Only staff and students seem to be aware of these interactions. Donna described how she encountered resistance when expressing concerns about individuals with disabilities. She described these as "... hostile aggressions, [not] "microaggressions", toward people with disabilities. I have disability issues. Even though I look like everybody else." Donna's "invisible" disabilities demonstrates the need for awareness and analysis of various forms of differences that may not be obvious. This point was further illustrated by Anthony. He was the only student who expressed awareness about students and other individuals with disabilities. In recalling that, he said, "I had interactions with one student who is legally blind...[but] I am not aware of more people with disabilities on campus."

The last factor presented in Table 6.6, that the participants interviewed were aware that environment and context influenced identities and experiences, was environment or context. It was conceived as physical spaces and human structures where learning and other interactions occurred in the past and present. For example, Charlene was conscious of how the environment in which she grew up affected her work. She remembered it as a close-knit rural community where everyone knew, looked out for, and helped each other. She added that while some might consider this "strange" it was "normal" to her and others who lived and experienced it. Some participants realized the contextuality and complexities of racial identity. Particularly, Donna a White woman who grew up as "a privileged minority" in another country was not familiar with much of the U.S. dominant culture. She indicated that her awareness of the cultural differences made her feel lost at times. Roxy noticed racial clustering among students. These groups made it

easy to differentiate between international students, students of color, and White students. Roxy also notices the demographic variations of the different cohorts. Fatima associated some of her personal interactions with Whites with historical colonialism in her native country, although she recognized the value of cross-cultural relationships.

[When] I came to this department... I was very untrusting of White people because of the history of my country. Our interactions with White people have always been like, they take advantage of us and they leave us... With time, I am seeing things from a different perspective. I'm understanding how they think and how they interact with me... I feel like it has really helped my learning. ... having a cohesive cohort that shares [ideas] really helps with diversity and understanding [of] each other. I'm relating more to my cohort in a positive sense.

Pablo also acknowledged in his comments that inter-racial interactions are beneficial. He was aware of how

[The DGH] helped us create an environment where we are together. ...[When members of my] cohort take the same classes [and] go through the same things together [it] helps develop very good relationships...

Part II: Institutional Awareness

Learning, teaching and working experience in a predominantly White Institution

During interviews, faculty, staff, and students described how working, teaching or learning in the DGH and in a predominantly White institution impacted their experiences. Analysis of responses provided to the CCQ-DKASA indicated that all participants were highly aware of the ways in which systematic and institutionalized racism, poverty, and prejudice negatively affect members of racial, ethnic, and other minoritized populations. When

interviewees were asked about experiences related to cultural diversity their reactions were discouraging. They were aware of situations in which dynamics of power and privilege affected them and individuals they interacted with. The main topic they addressed and specific issues raised by participants are included in Table 6.7.

Differential treatment experienced by minoritized faculty was evident in these comments indicating that institutional standards seem to be different for minoritized faculty. Particularly, participants expressed a feeling of oftentimes being in the wrong place and having very few spaces to make mistakes. Participants described situations in which they felt that they “didn’t belong in this group or club of individuals” when referring to their peers and colleagues. Interviewees also described a situation in which these general feelings were reinforced by specific experiences, one participant described an instance in which a professor seemed unfairly treated after a good teaching performance, indicating

Recently, [a professor] was removed from a class without explanation. They [told the professor] ‘you aren't going to teach this class anymore’... The ironic thing was that the previous class [the professor] taught had a rating of 4.0. Like a top rating in the school, but they didn’t explain anything. They just said, ‘[the professor is] no longer [going to be] teaching this class.’ [the professor] was left hanging [and asking] ‘it’s there an explanation? ‘No explanation.’

The communication between staff and faculty of color seem to be good. For example, Peter’s interactions with staff and student members was very good. He said, “I don’t know if it’s a power dynamic, but they tend to be much better. Personally, I have very good relations with staff members” He also indicated, “the minorities in a lot of our classes tend to be African students. They can relate with me. I can relate with them so teaching becomes easier. However,

Peter encountered challenges. He noted that, “It is much more difficult as a faculty member if you are minorit[ized]. ...whether unconsciously or consciously, you are viewed differently by

Table 6.7

Cross-cultural awareness of faculty and staff

Topic	Awareness issues
Minoritized Faculty Experiences	<ul style="list-style-type: none"> Oppressive environment Differential treatment Negative stereotyping Disrespect Discouragement
Training alone is not enough	<ul style="list-style-type: none"> Diversity training has not increased DEI Diversity training as strategy to increase diversity is not enough Cultural humility a better strategy to understand privilege
Power Dynamics	<ul style="list-style-type: none"> Senior White faculty belittles work of African American faculty in front of a large audience Junior faculty feels powerless in front of authority of senior faculty Students, including students of minorities, witnessed biases, discrimination, and abuse from senior faculty Recognizing institutional discrimination
Stereotyping roles	<ul style="list-style-type: none"> People of color more often than not are stereotyped into least skilled roles
Inequalities of race, gender and sexual orientation	<ul style="list-style-type: none"> Humanizing LGBTQ out of the HIV/AIDS and STD stigma Most leadership positions are held by straight men Women commonly struggle to get parity People of color and women are often stereotyped in positions of less hierarchy. Systemic racism doesn't allow room for fighting discriminatory battles
Identity Awareness	<ul style="list-style-type: none"> Recognizing own identity and the identity of others
Lack of Diversity	<ul style="list-style-type: none"> Impact of patriarchy on faculty of color and junior faculty Diversity hires make DEI conversations richer
Breaking the norm	<ul style="list-style-type: none"> The experience of a female leader Efforts from staff to be empathetic

Hierarchal divide	Some senior faculty overshadow the efforts of junior faculty and staff to increase DEI Oppressive behaviors that ston learning Impact of discrimination on reputation of the department
Global White male domination	White male leadership in non-White Countries

students and evaluated differently. The perception of how smart you are is different.”

Minoritized faculty indicated that mistreatments and wrong assumptions have been the norm in the institution. In Peter’s experience, when something good happens that is an exception. As he pointed out, “[faculty of color] are allowed [fewer] mistakes in [their] speech, actions, and in results. During observations and interactions with faculty and participants in this study, the investigator noticed that when minoritized faculty say something in a meeting, they are very careful about what they say. It was confirmed by participants when the investigator discussed her assumptions and understanding of their interactions. Participants in the study and other faculty in the university indicated that oftentimes, faculty of color prevent themselves from sharing their ideas or asking questions during meetings because their voices are often ignored, or they are scrutinized for saying something that is on their minds. It was confirmed by participants when the investigator discussed her assumptions and understanding of their interactions. Participants in the study and other faculty in the university indicated that oftentimes, faculty of color prevent themselves from saying anything during meetings because their voices are often ignored, or they are scrutinized for saying something that is on their minds. According to some of the interviewees and throughout interactions with other faculty in the institution, most faculty of color shut up unless they really need to say something. For many members of diverse groups not talking and getting treated badly is the rule. Interviewees indicated that, in this university, when faculty of color gets treated well that is the exception. Particularly, Lindsay was aware of challenges to improving cross-cultural communication.

After years of attending cultural diversity trainings, she expressed disappointment at the amount of progress made. Institutions claim to continue promoting the idea of cultural competence without accompanying action steps to increase diversity, guarantee inclusion, and achieve equity. She thought cultural humility was a better goal and emphasized that training alone is not enough to provide faculty, students, and staff with the knowledge and skills to change attitudes towards DEI. As she explained,

I have been going to diversity training for 25 years. Yet the institution has not changed at all. It is really not more diverse than when I started as a student. Personally, I feel like we need some other methods besides just going to training and workshops if we are going to move on in this area. I don't think that it is really working. Although it has worked to make me feel like I am a good person because I go to diversity trainings. I don't see that the university has actually gotten more diverse. In terms of whether people are having a better experience I don't know, maybe, but it hasn't changed the spectrum of who is attending the university.

Every university I have been at has diversity committees, diversity day, and lectures sponsored about diversity. The environment [feels like], 'Yeah! we talk about diversity.' ... It feels like I have been doing cultural diversity training my whole educational life but yet we are not making any progress... I am happy that new workshops are a little better at emphasizing cultural humility. It might be a better strategy. ...[However] there is a lot of room for criticism for what has been done so far. I don't think that [DEI] has really moved much. It makes people feel like they are doing something. It is a little shallow.

Lindsay recognized the challenges African American faculty encounter. She used an experience in which she witnessed an individual being interviewed for a faculty position at the university to substantiate her awareness:

A prominent African American scientist came to interview for a job at our university. I watched one of our more senior scientists treat her horribly, ... in a way that I could not have imagined was even possible. I am still very ashamed that I was part of that experience. People in my department didn't realize how bad it was at the time...Both of those scientists knew each other for many years. It wasn't like this was a total stranger attacking her from out of nowhere. It was actually done under the rubric of, 'Oh! we go back such a long way. So, tell me why your research is a total [mess].' This is not a direct quote, but it was a very demeaning question.

I just felt and still feel awful at having been a witness to that experience. [Another] part that was awful about that experience was that we had trainees in the room that were watching ... I thought, what on earth are they thinking? Can you be an African American woman, a senior professor interviewing for a really big job at this university and this is how you are going to be treated? Is somebody going to come to your job talk and treat you with such disrespect in public when you cannot even say anything about it?

Lindsay was also aware of how the mistreatment of this professor was affecting the students who were present. She noticed that

The room where this happened had about 70 people and the interviewing committee was about ten people. Nobody said anything. People, ...after work tried to mitigate. After [the antagonist] asked his question, some other people said, 'We love your talk. It was great;' and asked [the visitor] kinder questions. At the end, [people] thanked her for coming and

said nice things, but [this experience] was unbelievable. I thought, what do we say to ...all the [students] watching this? What do they think? ... I didn't know what to do. This [faculty] is so much more powerful than I am. Really, am I going to stand up and say, 'that was a rude question,' in front of my whole department. ... It didn't seem that anything would make it better because the words had already come out of his mouth... I felt talking about it after the fact was the way [for me] to address it. ...it was the most embarrassing, shocking and awful [experience] I have ever seen. We have to fix this... I still think people haven't done anything. But just verbalizing it gives me some permission; [saying] it aloud was very therapeutic for me. I ... joined a diversity committee because a lot of people in our department think we do not have a problem. They think we are fine. Clearly, we have a problem.

Lindsay also described how gender impacts opportunities for women. She added,

...women are struggling to achieve parity with men in all the fields that we are working. It is a huge issue ...that women ...deal with on a daily basis. Not just with our colleagues but also with [populations served]. ...it is a space I [have felt] very comfortable navigating for a long time. ...It is not impeding me anymore, but it is sort of annoying that we are still dealing with ...women ...[being] paid less, and often [passed] over for leadership positions.

Other interviewees were cognizant of presence and effects of racial, gender, and sexual orientation-based stereotyping and discrimination. Female, LGBTQ, and racial minoritized faculty members often felt scrutinized and harshly criticized by peers who assumed they needed to be supervised. Sometimes, their expertise was suspected or dismissed, and they were made to feel belittled. Alexis and Peter provided examples of these demeaning situations. Peter was cognizant of the held and oversimplified image in

which people of color, especially individuals of African ancestry, have been seen. He shared his own experience, describing the way he has been treated,

I have been in the corridors, if there are spills, [people believe] I am the janitor, because I'm black.... All of a sudden ... I am automatically one of the janitorial staff because the janitorial staff looks like me The assumption is that you belong to this group, that you don't belong to the faculty, and the signal is that it is because of your skin color or accent.

Alexis was sensible of stereotypical assumptions that LGBTQ people are transmitters of diseases. He said,

I tried to talk to my colleagues about... doing a service to humanity by bringing [LGBTQ] people, [who are mostly subjects of [HIV studies], out of the shadows. Bringing them a sense of self-worth by connecting them with other human beings like themselves in places where [there doesn't' seem to be] a space for them. I was trying to look for mentorship [hoping for encouragement,] ... but instead when I shared my ideas [heterosexual people in power] shot them down...

Discordances based on sexual orientation, race, and gender were not the only ones the interviewees reported observing in their routine work and learning environments.

Rodrigo added that in his program “the way these imbalances are presented is more related to hierarchy. There are more women, but leadership positions are mostly held by men.

The participants interviewed were aware that for members of diverse populations, reaching positions with higher pay and statuses did not do much towards changing how they are treated by members of dominant populations. Some interviewees indicated that sometimes faculty of color have been addressed as student by staff and faculty during

meetings, even after being introduced as faculty members. One participant recalled a situation in which a hiring committee was interviewing candidate for a leadership position. A Black faculty was introduced along with a White student and other committee members. One of the interviewees would continually ask the faculty ‘What do students think?’ while addressing the student as faculty. Particularly, Peter associated being disrespected in front of an audience with racial prejudice because he is familiar with this situation. He said, “I’ve been in a place where I was introduced to speak, and I spoke. Then you know someone said, ‘let’s hear from someone who actually knows something,’ essentially belittling my presentation because someone was going to come and speak who happened to be White...” Peter recognized that “the system does not reward [minoritized faculty] for fighting discriminatory battles.” Peter’s comments align with observation made by the investigator as well as similar responses provided to her when recruiting participants for this study. Various faculty expressed discouragement to explore issues of equity. To a high degree their words tried to dissuade the investigator’s interest in the topic by indicating that nothing has been done in the past. Minoritized faculty from different schools and programs indicated that they are oftentimes overburdened doing their jobs as faculty, representing their minoritized groups, and fighting discriminatory battles.

Several other interviewees shared comments that indicated awareness of other important aspects of authentic culturally diverse interactions. For instance, Donna believes everyone should be aware of their own identity and respect diverse identities of others to improve the quality of interracial interactions and cross-cultural communications. Roxy was conscious about the challenges experienced by faculty and staff advocating for diversity and how they are overloaded with this responsibility

without appropriate leadership support. She was concerned about the over-reliance on people of color to facilitate diversity initiatives and said, “if we’re going to continue to rely on the faculty and staff of color to carry everything through, that’s not sustainable and it’s not fair.” Roxy was also aware of how the diversity composition of groups made conversation richer and improved learning about cultural diversity.

Alexis shared observations and insights about challenges faced by female leadership. He was aware of when he started seeing female leadership,

I started to reevaluate special pressures of being the first female leader of our department, trying to understand ...dynamics and ... decisions ... [after] a lot of people come at her with some really harsh criticisms. I wonder ... how much of it is turned at her because she’s a female leader [in a male dominated institution].

Furthermore, Roxy was very perceptive about gender inequities in the department.

Roxy’s perception was illustrated by her comments that “older White men in the department continue to be patriarchal [and make] certain remarks that were clueless. ...It’s just a very strong sense of hierarchy... [that] feels oppressive It makes staff feel like they’re being stepped on; it makes students feel like they don’t matter; and it is more a general pattern and atmosphere. ... You can just tell that [when] some of the older faculty in the room are not taking a particular lesson on cultural competency seriously, while the staff and the younger faculty are. That sets up a divide... You see the ... old guard just not getting it and it’s frustrating because they hold the power. So when you want to bring in more discussions about social justice and things like that it’s harder to advocate because they don’t get it. ... That changes how we are able to work... [It seems like they] don’t think that it is an issue that actually affects people’s learning and the reputation of the department.

Jessica suggested that faculty need to be more aware of the effects of White male dominance on global health efforts in non-White predominant countries, describing how some faculty bring awareness about these factors. She pointed out that,

It's interesting [to see] the shifting ties in global health [and the way] it was started by White men who had a lot of power and money to start these programs abroad. They imposed their own agendas on other cultures and that's something that ... we are always critical [of] how often White people are leading programs in non-White countries.

Students were also aware of issues that influence cross-cultural communication. They shared some aspects of personal journeys that affected their interactions in the university. The main topics they addressed, and some specific issues raised were included in Table 6.8. The experiences and issues mentioned by student interviewees could be incorporated into the DGH reform efforts. Hakim was aware of the lack of diversity in the institution, especially faculty and limited interactions among students. He recalled,

After moving to the U.S., ... I do not see myself in a challenging environment which is not the case for many other students who just moved to the US... For me, it is sad to see that there is a lack of diversity. I recognize lack of diversity of perspectives in the [course] content. [It is missing] the views of the populations we are studying. [There is lack of] diversity of faculty representatives from the countries we are studying. We could learn more. In many courses, the content is taught without context. I haven't seen anyone from my cultural background teaching. I haven't even seen a guest speaker with my cultural background since I started this program. Only once an African American faculty was invited. We discuss problems of diverse populations and we do not hear their perspectives. They are people from different cultures who are very well educated. They

can do a great job teaching a class or being part of a class. Graduates might be good with technicalities such as how to collect data, how to do analysis but they are not training nor have the foundation to understand others... You do not see [White students], socializing with members of minoritized groups.

Table 6.8

Cross-cultural awareness of students

Topic	Awareness issues
Developing thicker skin	Lack of diversity of faculty and students Lack of community perspectives Lack of inclusive content in GH programs Poor preparation to understand populations to be served
Diverse perspectives	Benefits of having diverse faculty
Limitations of individual backgrounds	Personal limitations to provide culturally responsive services Willingness to seek appropriate training
Missing voices	Lack of representation of affected populations White dominance during anti-racism class
Power and privilege	Faculty racism Administrative support to faculty Impact students emotionally and academically
Multidisciplinary perspectives	Need for inclusive teaching/learning strategies

The lack of diversity among faculty made learning experiences more challenging for Anthony. He described the limited opportunities he had as a student. He also acknowledged the importance of tying the history of diverse populations to the disparities they face.

In order to have class with a non-white American professor I had to go to a different school. In the DGH we only have one... teacher that is from Iran. It was the only class in the DGH and SPH. There was also a German teacher in the department. ... There was one class that was taught by one teacher who was Filipino and that was a class for me was very interesting. That class I took it outside of the program outside of public health. It had

a lot of discussions and interactions. I learned a lot and understood some of the history of the Filipino in the US.

Francis acknowledged her own identity and the limitations it brings. She expressed the need to improve learning opportunities to be able to provide services to all populations,

I am myself White. I've always come from a place where I am part of the majority... I am aware of that. I have always tried to find additional training. [I try to] go to places where I am not the majority to be able to experience how that feels. [I want] to be able to provide for or to provide care [in places] where I might not be the majority.

Other students were aware of the need diverse faculty to address sensitive issues related to diverse populations. They were also aware of the lack of content and context to address cross-cultural issues. Fatima explained,

I took the Undoing Racism class, I was shocked that the people that came to teach the class looked White. The lady was obviously White American, and the man sounded American but told us he was from somewhere in the Middle East. I kept waiting for the third Black person to show [up] because how can you talk about racism in America without bringing a Black person. ... I'm waiting for the victim to come and have his voice heard.

Students were informed about a few incidents involving issues of power and privilege that influenced their learning experience. In one class, after facing what students called open racism from a faculty member, some students dropped the class, and had to pay additional fees to change their schedules. Other students could not find alternatives and decided to take the class after the instructor was changed. Hakim explained,

A White professor on health services made a very racist statement. ...About half of the class left that classroom. Students went back to the administration and the Dean tried to convince students that the [professor] didn't mean what he said, [and encouraged the] students to move on. Even when the program assigned a new faculty, the barrier already existed between students of color and the new faculty because the new faculty was also White. This is an example of how a faculty affected the learning process of many students.

Sarah, who was completing a dual program was mindful of how her interdisciplinary perspectives affected her participation in a global health classroom. She presented an example of a classroom dynamics influenced by language associated to a particular discipline. She said,

Power and privilege come into play for me in my classes in global health. [It included] Global Health students, ... public health students, ... economics students, [and] medical students. ...I always felt like I was in a position of less power ...[because] I didn't understand a lot of the global health jargon. I felt like I had to explain my views and felt excluded from the group.

She also was cognizant of gender and racial dynamics that affected her and her co-workers' experiences. Sarah indicated,

Power and privilege overlays everything that we do. There's no escaping that. I've had sort of an interesting set of experiences as [my supervisor] ... has changed over the last five years --an American man, American woman, American man again, and now a man of non-European ancestry.... Those two men were much harder to work with and work for regardless of race and ethnicity it was harder to work for the men. The non-White man was a bit more subtle than the

White American men. [With] the woman . . . , I never had any sense of [her] questioning my capacity, capability, or my ability to expand and contribute in valuable ways. No question of my intelligence or role. Very rarely [I experienced] those small insults like being asked to be the person to always take notes at meetings and [other] things as the only woman in the room. That didn't happen so much under her [leadership] but under the two men those things were pretty frequent. One of the things that frustrate me most about that experience is that I'm pretty secure and outspoken. I have a lot less fears in that kind of sphere than somebody who is a minoritized or comes from a different culture or from a different country. I was also aware of how a [foreign] female co-worker felt very uncertain about pushing back against our male [supervisor].

Awareness of Institutional efforts to increase DEI

Both on the survey and during interviews, participants indicated that in the DGH and the university the number of diversity committees has increased. Faculty and staff have heard about these efforts during meetings in their respective departments. Some of the faculty also reported participating in a combination of committees since they have joint appointments in different departments and schools. In their efforts to improve the educational environment some of these committees were more effective than others.

Faculty, staff, and students were aware that these committees reviewed hiring and admissions processes, department and school policies, and other initiatives to increase diversity and promote equity and inclusion. Interviewees shared their perceptions of DEI committees. Some of their thoughts and perceptions are summarized in Table 6.9.

In reflecting on his service on a diversity committee Rodrigo recalled: “we talked about how we can make [the program] more attractive for people from different backgrounds...I think that increasing diversity is something that is on the agenda. I am optimistic on that.” Other interviewees who had also participated on department and school diversity committees had a different perception. Although they were familiar with DEI efforts and were committed to change, they thought the proposed changes were more symbolic than substantive, indicating that across campus change efforts exist in this framework of checking boxes without substantive actions. Some interviewees explained that these efforts are very relevant and a good first step. Similar to Charlene, they clarified that the next step is to put money where people's boxes are being “ticked.” Real actions are accompanied by financial support.

Table 6.9

Interviewees awareness about institutional efforts to increase DEI

Participant	Improvement strategy used and current results
Faculty	Recruitment of diverse faculty. Increased diversity in program. Changes can be made when there is action and funds. Currently, in some programs these efforts have been symbolic.
Staff	Improve diverse faculty search. It has been ineffective There are good intentions but lack of commitment. Some efforts include Revision of hiring practices, Update of hiring policies, Admission of international students, Admission of underrepresented students at school level, Creation of the Center for Anti-Racism and Community Health (ARCH). One successful effort was the hiring of the director of Diversity, Equity, and Inclusion (now, Dean of DEI).
Students	Many emails promoting training and lectures. These are offered as extracurricular activities, making participation more challenging. Refer student to organizations like GO-MAP which are used as tokens or symbols of inclusion while the university has not improved diversity and support to members of diverse groups has been ineffective.

Charlene and Peter indicated that the institution needs to acknowledge the lack of faculty diversity and be willing to hire and invest to bring them in. In this respect, Charlene did not think

that diversity efforts have been successful because committees and their members did not have clearly defined conceptions and action plans. She continued saying,

[while] there have been policies around increasing faculty diversity. I don't think they have done anything. I don't think they have been effective. I mean, there's no evidence that they have been effective. ... Twice now I've been aware of faculty searches in which [faculty of color who] seemed to be really well qualified [applied]... In both cases they were not selected... [They] really seemed to be really well qualified, certainly as well qualified as the person who was selected. You just think what is this? Did somebody miss the memo there? The search committees have their own little ideas about who they want. If that person doesn't look like the person they have in mind, you know. Something else needs to happen, I'm afraid.

Alexis also was familiar with the existence of diversity committees in the DGH and SPH and other diversity efforts. However, he thought commitment to these efforts were more guided by good intentions than by the actions to accomplish the necessary changes. In supporting his perceptions, he explained that

We have the diversity, equity, and inclusion committees at the school level and the department level. We had a number of trainings. I think there's revision of hiring practices or hiring updated policies. I think that there's commitment at least on a verbal level for having diverse staff and faculty. I've seen diverse candidates come in. Not everyone has had a successful hire, but I think there's at least an effort in that goal... [with regard to students] there have always been more... international students... they're being more successful in getting more underrepresented student on the school level... they've hired the Director of Diversity and Inclusion ... Hopefully... soon they will hire [a director] ... for the Anti-Racism Center for community Health (ARCH).

Alexis' perceptions resonated with those expressed by Charlene, Donna, and Peter who questioned the genuineness of diversity initiatives and qualified current actions of committee members as limited to "ticking boxes."

Students were aware of some cultural diversity activities promoted within their programs, department, school, and the university. These included seminars, workshops, movie screenings, and the Graduate Opportunities and Minority Achievement Program (GO-MAP) which develops initiatives to expand education opportunities for underrepresented minoritized (URM) populations. However, students expressed concerns that these efforts were not accompanied with enough broad institutional structural support. For example, Francis pointed out that although departments, schools, and the university promote these events by emails, oftentimes activities do not fit students' schedules. She was frustrated in personalizing the conflicts:

I get so many emails all of the time and there's so many screenings of movies; there's lectures; there's ... student led programs. There's no shortage of those types of activities and they are largely around diversity and inclusion. Unfortunately, most of them are extracurricular activities and the times in which they are offered do not fit my schedule.

Pablo recognized that the Graduate Opportunities and Minority Achievement Program (GO-MAP) and similar initiatives lacked wider institutional support and are used to prevent criticism; to give the impression that DEI is improving; and to give the appearance that diverse students are being treated fairly. As he said,

[Leadership in] the institution often mentions an overall commitment to social justice... if you are looking for inclusion, you are guided to go to GOMAP. [Although] it is a great place to go for students of color, ... diversity and GOMAP have been used as tokens.

Recognizing successful teaching strategies

Faculty, staff and students who participated in interviews were conscious of teaching and learning strategies that were the most helpful to them while receiving cultural diversity and cross-cultural training. These strategies were included in Table 6.10. Participants considered that these strategies could contribute to improving DEI in the department, respective programs, and the university. Most participants agreed that small group discussions are one of the most helpful teaching strategies. Faculty, staff, and students also emphasized the importance of having members of diverse cultural groups participating in discussion groups. They were aware that this is particularly challenging in a predominantly White institution. Nonetheless, interviewees emphasized how important it is to directly listen to members of diverse populations and the perspectives they bring. They were appreciative of learning opportunities in which they could directly interact with members of diverse populations, and they were receptive to having practical experience where they were not part of the majority. For example, Lindsay was aware of the importance of listening to people's stories and participating in conversations that made people uncomfortable. She acknowledged, "the need to have empathy for other people's experiences and to recognize that their experiences and perceptions of what is going on maybe very different from my own." To underscore this point Lindsay recalled "an activity about stereotyping which made everybody very uncomfortable. We had a lot of discussion about why we were uncomfortable and what we could do to move through that to get to a different place." Rodrigo recognized the importance of discussion group engagements, while Alexis appreciated the multiple perspectives this approach to teaching and learning elicits. Francis and Sarah were also cognizant of discussion approaches to learning since they allowed students to tell their stories. Fatima added some comments about the value of having members of minorized groups as instructors for both students' interactions and teaching quality. She remembered that "last

year, some of the Black students told me to my face; ‘we’ve never had a Black TA before’... Like they’ve never had a Black female TA ever and these were students that were graduating from the SPH...”

Table 6.10

Teaching and learning Strategies

Participant	Teaching/learning Strategies
Faculty	<ul style="list-style-type: none"> Personal stories Group discussions Videos Readings Practical activities Pair discussions Include representatives from different groups in discussions
Staff	<ul style="list-style-type: none"> Group discussions Films Readings Lectures Develop cross-cultural vocabulary Exercises of identity development Organize round tables Personals stories Discussion of contentious topics respecting backgrounds and opinions Group didactics Deep conversations about sensitive issues such as long-term impact of slavery
Students	<ul style="list-style-type: none"> Small group discussion Sharing personal stories Pay attention to body language, voice intonation, and other non-verbal signs Readings Practical activities Videos Group or pair discussions Writing During coursework papers should address the culture of the country explored Visuals Listening Small group discussions including members of diverse groups Personal testimonies and experience of people from diverse cultural values Experience other cultures where you are not the majority

Summary

In assessing their levels of self-awareness of various issues and dimensions of diversity, faculty, staff, and students explored how their identity and cultural backgrounds impacted their experiences in a predominantly White institution. Participants in the survey and interviews reported strong levels of awareness of their own racial, ethnic, and cultural identity; stereotypes, biases and prejudices; and how systematic and institutionalized racism, and poverty negatively affect different racial and ethnic populations. Some students highlighted the limited opportunities they have to interact with various populations that actually comprise the U.S. Indicative of this was the fact that there was no staff of AIAN, NHPI, or African ancestry; no student of NHPI or AIAN background; and only small representation of diverse members of the faculty in the research sample. Furthermore, participants, in the survey and interviews were aware that the small representation of diverse students was achieved through the admission of international students, emphasizing the underrepresentation of African American students and diverse faculty on campus.

Participants across groups were aware that their departments have a mission, vision, and goals to promote diversity, cross-cultural communication, and culturally responsive education. However, the levels of awareness varied somewhat by the type of participants (i.e., faculty, students, and staff). Regardless of the levels of awareness reported by groups, the focus was more on needs and initial efforts than on practice-based diversity actions. All participants by group agreed that their programs, the department, and the institution have insufficient diversity in students, staff, faculty, learning content, and experiences.

On the CCQ-DKASA participants indicated high levels of awareness of the effects of systematic and institutionalized racism, poverty, and prejudice on members of racial, ethnic, and other minorities populations. Participants were most aware of the impact of race and ethnicity.

However, gender, sexual identities, language skills and accent, religion, disabilities, and environments were noted as well. Some participants of European ancestry were aware of their White privilege and the impact of race on the experiences of individuals of non-European ancestries. They recognized the levels of discrimination, biases, and isolation experienced by members of diverse cultural groups. When asked about their experiences, the reactions of interviewees were discouraging. They had observed or experienced situations in which dynamics of power and privilege impacted them negatively.

Participants were aware of some institutional efforts to increase DEI, such as more diversity committees. But they considered teaching and learning strategies that involved group discussion more valuable. They were also mindful of the importance of having members of diverse cultural groups participating in discussion groups. However, realizing this was particularly challenging in a predominantly White institution. They were aware hiring and admitting more members of diverse cultural groups could alleviate this situation, but participants concluded that it has not been a priority in the school, department DEI efforts, and the various programs where they learned and work.

Chapter VII

Skills and Attitudes Domain Results

For the purpose of this study, skills were defined as levels of expertise and abilities faculty, staff, and students must have to address cultural diversity and cross-cultural communication. They included aptitudes, prowess, and readiness of participants to manage challenges related to racial, ethnic, and cultural identities, stereotypes, biases, and prejudices; institutional and systemic discrimination; racism, and oppression. Items included in the Skills domain of the CCQ-DKASA are listed in Table 7.1. Descriptive statistics, including the total distribution of score frequencies, means, and confidence intervals for faculty, staff, and students are presented in Table 7.2.

Irrespective of groups most participants rated items in this domain within the ranges of “moderate” and “somewhat” skilled. Faculty rated two of 20 items in the “very” skilled range, indicating that they had the expertise to appropriately interact with people from different cultural backgrounds. Staff rated four of 20 items (27a, 27b, 27g, and 27k) in the “a little” skilled range. These same items received the lowest scores from faculty and students as well. The low rating by staff may have been affected by the fact that many performed administrative duties and were not directly involved in delivering health care practices. Item 27k might be worth exploring further in determining staff training needs. It addressed advising skills and practices for culturally sensitive communications. The variance in mean scores for items by participating groups are presented in Figure 7.1.

Table 7.1

Skills Domain items in the CCQ-DKASA

SKILLS DOMAIN	
26a	Greeting people with different cultural backgrounds in a culturally sensitive manner
26b	Eliciting perspective about learning or communication styles
26c	Eliciting and discussing information about use of folk remedies and alternative healing modalities
26d	Eliciting and discussing information about folk healers and alternative practitioners
26e	Developing culturally sensitive examinations, needs assessments, or intervention plans
26f	Performing culturally sensitive examinations, needs assessments, or intervention plans
26g	Providing high quality culturally responsive education, advising, or other services
26h	Working with language interpreters
26i	Assessing health literacy
27a	Conflicts relating to interventions, diagnosis or treatment caused by cultural beliefs
27b	Adherence/compliance problems caused by cultural beliefs
27c	Ethical conflicts caused by cultural beliefs
27d	Apologizing for errors and comments based on personal biases, prejudice or lack of knowledge, and resolving the issues
27e	Interacting with individuals from cultural, racial, and ethnic backgrounds different than your own
27f	Interacting with individuals with limited English proficiency and language accent
27g	Interacting with individuals who insist on using, seeking, learning about and supporting folk healers and alternative therapies
27h	Identifying beliefs that are not expressed by individuals but might interfere with outcomes of your services
27i	Being attentive to nonverbal cues or gestures that might have different meanings in different cultures
27j	Interpreting different cultural expressions of pain, distress, and suffering
27k	Advising others to change behaviors or practices related to cultural beliefs that impair one's communication in a culturally sensitive way

Table 7.2

Skills domain descriptive statistics and 95% confidence intervals for the means of participant by group

TOTAL RESPONDENTS						FACULTY					STAFF					STUDENTS							
#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R
			LB	UB					LB	UB					LB	UB					LB	UB	
26a	111	3.84	3.65	4.03	M	26a	38	4.16	3.93	4.38	V	26a	26	3.88	3.54	4.23	M	26a	47	3.55	3.19	3.92	M
26b	110	3.69	3.48	3.90		27e	37	4.11	3.85	4.37		27e	26	3.77	3.35	4.19		26b	46	3.57	3.22	3.91	
26e	111	3.29	3.00	3.57		27f	37	4.08	3.76	4.40	M	27f	24	3.71	3.23	4.18		26e	47	3.28	2.87	3.69	
26f	108	3.29	2.99	3.59		26h	38	4.00	3.50	4.50		26b	26	3.69	3.21	4.17		26f	47	3.13	2.69	3.57	
26g	110	3.26	2.99	3.54		26b	38	3.84	3.51	4.17		26h	26	3.58	3.05	4.10		27e	47	3.77	3.41	4.12	
26h	111	3.51	3.22	3.80		26f	36	3.72	3.25	4.19		27i	26	3.15	2.72	3.59		27f	47	3.64	3.28	3.99	
26i	111	3.10	2.82	3.38		27i	37	3.65	3.32	3.97		26c	26	3.08	2.50	3.66		26g	46	3.09	2.63	3.54	S
27d	110	3.18	2.94	3.45		26g	38	3.61	3.16	4.05		26g	26	3.08	2.51	3.65		26h	47	3.09	2.62	3.55	
27e	110	3.88	3.69	4.08		27d	37	3.49	3.07	3.90		26e	26	3.04	2.31	3.69		27d	47	3.09	2.72	3.45	
27f	108	3.81	3.59	4.02		26e	38	3.47	2.99	3.96		26d	25	2.96	2.20	3.72	S	27i	47	3.09	2.72	3.45	
27i	110	3.29	3.07	3.45		26i	38	3.39	2.94	3.85		26f	25	2.96	2.35	3.57		26i	47	3.04	2.64	3.45	
26c	110	3.04	2.75	3.32	S	27j	37	3.38	2.99	3.77		27d	26	2.92	2.38	3.47		27j	47	2.91	2.54	3.29	
27j	109	2.96	2.73	3.20		26d	37	3.30	2.81	3.79		26i	26	2.77	2.06	3.48		26c	47	2.83	2.36	3.30	
26d	109	2.95	2.66	3.25		26c	37	3.27	2.80	3.74		27j	25	2.44	1.98	2.90		26d	47	2.68	2.21	3.15	
27k	109	2.73	2.49	2.98		27k	37	3.24	2.80	3.69		27h	24	2.29	1.82	2.77		27k	47	2.68	2.34	3.02	
27h	107	2.69	2.44	2.94		27h	36	3.03	2.58	3.47	S	27c	24	2.13	1.67	2.58		27h	47	2.64	2.24	3.03	
27c	108	2.49	2.26	2.76		27b	37	2.95	2.49	3.40		27b	24	2.08	1.62	2.55	L	27g	47	2.55	2.16	2.95	
27g	107	2.50	2.24	2.77		27a	36	2.86	2.41	3.31		27k	25	2.08	1.62	3.02		27c	47	2.43	2.09	2.76	
27b	108	2.46	2.22	2.71		27c	37	2.81	2.40	3.23		27g	23	2.00	1.48	2.52		27b	47	2.28	1.92	2.63	
27a	107	2.38	2.14	2.63		27g	37	2.76	2.28	3.24		27a	24	1.96	1.50	2.42		27a	47	2.23	1.88	2.59	

Scale: Very Much (V) 4.1-5.0 Moderate (M) 1.1-4.0 Somewhat (S) 2.1-3.0 A Little (L) 1.1-2.0 Not at All (N) 0.0-1.0

#: Item number n: number of participants m: median score CI: confidence interval LB: Lower Bound UB: Upper bound

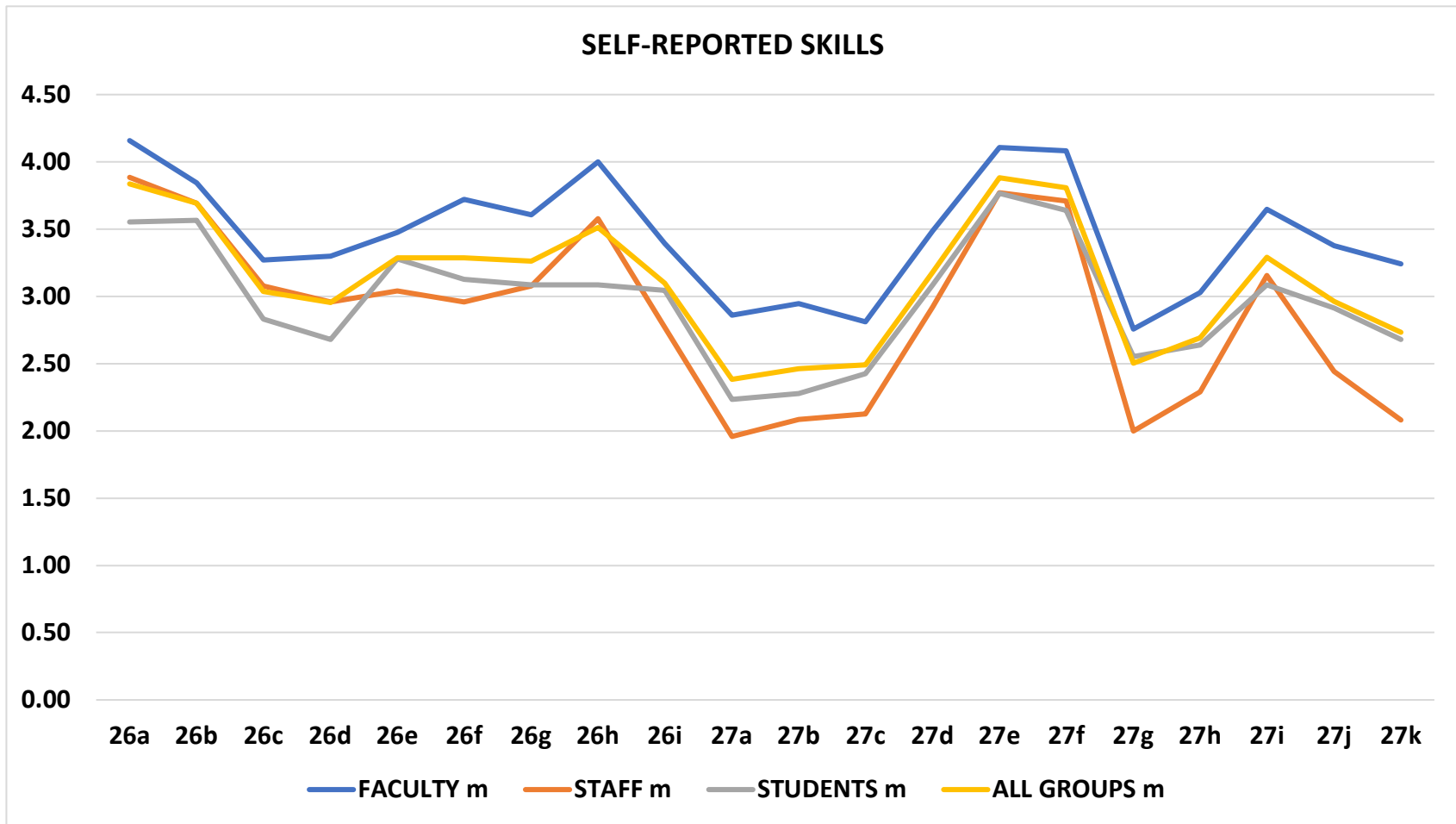


Figure 7.1. Median by participant group and reported skills

On the CCQ-DKASA, participants described some skills to improve cross-cultural communication. But rather than skills per se these suggestions were more about preconditions or receptivity to skills development. For example, some staff members suggested,

truly embracing diversity necessarily includes societal permissions for open expression of personal cultural and even religious tradition and mutual willingness to respectfully tolerate and even potentially embrace or adopt elements of another tradition without condemnation or resentment, because after all, Culture, like Nature, abhors a vacuum.

Interviewees also identified abilities necessary for mutually beneficial interactions with members of diverse cultural groups. Some of these were summarized and included in Table 7.3 which presents skills identified by combined groups and within each group.

All participating groups identified willingness to learn and checking their own privileges as important to improving diverse relationships and cross-cultural communication. Jessica, Hakim, Pablo, Charlene, and Anthony agreed that listening is an important skill in cross-cultural communications. Lindsay elaborated further using a situation she experienced:

There was a racial incident in the DGH, and a meeting was organized to debrief it. I was extremely impressed at the leaders of the department because they did so much listening during that meeting. I had assumed [leaders] were going to just talk...[but attendees] poured out their feelings ... and it really affected me hearing their perspectives and also seeing people in leadership positions just listening...I don't think I have seen so much listening displayed so actively.

Anthony emphasized the importance of listening to populations served by health care professionals because,

We are learning to explain to people around the world how they should do things ... themselves. ... Just seating, spending time listening, and looking at what people have to say ... are the best ... [ways to start] building from what you heard and [use] your knowledge to find a solution or start a relationship with people...

Faculty, staff, and students also indicated that willingness to speak-up, stand-up, understand, communicate, and share are necessary to improving equity, and inclusion. One of the “speaking up” skills that interviewees from each participant group agreed to was checking one’s own privileges. Particularly, Lindsay said that recognizing White privilege can help individuals to identify automatic benefits received without merit and address power imbalances. Hakim added

the social construct of race has a big role in what we do. How do you behave if you do not know those privileges? If you do not [recognize] implicit biases ... [you] are not going to be aware of power dynamics. [It is important to understand] the role of power dynamics and how we are part of it.

Francis, Charlene, Donna, Sarah, and Anthony agreed that “questioning own assumptions” is necessary for individuals to challenge their views and recognize biases. Alexis thought, “being open to receiving criticism and not taking it personally” was hard but very important. Other faculty and students emphasized respect and self-awareness for improving cross-cultural communication and relationships. Comments made by Sarah and Peter are illustrative of the reasoning for these choices. Sarah said, “...self-reflection and self-awareness [are] incredibly important” and “there needs to be a structure ... and a pedagogy” to help develop these capabilities. Peter added that they were essential abilities to avoid microaggressions. For Rodrigo, “the key is to be respectful. ... [because] when there is a lack of respect, [communication] is not going to work.”

Furthermore, faculty and students reaffirmed the importance of being inclusive. Lindsay referred to the need for historical and contemporary analysis of disparities on the curriculum content while Pablo recommended increasing diverse faculty in the institution. Hakim and Rodrigo, on the other hand, identified emotional intelligence as an important skill to communicate with different people. Although several other interviewees added to the list of skills for better cross-cultural relationships and health practices, they did not elaborate on them. For example,

- Alexis: “Grounding in the history and the context of [diverse] communities and [their] vocabulary.”
- Donna: Willing to admit mistakes and ask for forgiveness; be willing to be vulnerable and humble.
- Francis: Curiosity and compassion instead of preconceived notions
- Sarah: Be thoughtful and avoid visceral and judgmental reactions
- Roxy: Learn how to think critically.
- Fatima: Be kind.
- Lindsay: Leadership that “advocate for students and diverse trainees.”
- Jessica: Self-advocacy

Even though faculty, students, and staff acknowledged the importance of “apologizing for and resolving errors caused by lack of knowledge, prejudices and biases” (item 27d), only faculty and staff considered asking for forgiveness as a necessary skill to improve cross-cultural relations. All participants recognized their limited ability to be attentive to non-verbal cues (Item 27i), which was rated within the “moderate” level by faculty and staff and “somewhat” by students. Identifying cultural beliefs not explicitly expressed (item 27h) was also rated by all participants in the “somewhat” skilled category.

During interviews, only Donna, a staff member, added “Identify[ing] emotional cues and ...fostering your observational skills” as necessary. Faculty and student interviewees identified “advice” as a helpful cross-cultural skill. Lindsay and Pablo added the importance of checking one’s own privileges. Critical thinking was another skill identified by staff. Roxy suggested that critical thinking process is composed of a variety of skills that can improve diversity, equity, and inclusion. These included

...learning the context and learning how to think critically ...Learning how to speak directly to people and not just take hearsay or stereotypes as reality. ...knowing that the person that you’re working with is probably the expert on whatever they’re doing and [that] you’re just there to either learn or provide whatever support you can. [You need] to give the person you’re working with the same kind of standing and respect that you would give your colleagues at the university. Really look at people as your fellow human beings.

Checking power imbalances, being open-minded, having empathy, and increasing language skills were necessities for Hakim. When explaining why language skills are important, he said it would be ideal if health professionals could speak the native languages of their clients. Anthony and Francis agreed, because (as Francis said) “being able to talk to people in their own language [would help] finding out what their traditions are” and improve designing appropriate care plans or interventions. Hakim, Pablo, Anthony, and Sarah stated that to improve cross-cultural communication and address existing health disparities a “public health practitioner ...[should be] given the [skills] to interview people and be taught how to collect data” in a culturally appropriate manner.

In this study, attitudes were defined as favorable or unfavorable feelings, emotions, and beliefs assigned by faculty, staff, and students to concepts, persons, or objects based on their

experienced or observed behavioral responses towards diversity and cross-cultural communication (Last, 2007). This domain in the research included inclinations, prejudices, bias, preconceived notions, ideas, fears, threats, and other convictions impacting health disparities, equity, and inclusion of members of diverse cultural groups (Miller and Brewer, 2011). It was examined by 33 items on the CCC-DKASA—32 items were rated using a scale provided and there was one open-ended question.

On the survey, participants rated their attitudes towards factors contributing to health disparities; importance of cultural differences when interacting with people from diverse cultural backgrounds; effects of biases and discrimination on cross-cultural interactions; levels of comfort when communicating with and caring for culturally diverse individuals; and recognition and responses to situations affecting members of culturally diverse groups and their colleagues during working and learning experiences. Items included in the CCQ-DKASA Attitudes domain are listed in Table 7.4. Frequencies, means, and confidence intervals for faculty, staff, and students and for the total distribution of scores are presented in Table 7.5. Participants from all groups scored most items within the “very comfortable” or “very important” ranges. Specifically, student participants scored 28 of 32 items within this range, which was 94 percent. Faculty and staff scored 26 and 23 items, respectively, within the same range.

In the past, health and other challenges experienced by members of diverse cultural groups were often attributed to genetics. Across groups, participants rated the importance of genetics at the lowest level of the “moderately important” range and gave priority to a series of factors that are directly influenced by knowledge about, awareness of, skills to serve, and attitudes towards members of diverse cultural groups. Item 28d, which indicated that poverty contributes to health disparities, received the highest score from faculty and students, and

second highest from staff. Staff gave its highest score to item 28o (access to health care), as the most important factor contributing to health disparities. This item was scored as a second highest by faculty but received a lower score from students.

Across groups, participants rated item 28m (socioeconomic status) as the third most important factor contributing to health disparities of members of diverse cultural groups. Students placed item 31c (understand equity and cultural sensitivity to address existing educational and health disparities) fourth. Yet, the rating of this item was higher than faculty and staff. Faculty rated Item 28e (educational status) as the fourth most important factor impacting health disparities. Students and staff also rated this item within the “very important” range. Students rated item 28s, (institutional discrimination) fifth. They were followed by staff and then faculty who also recognized it as a “very important” factor determining health disparities of diverse cultural groups. Students and faculty rated item 32a (comfortable caring for racially, ethnically, and culturally diverse individuals), as “very important.”

Only students rated “training in biases, cultural diversity multicultural health care, and cross-cultural communication” (Item 31a) within the “very important” range. They also indicated that racial, ethnic, and cultural differences (item 30e) are “very important.” All participant groups felt “a little comfortable” working with peers and colleagues, or serving individuals who make derogatory comments about their cultural background or orientation or about people with cultural backgrounds or orientations different than their own (items 32d and 32e). Scores provided by individual groups and all participants are depicted in Figure 7.2. This figure demonstrates that most responses were consistent, --more so that responses to the other domains (awareness, knowledge, skills) examined in this study. In responses to the open-ended question (CCQ-DKASA Item 29) participants identified other important factors contributing to health disparities of cultural groups they encountered most frequently and issues generally

affecting the health of members of diverse cultural groups. A summary of these responses by students, faculty, and staff are presented in Table 7.6. Faculty and staff identified violence which may correlate with incarceration and criminalization suggested by faculty and students.

Intra-group discrimination, spatial mobility, and transportation were identified by students. These issues may be somewhat aligned with immigration status, ethnicity, and homelessness listed by faculty, and with national discriminatory policies suggested by staff. Attitudes associated with discrimination based on gender, sexual identity, and race were noted by the participants as important factors for consideration during cross-cultural communications. The analysis of these data revealed that in most instances, the participants either talked about their attitudinal and behavioral reactions to occurrences (or lack thereof) in their learning and working experiences or described some action or event from which attitudes could be inferred rather than dealing with attitudes explicitly.

Students indicated that lack of interactions with and exposure to issues affecting individuals from different cultural backgrounds produce attitudes that are counterproductive to culturally sensitive health care. Personal ignorance was identified by Alexis, Charlene, Lindsay, Pablo, and Anthony as an important factor that affects attitudes of faculty, students, and staff towards culturally diverse individuals and groups. These attitudes, in turn, influence understanding and behaviors when discussing inclusion strategies in the DGH and the university. For example, “sometimes the way people have solved [cross-cultural communication challenges] is by hiring people who look like them and they feel comfortable with. [But]...it is [not] a good solution. We should ...hire ...diverse people, Lindsay recommended. Anthony also mentioned the importance of listening to the experiences and opinions of people with diverse cultural backgrounds.

Table 7.4

CCQ-DKASA Attitudes domain items (edited)

ATTITUDES DOMAIN	
28a	IMPORTANT factors contributing to health disparities: Genetics
28b	IMPORTANT factors contributing to health disparities: Lifestyle
28c	IMPORTANT factors contributing to health disparities: Environment
28d	IMPORTANT factors contributing to health disparities: Poverty
28e	IMPORTANT factors contributing to health disparities: Educational Status
28f	IMPORTANT factors contributing to health disparities: Illiteracy
28g	IMPORTANT factors contributing to health disparities: Ageism
28h	IMPORTANT factors contributing to health disparities: Sexism
28i	IMPORTANT factors contributing to health disparities: Racism
28j	IMPORTANT factors contributing to health disparities: Classism
28k	IMPORTANT factors contributing to health disparities: Ableism
28l	IMPORTANT factors contributing to health disparities: Homophobia
28m	IMPORTANT factors contributing to health disparities: Socioeconomic status
28n	IMPORTANT factors contributing to health disparities: Access to healthy food
28o	IMPORTANT factors contributing to health disparities: Access to Health care
28p	IMPORTANT factors contributing to health disparities: Social Support
28q	IMPORTANT factors contributing to health disparities: Language access
28r	IMPORTANT factors contributing to health disparities: Social Discrimination
28s	IMPORTANT factors contributing to health disparities: Institutional discrimination
29	Other IMPORTANT factors contributing to disparities of the culturally diverse groups
30a	IMPORTANCE OF racial, ethnic and cultural differences in interactions with patients/clients
30b	IMPORTANCE OF: racial, ethnic and cultural differences in your interactions with health and other professional colleagues
30c	IMPORTANCE OF: racial, ethnic and cultural differences in interactions with Students
30d	IMPORTANT OF: racial, ethnic and cultural differences are in interactions with Staff
30e	IMPORTANCE OF: racial, ethnic and cultural differences in interactions with Faculty
31a	How IMPORTANT is it for you to: Receive training in biases, cultural diversity, multicultural health care, and cross-cultural communication
31b	How IMPORTANT is it for you to: Understand individual needs of the people you serve
31c	How IMPORTANT is it for you to: Understand equity and cultural sensitivity to address existing educational and health disparities
31d	How IMPORTANT is it for you to: Understand and be “in tune” with the meaning of ethnic dispositions, behaviors, and experiences
32a	COMFORTABLE: Caring for racially, ethnically, and culturally diverse individuals
32b	COMFORTABLE: Caring for individuals with limited English proficiency
32c	COMFORTABLE: Working with peers and colleagues with cultural backgrounds or orientations different than your own
32d	COMFORTABLE: Working with peers and colleagues who make derogatory comments about serving individuals with diverse cultural backgrounds or orientations
32e	COMFORTABLE: Working with or serving individuals who make derogatory comments about your cultural background or members of your group

Table 7.5

Attitudes Descriptive statistic and 95% confidence intervals for the means of all participating by group

TOTAL RESPONDENTS						FACULTY					STAFF					STUDENTS							
#	n	m	95% CI		R	#	n	m	95%CI		R	#	n	m	95% CI		R	#	n	m	95% CI		R
			LB	UB					LB	UB					LB	UB					LB	UB	
28d	111	4.92	4.86	4.98	V	28d	38	4.95	4.87	5.02	V	28o	25	4.88	4.74	5.02	V	28d	47	4.94	4.86	5.01	V
28o	110	4.85	4.77	4.93		28o	38	4.92	4.83	5.01		28d	26	4.85	4.66	5.03		31b	47	4.89	4.80	4.99	
28m	111	4.82	4.74	4.90		28m	38	4.87	4.76	4.98		28m	26	4.69	4.47	4.91		28m	47	4.85	4.73	4.97	
31b	110	4.73	4.61	4.84		28e	38	4.82	4.65	4.98		32c	25	4.64	4.38	4.90		31c	47	4.85	4.73	4.97	
28p	111	4.71	4.61	4.81		28f	38	4.76	4.55	4.97		28c	26	4.62	4.36	4.87		28s	46	4.83	4.70	4.96	
28i	111	4.70	4.59	4.81		28p	38	4.76	4.62	4.90		28p	26	4.62	4.41	4.82		28o	47	4.79	4.63	4.95	
28r	110	4.68	4.57	4.79		32c	38	4.74	4.55	4.92		31b	25	4.60	4.33	4.87		28r	47	4.79	4.64	4.94	
28e	111	4.66	4.54	4.78		28i	38	4.71	4.52	4.90		28n	26	4.58	4.32	4.84		31d	47	4.79	4.64	4.94	
32c	108	4.64	4.52	4.76		28r	37	4.65	4.44	4.86		28i	26	4.58	4.32	4.84		28i	47	4.77	4.59	4.94	
28f	110	4.64	4.51	4.77		31b	38	4.61	4.35	4.86		28r	26	4.54	4.28	4.80		28j	47	4.74	4.57	4.92	
28c	111	4.63	4.52	4.74		28j	37	4.57	4.31	4.82		28q	26	4.50	4.24	4.76		28p	47	4.72	4.55	4.89	
28j	110	4.63	4.50	4.75		28n	38	4.55	4.29	4.81		28s	26	4.50	4.26	4.74		28c	47	4.70	4.53	4.87	
28s	110	4.62	4.49	4.75		28c	38	4.55	4.35	4.75		28j	26	4.50	4.24	4.76		31a	47	4.70	4.48	4.92	
28n	111	4.60	4.47	4.74		28b	38	4.45	4.14	4.75		28e	26	4.50	4.24	4.76		28n	47	4.66	4.45	4.87	
31c	111	4.58	4.42	4.73		28q	38	4.45	4.16	4.73		28f	25	4.48	4.19	4.77		28e	47	4.62	4.41	4.83	
31d	111	4.56	4.41	4.70		31d	38	4.45	4.15	4.74		28l	25	4.44	4.17	4.71		28f	47	4.62	4.41	4.83	
28q	111	4.53	4.40	4.67		28s	38	4.45	4.14	4.75		30a	24	4.38	4.01	4.74		28q	47	4.62	4.43	4.81	
28l	107	4.45	4.30	4.59		31c	38	4.42	4.09	4.75		28k	26	4.31	3.92	4.70		28l	45	4.58	4.39	4.76	
28h	110	4.35	4.18	4.53		28h	38	4.39	4.12	4.67		31d	26	4.31	3.95	4.66		32c	45	4.56	4.35	4.76	
30a	105	4.30	4.11	4.50		32a	36	4.33	4.02	4.65		31c	26	4.31	4.03	4.58		28k	46	4.41	4.13	4.70	
31a	111	4.28	4.07	4.48		28l	37	4.30	3.98	4.61		28h	26	4.27	3.94	4.60		30a	47	4.40	4.12	4.69	
28b	111	4.27	4.10	4.44		28g	38	4.26	3.99	4.54		28b	26	4.19	3.85	4.54		28h	46	4.37	4.06	4.68	
28k	108	4.26	4.08	4.44		32b	36	4.17	3.84	4.50		30c	25	4.04	3.65	4.43	M	30b	47	4.26	3.96	4.55	
28g	111	4.15	3.98	4.32		30a	34	4.12	3.74	4.50		31a	26	4.04	3.59	4.49		30c	47	4.23	3.94	4.53	
32a	106	4.11	3.91	4.31		28k	36	4.03	3.66	4.39	M	30b	25	4.00	3.62	4.38		28b	47	4.17	3.89	4.45	
30c	110	4.04	3.83	4.24	M	31a	38	3.92	3.51	4.34		28g	26	3.96	3.57	4.35		28g	47	4.17	3.90	4.44	
30b	107	4.03	3.83	4.23		30c	38	3.79	3.40	4.18		32b	24	3.75	3.26	4.24		30d	47	4.13	3.81	4.45	
32b	107	4.01	3.81	4.21		30b	35	3.74	3.34	4.15		32a	23	3.74	3.23	4.25		30e	47	4.13	3.80	4.46	
30d	111	3.86	3.64	4.07		30d	38	3.61	3.18	4.03		30d	26	3.73	3.33	4.14		32a	47	4.13	3.83	4.43	
30e	110	3.80	3.57	4.03		30e	37	3.46	3.02	3.90		30e	26	3.69	3.24	4.15		32b	47	4.02	3.72	4.32	M
28a	110	3.25	3.00	3.49		28a	38	3.18	2.72	3.65		28a	26	3.27	2.73	3.81		28a	46	3.28	2.94	3.63	
32e	110	1.90	1.65	2.15	L	32e	38	1.97	1.54	2.41	L	32e	25	1.84	1.37	2.31	L	32e	47	1.87	1.46	2.29	L
32d	110	1.71	1.47	1.95		32d	38	1.76	1.33	2.19		32d	25	1.52	1.12	1.92		32d	47	1.77	1.36	2.17	

Scale: Very Comfortable/ Important (V) 4.1-5.0 Moderate (M) 1.1-4.0 Somewhat (S) 2.1-3.0 A Little (L) 1.1-2.0 Not at All (N) 0.0-1.0

#: Item number n: number of participants m: median score CI: confidence interval LB: Lower Bound UB: Upper bound

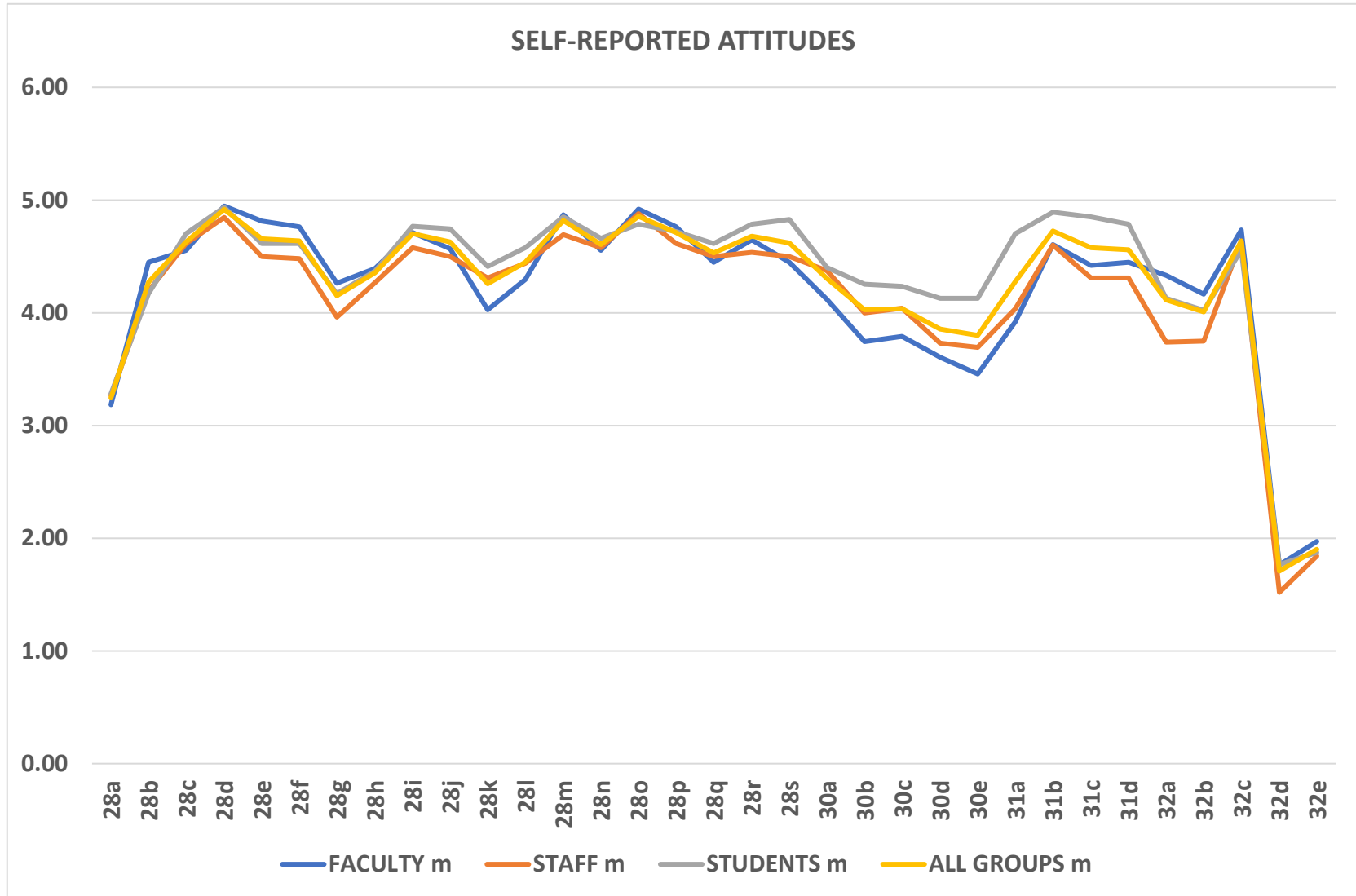


Figure 7.2. Median by participant group and reported attitudes

Table 7.6

CCQ-DKASA Item 29 Additional factors contributing to health disparities

Participants	Factors
Faculty	<ul style="list-style-type: none"> Drug use Violence Neighborhood safety Walkability Frequency of incarceration Sex work HIV Homelessness.
Staff	<ul style="list-style-type: none"> Immigration status Ethnicity Market forces National discriminatory policies Funding cuts for key programs Personal ignorance of the existence of a disparity Structural violence
Students	<ul style="list-style-type: none"> Criminalization Incarceration Intra discrimination Homophobia Beauty standards that disempower Black and Brown children Emotional health Mental wellbeing Spatial mobility Exposure to different cultures Gender discrimination Transportation

Attitudes towards cross-cultural experiences and DEI

Faculty, students, and staff provided many examples of experiences and dispositions indicative of DEI attitudes towards culturally diverse groups. Some of these are included in Table 7.7. Their examples also describe actions and strategies corresponding to attitudes of individuals and groups who experience tensions in the classroom. Some of them denote successful and positive attitudes to address challenges faced by members of diverse cultural

groups; other offer alternatives that promote more positive efforts to improve working and learning environments.

Table 7.7

Attitudes identified by faculty, students, and staff

Participants	Positive attitudes	Negative attitudes
Faculty	Friendly, respectful, modesty, broad-mind, humble, tolerance, responsiveness, responsibility, perseverance, reliability, considerate, confident, hopeful	Macro-Microaggressions, hostility, frustration, alienation, anger, racial slurs,
Staff	Responsive, flexible, cooperative	Fears, rebellion, insensitivity
Students	sympathetic, careful, pro-active, straightforward, honest, thoughtful, communicative, participative, willingness, humility, shy, resourceful, acceptance, friendly, self-protection	prejudiced, irresponsibility, thoughtless, dominating, control, selfish, anger, fears, controlling, self-centered, endurance, complaining.

Faculty provided examples of situations in which they or their students successfully addressed classroom tensions, including dynamics of power and privilege. Their description allowed the investigator to identify postures toward diversity, equity, and inclusion. Rodrigo, during his work at the department, has not experienced or observed classroom tensions due to cultural differences. He indicated that interactions have been friendly and respectful. However, Lindsay described reactions that caused and solved tensions in the classroom and identified other behavioral responses when interacting with students and individuals receiving services off-campus. Peter identified macroaggressions and microaggressive attitudes, clarifying that the latter are the most prevalent. In most cases, macro-and microaggressive compartments have been hard to

address successfully, especially because of the subtle nature of the majority of these insults, he said.

Charlene indicated that, over her many years of teaching, responding to individual beliefs during class discussions has been challenging. She admitted that she has not always been able to find successful solutions to negative preconceived notions that arise in class discussions. Students identified how situations with the behaviors of their peers or instructors have caused classroom tensions due to prejudiced, irresponsible, and thoughtless comments embedded in dynamics of power and privilege. They also described how some faculty taught them ways to be more sympathetic, careful, and pro-active, especially when trying to understand and address factors affecting cultural groups different than their own. Staff also shared some strategies to respond to cross-cultural differences with co-workers and improve communication issues in their work environments.

Lindsay's posture showed modesty and an open-mind to solve tensions. She said, "[sometimes] when someone brings a concern, I say it is a really good concern and put it out to the groups asking them, what do you all think about [this]?" She was pro-active, by posing issues for group discussion and considering the impact this or a similar situation may have on other students. Oftentimes, this strategy helps her find better solutions. Other students were more straightforward and direct in addressing diversity issues, Lindsay recalled:

We had one ...young White student who was dominating the classroom discussion and felt that he had something to say about everything. He was talking way too much, and some people gently said, 'maybe somebody else can talk now.' ... it is impactful when it is coming from a peer.

Charlene described how oftentimes tension arise when some students try to dominate and control small group discussions. She identified some helpful and successful strategies to deal with this type of situation, including discussions about being a leader and not dominating; frustrations of group work when one individual arbitrarily dominates; and separation of group members to end alienation. Charlene recognized that some of these problems do not always get solved and described one unsuccessful case.

[One student] was alienating others. She wanted to take control and said she would do things she wouldn't do ...but she would get angry if somebody else did it. ... [it was] very dysfunctional. ...[It is my] strongest memory of cultural problems..[that] was not successful[ly solved].

Charlene was tolerant and responsive in addressing issues interfering with learning. She indicated that when issues caused by cultural differences are not solved one needs to persevere and develop corrective strategies. Dominance of group work was also an issue faced by students, Francis recalled,

In one of our group projects ... a really enthusiastic lady ...[wanted] to do all of the work. She went ahead and took [it] upon herself and submitted it. [When] we got feedback and it was not done right. We were really upset that she turned it in because we haven't had a chance to review it. ... There was a lot of tension there; she always presented herself like she was the expert on everything... It was frustrating. She was from the Latino culture. She really did good work. She was really strongly opinionated and very strongly motivated... She was well-known in the school [by] the faculty and ... she seemed more like faculty than a student. ... [To address the situation,] we started doing online documents. We would agree on have each document reviewed by everyone

by a specific date and then submit it by a specific date. Everyone would have to sign off on it.

In and outside classrooms, faculty and students were exposed to positive and negative attitudes of people they encountered. Lindsay said that this happened during field work interactions and recalled a time in which an individual was “spouting racial slurs.” In this situation, she felt she was responsible for serving this hostile member of the community and protecting her students. Lindsay was mindful about the safety of her students and the illness of the person served. She was confident that the students did not need to confront him. Lindsay was positive and considerate while her students were honest and thoughtful towards her approach.

...we just took care of him, let him talk [and] say all those crazy things and then when we were done, we left. When we were in the hallway, I addressed the group saying ... ‘I don’t agree with his statements. I am sorry you had to hear that.’ ...I asked students ‘can we have a little discussion about what we can do in the future...?’ ...we went through the scenario ... and moved on. Two of the students came to me afterwards and basically said, ‘no one has ever talked to us about this specifically and we are really glad that you said something about it. It made an impact on us.’ ...It was nice to get feedback from students indicating that it was important that [I addressed the situation].

Students like Fatima recalled the attitudes of her peers when having contentious arguments about “slave trade, ... dynamics of power addressing White privilege and the White savior complex.” She identified selfishness in attitudes like Whites “helping other lesser cultures somehow [makes them] feel good and special.” Fatima also described how some students were participative and communicative when tensions occurred: “A couple of readings were sent out and people read about it. [When] we came back to class, we discussed it., ...[and] we resolved

[those tensions].” Fatima indicated that the voices of both minoritized and White students were heard.

Francis also described why some students were irate and fearful during interactions in a class and how an instructor willingly addressed the issues causing their reactions.

A teacher was trying to facilitate a conversation around LGBTQ care, and it was done poorly. People on every side of the conversation felt scared and angry by the end of the conversation. It was really unfortunate, but it was also a really good lesson on what not to do. ... We came back to it at a later date. Our instructor invited a different faculty and an expert on the topic. They provided information, led and facilitated the conversation.

Anthony indicated that students from majority groups were often controlling and self-centered while minoritized students were shy in class interactions. He described his approach to dealing with these tendencies:

Graduate students who were used to the system [were] ... taking most of the voice and discussion. ... International Asian students initially were not willing to participate ... My focus [was on] spending more time on [answering] questions for those who were not willing to answer questions at the beginning of the quarter ... At the end of the quarter [minoritized students] were much more able to ask questions without ... prompt. ... I spent time answering them in lots of details and tried to show that it wasn't a simple question... [I used] a lot of validation ... [and] prompting to put people at ease...

Anthony noticed that students were more accepting of other students' points of view after engaging in some behavioral assessments. Consequently, he believed

all students [should] take some assessments like the MbtI, personality type, the emotional intelligence assessment, and the work environment assessment.” These [assessments] helped because it is not only the [lack of] cultural communication

that cause some problems for people who do not know about cultural diversity training, but it is also their lack of emotional intelligence. [Furthermore], people within the same culture are different. To have cross cultural communication within one culture or different cultures people need to have knowledge and willingness to understand.

Despite some students being hostile in class based on their preconceived ideas about what their instructors should look like Fatima used her friendliness and showed endurance in managing discriminatory behaviors. One example of this is evident in the following comments:

The first day [of class] after we introduced each other...some students left my group. ...I noticed all of them were White... Then one of the students made a complaint. She emailed one of my lead instructors [indicating] that she didn't like the atmosphere of the class. My lead instructor directly interacted with the student, telling her, 'this is a competent person that has done this before... you should come in and talk about this with her.' The following two weeks, I would do things in class, but I wouldn't necessarily be interacting with that student directly because I wanted to give her time to see how I was doing things with other people. I was also subconsciously trying to protect myself. After a few weeks, the student became very active in the class, asked questions to contribute, and emailed me for questions about homework.

Fatima also described her approach to better understanding the perspectives of dominant group members and find support as a student of color. Having a majority group and a minoritized group mentor helped her address difficulties encountered when navigating through cultural diversity issues. She explained these benefits as follow:

I regularly go to [my White female advisor] when I'm in uncomfortable [ethnoracial] situations. I ask her what ...[White] students [are] trying to say [and] how would I come across if I [take a particular position.] ...The other faculty I go to is minoritized like myself even though ... she's lived [in the U.S.] her entire life. ... She [uses] her experiences to help me interpret what is happening to me.

White students also had different reactions when racial tensions occurred. Sarah recognized that many people do not understand the experiences of students of color or the concerns of parents of biracial children about their future. She indicated that participating in a meeting about racial tensions helped her see a variety of perspectives, reactions, and standpoints. Sarah acknowledged that

As a White woman I am limited. No matter ... how well intentioned I would be, I would never be able to fully stand in somebody else's shoes or see through their eyes. ... there were probably two dozen or more [perspectives] in terms of what everybody brought to that encounter. ... We were all making assumptions. [Some comments were] compassionate and understanding. Another was ... quite angry ...it wasn't like everybody came to ... shared understanding but [listening to everyone's perspective] was ... [a] powerful experience.

Anthony described the reaction of one of his professors to tensions about racism during classes. The professor

took ten minutes to answer questions and give very detailed and very positive [responses to the questions students asked]... [it was] very good because he was acknowledging his shortcomings and at the same time, he was constructive in his answers. Not just lip service and no trying to defuse the situation but to show the limitations in the structures of the department [as well as] in the intercultural sensitivity of different people and

different groups. ...He was very good at not trying to make the problem disappear but show there was a problem and acknowledged the need to work on it. ... He was very credible. My classmates were not victimized and were satisfied with his speech and his interaction. ... It was very well done.

Students appreciated when faculty actively engaged in helping them better understand issues created by lack of cross-cultural understanding. These differences were difficult for Sarah to address when one does not have any related experiential learning. This void was compensated somewhat for students when faculty used their personal stories to address classroom tensions. To support this idea Sarah used this example of one of her professors:

Professor Babigumira was great about sharing his stories ... We would ask technical questions ... bringing our own assumptions as to how healthcare delivery might work in a particular setting. [When tensions arose, his approach was to use] personal stories [to] respond... Often times professors would say, this is how it generally works, but he very rarely did that.

Staff also shared some of the attitudes they adopted to address cross-cultural communication issues. Donna indicated that, in most cultures, when people encountered differential power dynamics, those with the least power tend to keep silent. In a previous job, she overheard one of her supervisors complaining to other people openly about her performance. She indicated that she “was not given direction, nor was she given the opportunity to explain and defend her choices, given the vacuum of communication.” She added,

Because of my cultural programming to “be nice,” I remained passive, and just kept trying harder to please. ... [However,] I was miserable in that job until I finally overcame

the programming and was able to confront my supervisor about [how I felt], and to request fair treatment and honest communication. After that day, there was a complete transformation. Sometimes you have to ...make yourself be heard.

Donna also described her attitude about addressing cultural differences, in personality, working styles, and communications. She said that oftentimes, in working environments, people do not have time, or do not feel encouraged, to talk, causing individual tensions and impacting the quality of the work. To counter these tendencies, she said,

one favorite thing I do to solve personality issues and address workplace tensions is to ask the person to go outside of the work environment and get a cup of coffee. I like to ask, 'how I can make that person's job easier – what do they need from me, [and] how can I be more responsive.' Inevitably, we end up discussing ways in which we can mutually make each other's job easier. It has resulted in [appreciation of our personal] "world"; conflict resolution; increased productivity; and gaining friendships outside of the work structure.

Leadership: Attitudes about cultural diversity, equity, and inclusion

Some faculty interviewed provided examples of how members of teams in the department or schools helped them better understand how their attitudes and actions affected members of diverse cultural groups. But others indicated that leaders had not offered any support in these areas. For example, Charlene did not witness these interactions personally, but Lindsay offered positive endorsements explaining that

[Although] our leadership is not very diverse, I have been pleasantly surprised [by approaches taken by some members of the department's leadership], chiming in and offering support when we were starting to have diversity training. Having

people in leadership attending and saying ‘this is really great, I love it, it is a very good workshop and you should go’ instead of eyerolling and saying ‘yeah everybody should go’ but as lip service. Having their enthusiastic buy in was good. [The advocacy of] leaders also makes a difference at the university... It is good to see ...[students] being pulled up.

Rodrigo also credited leaders for developing inclusive practices. Other members were concerned about the ambivalence of department and school leaders towards cultural diversity and inclusion. Donna commented that

...there is recognition of the importance of inclusion. [But inclusion] doesn’t come from [most members of leadership]. ...Leadership is old-school, patriarchal, and hierarchical. [In the department, leadership has made commitments to diversity verbally many times... and recently [the SPH began] ...a diversity programs initiative. ... [But oftentimes] there is a lead-by-example gap.

Jessica described a racial incident in a class and the response of leaders to the respective complaints of students as indicative of doubts about the genuineness of their comments: that they thought about the commitment of leadership to diversity indicating,

[Recently] ... a professor... didn't have any repercussions for [the racial comments] he said. The fact that the SPH defended him [shows] a lot of bureaucracy and politics. ...The talk around the diversity initiative... is very generic. A lot of people in positions of power do not necessarily know how to go about tackling this big issue.

Other students were grateful for what leadership is doing. For example, Fatima and Hakim applauded small gestures of inclusion that made their networking experiences positive. Fatima said,

“[Our program director], a White man, ...likes [to] have potlucks at his home. He tries to sit with [students]... and interact with us... Every time, I interact with this person, I feel really good. I feel like I have spoken with someone who is my equal.

Hakim recalled how open minded and thoughtful a program leader was when he invited students to his home. Hakim indicated, “at that time there was a big feast for the Muslims. We were told, ...that they were preparing food also for Muslim students. It was very considerate...” Thus the participants recognized the impact of positive and negative attitudes of leaders and the importance of their perspectives for improving cross-cultural interactions. Yet, some expressed frustrations, hopes, and expectations.

Cultural Humility

Cultural Humility is a construct to understand self and general cultural knowledge. The process of developing cultural humility helps health care professionals recognize that no one can be proficient in the beliefs and histories of members of cultural groups different than their own and shows that cultural humility is not a competence similar to others required in professional fields. Participants in each of the domains of this study included instances in which they recognized the term, its importance, and development. They also identified knowledge and experiences (or the lack of) needed to become culturally humble; described their awareness of the term and the effects it has on culturally appropriate education and services; and related the term within skills and attitudes necessary to maintain self-reflection, a lifetime commitment to learn from the people they serve, and improve health and sense of wellbeing of members of diverse cultural groups.

The term “Cultural humility” was identified by participants across groups. However, many of them did not hear this concept when taking cultural diversity and cross-cultural communication training or have a mastery of its meaning. Most of them indicated that they have heard about it in other settings. Hence, the data collected is more about the need to know than about real knowledge acquired. Table 7.8 shows how interviewees were introduced to “Cultural Humility.” Comments acknowledged that it is a way to improve understanding of other cultural groups. The perspectives and explanations provided by participating faculty, staff, and students improved the sense-making of responses provided on the CCQ-DKASA.

Table 7.8 Interviewees “Knowledge” about Cultural Humility

Interviewee	Cultural Humility
Faculty	Not included in cultural diversity trainings Used in general as a monitoring teaching strategy Heard on informal discussion
Staff	Did not hear in diversity trainings
Students	When mentioned the meaning was unclear Not heard in respective programs Heard in a different school Mentioned in issues related to leadership level 5

Faculty, staff, and students who participated in the CCQ-DKASA and during interviews also described some abilities and attitudes to maintain positive interpersonal relations with members of culturally diverse groups. These included:

- Listen to the experiences of diverse populations without making judgements
- Interact with members of diverse cultural groups
- Be alert and willing to question your own expectations and assumptions

- Self-aware of limitations of knowledge
- Be open-minded
- Be aware of how one's own behavior, attitudes, and words affect people around us
- Be curious and capable to appreciate differences
- Understand the changing nature of diverse cultures and the impossibility to be competent about the experiences of people of all cultural backgrounds
- Be humble, tolerant and respectful.

Historical perspectives can allow better understanding current challenges. In making this point Charlene explained how, in the past, “cultural competence” was used to describe the ability of people to understand and interact with members of diverse cultural groups, but she felt “a more appropriate term is cultural humility.... [Although] there are challenges that [may] never really be fully understood, ... people can be alert and should be willing to question their expectations and assumptions, in exchange for learning what people have to say.” Charlene’s uncertainty where and when she first heard “Cultural Humility” is indicative of its ambiguity in her program. She said, “it was in the university setting, it might have been from students or it might have been from another faculty. It was kind of in the discussion of the popular term ‘cultural competence.’”

Most interviewees were not familiar with the idea of culturally humility. Rodrigo and Peter had never heard the term in their workshops and Lindsay remembered only limited exposure. “In the more recent training I took in the big amphitheater in the SPH, they did talk about [cultural humility] a little bit. But this was on listening and trying to get those in teaching roles to be careful about what we say.” Alexis recalled that when Cultural Humility was

discussed in one of his trainings, the people failed to understand that it “is a long process. It’s a long journey where we’re all learning and no one person can know everything about everyone.

For Alexis, Cultural Humility is “the proper word to use for the idea of not considering yourself a cultural expert.” Although his definition aligns with the academic meaning of the concept, he was somewhat confused about its applicability. Even though Donna had not heard the concept in any formal training, she offered the following definitional attributes of it:

This term tells me, ‘I know that I don’t know from where this person comes. I don’t know anything about this person, and I know that there is a very high likelihood that if I assume that I understand how and why they do things, I could cause some severe pain or inflict some kind of damage to a relationship.’ I go in very aware of how my behavior, attitudes, and words are affecting the people around me.

Similarly, Jessica advised “understand[ing] the complexities behind the background [of people], and the history behind a situation to be able to respond appropriately.”

Anthony, Hakim and Sarah had not heard this concept in any diversity training they attended. Hakim stated, “I do not know if you would believe that, but the term cultural humility has not been discussed at all in my trainings. Nor in the program courses or courses I have taken outside of the department.” Sarah had “never heard that term” but she liked the sound of it. Francis was an exception, in that she had learned about cultural humility during a training she took in a different school. She recalled,

... when I was doing a lot of cultural training or trying to learn especially in my undergrad, the key phrase or hot topic then was cultural competence. Now, ten years later, it has kind of transitioned to you don’t ever really learn to be competent because things are always changing. If you’re not a part of that culture so you’re not going to be competent. It is more about being curious and learning to ask questions and being humble

and that is where cultural humility comes in. Now, it's more about finding that level of respect and being curious. That is cultural humility.

Recommendation from faculty, staff and students for improving DEI

Faculty, staff and students who participated in interviews also provided some recommendations for increasing equity, diversity and inclusion, although most of them extended beyond skills and attitudes. They are summarized in Table 7.9.

Table 7.9

Recommendation for improving DEI

Participant	Recommendations
Faculty	<ul style="list-style-type: none"> Constant training Accountability Financial investment Change from verbiage to clear and firm action Increase effectiveness of diversity committees Increase sensitivity Promote a global vision Widely embrace diversity, inclusion, and equity
Staff	<ul style="list-style-type: none"> Become more sensitive Promote a global vision Increase effectiveness of diversity committees Widely embrace diversity, inclusion, and equity Create coping spaces and support for populations that have been marginalized, discriminated, and oppressed Organize activities where members of all cultural groups can come together Facilitate difficult conversations Address implicit bias, macroaggressions and microaggressions
Students	<ul style="list-style-type: none"> Create coping spaces and pride support for populations that have been marginalized, discriminated, and oppressed. Organize activities where members of all cultural groups can come together. Facilitate difficult conversations Address implicit bias macroaggressions and microaggressions Include CLAS standards, CEPH competencies, and Institutional policies and initiatives in enrollment packages given by each program

Rodrigo, hopeful that everyone could learn to be respectful and inclusive, said:

... at this point...if some members of the UW community didn't learn to respect other people around them... if they haven't learned by now to respect other groups. It is never too late, we are [frequently] in training... regardless of age, we can always learn to change... This isn't kindergarten. I mean ...if you cannot change the nice way, people will have to respect the hard way. That's it.

Peter stated that changes in the department and school might not be achieved by just organizing meetings, developing guidelines, and completing punctual activities. He reiterated previous comments made by other participants in this study indicating that financial resources are a key element to improving DEI. In addition, Charlene added that individuals on leadership must hold members of hiring committees accountable for disqualifying equitable candidates of color during faculty searches. She extended previous comments indicating that the failure of committee members to increase efforts to welcome members of minoritized groups was a problem:

At the faculty level, there has to be more. I'm hearing all the time verbiage about how yes, yes, yes, we want diversity and we are committed to diversity. Then, when the actual decision comes, it doesn't happen... and there is not information [about why]... maybe [someone] from the very top... has to really, really, push ... when you have equally qualified faculty applicants for a position. [Members of hiring committees should be asked to] justify why you would not choose somebody from diverse background.

Hakim considers that leadership has the responsibility to provide information about policies, initiatives, and institutional efforts; follow up with clear actions to improve DEI; and

increase cross-cultural understanding in the institution. He also described attitudes of some students in the programs.

If [leadership] doesn't care about others, then there will be always be a missing piece in justice, equity, and equality. ... We need more diversity on faculty and in the content presented to promote understanding of diverse cultures. Just sending students traveling to other countries to implement or conduct research is not enough. Many [students] think that because they are Americans, they know everything.

Anthony devoted his last words during the interview to say that for DEI policy and effort to be effective, the institution needs to first address biases of individuals, starting with faculty and following with students. Pablo was confident suggesting that leadership should address implicit biases and dismantle racism. He exhorted leadership to ensure that along with increasing the number of students, faculty, and staff from diverse population, these individuals be given rights.

Get[ting] two African Americans, two Latinos, and two Asians ... it is not what diversity means. Probably physically. But intellectually, we have to understand what the problems are at the structural level. [In addition to] involving some people of color... giv[e] them the power of vote. ... We cannot achieve social justice and equity if [they have] not voice or vote.

Hakim insisted that research papers should include the perspective of the population researched. He said,

If I am writing a research paper talking about a specific disease, at least put some requirements ... to address the culture of the country not just the number of cases the disease has, how many [people] have died, and how we do not have treatment but hope to reduce the mortality from 50 to 25 [percent]. ... The department should expose their

students to learn ... anthropology. ... A science where they can learn about different cultures ... can help them understand the people. Why people act in a certain way. But we do not get any knowledge about cultural issues.

Concluding with his recommendations and comments, Hakim indicated that each department should have diversity champions, not just people who think they want to be on diversity committees but those who are engaged and understand the importance of diversity. “These people need to be engaged at higher levels at the departments, school and the university to discuss the importance of increasing understanding about different cultures,” Hakim said.

Summary

In the CCQ-DKASA, most participants rated items in the Skills domain within the “moderate” and “somewhat” ranges. Faculty indicated they were very comfortable interacting with people from different cultural backgrounds. The lowest scores across groups were given by staff. Some of these low scores could be explained by considering that some staff members at the DGH have responsibilities that are more administrative in nature and actions described on these items are more likely to be applied by health professionals during their practices as clinical or public health professionals. Across groups, the same six items received the lowest scores. These items are related to the understanding of cultural beliefs and behaviors impacting the health of members of diverse cultural groups, their styles of communication, and ability of participants to provide them with advice.

Faculty, staff, and students participating in the CCQ-DKASA and individual interviews also rated their attitudes towards factors contributing to health disparities and impacting inclusion of member of diverse population in the institution. They identified favorable and unfavorable feelings, emotions, and beliefs assigned to concepts and individuals based on their

experienced or observed behavioral responses towards diversity and cross-cultural communication. These factors included prejudices, bias, and discrimination as well as other preconceived notions and convictions based on race, ethnicity, gender, sexual orientation, and other socio-economic determinants of health and inclusion.

Participants in the CCQ-DKASA and interviews showed positive levels of comfort when communicating with and caring for culturally diverse individuals. In their assessment, they rated genetics as one of the least important factors impacting the health of members of diverse cultural groups. Participants across groups provided their highest scores to poverty as the most important factor contributing to health disparities. They rated access to health as the second most important factor. It was followed by socioeconomic status. Other relevant factors identified by participants included: understanding of equity and cultural sensitivity to address existing educational and health disparities; educational status; institutional discrimination; training in biases, cultural diversity, multicultural health care, and cross-cultural communication.

All participants in interviews highlighted the importance of increasing training and institutional commitment to DEI. However, in the survey, only students rated the item related to training within the “very important” range. Students also rated items about equity and cultural sensitivity; understanding of individual needs of the people served; and institutional discrimination within their most important factors influencing DEI. This could be interpreted as if students had higher levels of awareness and positive attitudes towards improving systemic and structural issues impacting disparities on members of diverse populations. Access to health care, socioeconomic, and educational status were factors identified as highly influenced by historical and systemic discrimination of members of diverse cultural groups. Participants across groups indicated feeling “a little comfortable” working with peer and colleagues or serving individuals

who make derogatory comments about their cultural background or orientation and the cultural backgrounds and orientations of members of cultural groups different than their own.

The interview data revealed abilities necessary to foster mutually beneficial interactions with members of diverse cultural groups. These included respect, self-awareness, empathy, inclusion, and tolerance as relevant aptitudes in managing challenges related to racial, ethnic, and cultural diversity, stereotypes, biases, and prejudices; and institutional and systemic discrimination, racism, and oppression. Yet, many of these areas of skills and attitudes were not explicitly taught and demonstrated in their programs. Still the participants were positive on the best way to improve knowledge about diverse cultural groups. They indicated that listening to their experiences and not making assumptions were essential to delivering culturally sensitive and competent health care to diverse constituencies.

The acknowledgement of the existence and relevance of factors contributing to health disparities in the CCQ-DKASA Attitudes domain and interviews demonstrated the perspectives of participants towards diversity, equity, and inclusion. According to participants, increased knowledge, awareness, and skills among faculty, students, and staff could be achieved by providing them with appropriate cultural diversity and cross-cultural communication resources, education, and support. Participants also recognized the impact of positive and negative attitudes of leadership, indicating that training alone will not improve DEI. They expressed their frustrations, hopes, and expectations for leadership to take actions that align to their verbal commitment to DEI.

These actions included guaranteeing accountability of hiring committees towards DEI goals such as increasing the number of students, faculty, and staff from diverse population in the institution; ensuring that members of diverse populations are active participants in decision making processes; identifying diversity champions in each department, schools, and overall

institution; ensuring that the curricular content, practices, and other trainings prepare students, staff, and faculty to understand, work with, and provide culturally responsive services to individuals regardless of their race, ethnicity, gender, sexual orientation, and socio-economic backgrounds.

Chapter VIII

Summary, Discussion and Recommendations

Research overview

This study explored perceptions of faculty, staff, and students who work and learn at the Department of Global Health (DGH) at a predominantly White university in the Pacific Northwest region of the United States. It documented factors that may contribute to health inequities. Participants also identified strategies to increase health care effectiveness and overcome imbalances operating at both the local and global levels. A theoretical lens based on existing scholarship in Multicultural Education, Culturally Responsive Pedagogy, and cultural competency trainings offered in health professional schools (including medicine, pharmacy, nursing, and psychology) were used. Background information described historical dehumanization of members of diverse cultural groups. It included the concepts of race, “eugenics,” and the irrational claim about White superiority; discrimination and health disparities in the U.S. such as the use of the most vulnerable populations for surgical experimentation and drug testing; underrepresentation of and challenges faced by members of diverse populations in health professional schools and careers; and assertions about how these factors affect contemporary health inequities.

A cross-sectional exploratory, sequential, and inductive research design with mixed methods, including a survey and a selected sample of individual interviews, was used to collect data. A total of 115 members of the DGH completed the survey, including 49 PhD, MPH, and Graduate Certificate students; 39 core, adjunct, clinical, and affiliate faculty; and 27 staff. In addition, a total of 14 individuals--six students, four faculty and four staff members, participated in individual interviews. The results unveiled basic demographic data and other characteristics of

the respondents. Faculty, student, and staff participants described perceptions of their preparation to recognize discrimination and issues of power and privilege in healthcare. They shared how cultural diversity and cross-cultural communication training received (or the lack of) impacted their skills, knowledge and awareness of, and attitudes towards populations of cultural backgrounds different than their own. Participants described how their respective programs and the DGH have prepared them to effectively and responsively work in cross-cultural settings. They also identified perceived training and practical gaps and provided recommendations for improvement.

Discussion

The participants in this study indicated that lack of diversity in health profession schools makes teaching and learning more challenging. They were aware that learning, teaching, and working experiences are affected by many factors including race, ethnicity, gender, sexual orientation, and disabilities. As indicated by Banaji (2016), Beattie (2013), LaVeist and Isaac (2013), Sabin et al. (2009), and Sue et al. (2009) different forms of discrimination influence learning and limit opportunities of health professionals to address health disparities and increase health equity. Similar factors are identified by Banks (2014) and Gay (2018) in their more general discussions. They demonstrate how Multicultural Education and culturally responsive teaching strategies are effective for addressing challenges encountered by racially, ethnically, socially, and culturally diverse populations learning and working in predominantly White educational institutions. Banks and Gay explain how educational leaders can use inclusive information and data to create new knowledge, improve students' performances, and address the damaging effects of prejudices, discrimination, and inequities.

Participants in this study identified how power and privilege affected their cross-cultural learning and working experiences. Some of them described the importance of recognizing White privilege and power imbalances. They also challenged Whites to acknowledge systems of oppression and their consequences. Their reactions were consistent with proposals made by scholars such as Applebaum (2010), Blackmore (2013), Berger and Peerson (2016), Brooks (2013), Brooks and Hopkins (2017), Cabrera et al. (2016), DiAngelo (2018), Dovidio and Fiske (2012), Durey et al. (2016) Fiscella and Sanders (2016), McIntosh (2015), Rainer (2015), and Topp and Chipukuma, 2016a). Scholars and participants recognized the importance of disrupting and dismantling connections among racism, sexism, and others forms of individual and systemic discrimination and oppression. Particularly, they noted how the lack of diverse perspectives in education, research, and practice impairs their ability to better understand and serve members of diverse populations at local and global levels.

While the participants had interacted with a wide range of members of diverse populations, they encountered individuals of European ancestry, heterosexual females and males, and people of middle and high socio-economic status most often. They highlighted the underrepresentation of African Americans, Alaska Natives, Native Americans and Latinx among students and faculty in the DGH and the university. Participants associated these demographic gaps with inadequate training for diversity, compromising the quality of their education and services, and limiting their capacity to interact, understand, and respond to the needs of diverse racial, ethnic, and cultural groups. These findings are congruent with studies conducted by Hall et al. (2015), IOM (2003), Leitner et al. (2018), Matthew (2015), Williams and Wyatt (2015).

The statistical analysis of the internal consistency of the CCQ-DKASA was completed to determine its reliability. The results provided evidence of the overall quality of the tool to consider its use and to proceed with the examination of the data collected with the CCQ-DKASA

and during interviews. Data derived from interviews enhanced the exploratory power of the survey results. One example of this was the effect noted about the absence of historical contextual information in the study of culturally diverse groups. Interviewees indicated that the histories of diverse cultural groups were not included in their trainings at all, or when historical events were discussed no connections were made to contemporary challenges in general and health care specifically. Yet, conscious efforts to expose these connections could bridge gaps and reduce challenges experienced by minoritized students, faculty, and staff. These gaps or absences also contributed to limited opportunities to develop behaviors and practices that improve culturally sensitive communications and culturally appropriate services interventions.

Most faculty members and students from the dominant population (White European Ancestry) who took the survey received little or no formal cultural diversity training. The little training that did happen occurred in locations beyond the DGH and related programs. Yet, during interviews, some of these participants rated their diversity knowledge and skills higher than culturally diverse participants. This apparent contradiction was not explicitly explained in the data. Some participants, after having time to think and elaborate responses to additional questions presented in the interviews, reduced their initial scores. However, other high scores may have been a consequence of the participants saying what they thought I (the researcher) wanted to hear, a conviction created due to their lack of exposure to and feedback about their cross-cultural interactions, or the fact that the initial higher rating was reported at the beginning of the interview. The corrected rating was provided after the participant had the opportunity to respond to several cross-cultural questions, learning more about the full scope of the topic. It might have helped them recognize that they knew less than they previously thought.

Contrary to a frequent assumption that minoritized individuals are automatically capable of working with minoritized populations this was not necessarily true in this study. Instead, some

minoritized faculty acknowledged limitations in teaching individuals from cultural backgrounds different from their own. Although it should also be the case for faculty from the dominant population, only a few recognized these challenges. This finding could be used as evidence to support the development and implementation of more culturally diverse knowledge and skills which could contribute to increasing cultural humility as characterized by Borden (2018), Foronda et al. (2018), Isaacson, (2014), Pinderhughes (1989) Tervalon and Murray-Garcia (1998).

In general, all populations should learn that by acquiring knowledge about culturally diverse groups, being humble, and keeping in check power imbalances, the quality of education and services provided to member of diverse cultural groups can improve. This outcome is also likely to reduce health disparities and normalization of diversity, equity, and inclusion (DEI).

According to data produced by this study, members of diverse populations continue to have limited access to health professional preparation; encounter difficulties in admissions, hiring, unwelcoming environments, aggressive treatment, biases, and a non-inclusive curriculum. Similar challenges have been described in previous scholarship by Boysen (2012), Park et al. (2006). Sabin et al. (2009), Sue (2010a, 2010b, and Sue et al. (2009). In this study, most members of minoritized groups felt that they were routinely scrutinized, harshly evaluated, and their opinions frequently dismissed or ignored. Conversely, some European ancestry students were not challenged or questioned under the assumption that they are more capable because they are White.

The experiences of minoritized faculty and staff were similar to those of minoritized students. Many were reluctant to share ideas with colleagues because they were not taken seriously or engaged. Some minoritized participants believed that the institution uses them as tokens or symbols of inclusion. They also indicated that programs to assist minoritized groups do

not receive nor provide them with sufficient support. Furthermore, some minoritized students and faculty believed that the department and school leadership have not taken serious actions to ensure that DEI is not a temporary effort.

Favorable and unfavorable feelings, emotions, and beliefs of the participants were assigned to concepts, individuals, and groups based on experienced or observed behavioral responses towards diversity and cross-cultural communication. Across groups, participants expressed positive attitudes towards increasing training and institutional commitment to DEI. They indicated that given existing positive and negative attitudes of leadership towards inclusion, training alone will not improve relationships, promote cross-cultural communication, and increase cultural humility. Participants expressed frustrations, hopes, and expectations about leaders aligning verbal commitment with actions that guarantee DEI. These included accountability for increasing diverse populations in the institution, their active participation in decision-making processes, and financial support to guarantee sustainability.

Factors increasing health disparities and their relationship to the quality of education and skills developed by health care professionals have been analyzed previously by Foege (2018), Foronda et al. (2018), Harper and Hurtado (2007), Shollen et al. (2009), Smedley et al. (2004) Sue et al. (2009). Their findings revealed consistent evidence of the insufficient and non-required character of culturally diverse trainings provided to and by health professionals. They also exposed structural features of education and health inequities. Similar disparities in other areas of education and performance have been addressed by multicultural education and culturally responsive pedagogy scholars.

Gay (2018), in particular, described several principles for guiding Multicultural Education and culturally responsive educational practice that are relevant to challenges experienced by the study participants. The following examples provide an overview of how

challenges encountered by participants in this study could be addressed using some of the elements she identified. A fundamental need is to develop an accurate knowledge base about cultural diversity and appropriately related cultural diversity curriculum content.

Content that incorporates health values and traditions of diverse communities and groups can be a foundation for health professionals. It can help them develop skills needed to better serve members of diverse cultural groups. Demonstrating caring and building learning communities can contribute to eliminating individual and systemic discrimination, unwelcome or hostile environments, aggressive treatments, and biases. Communicating effectively with ethnically diverse individuals and groups can facilitate creating constructive relationships and collegiality. Incorporating elements of cultural diversity routinely in instructional practices can improve the quality of education and career preparation for both minoritized and majoritized groups. All of these are needs repeatedly identified by the various groups of participants involved in this study—that is faculty, staff, and students.

Significance

The significance of this study lies in its implications for faculty, students, staff, and individuals holding leadership positions in health profession schools. It validates initiatives and individuals committed to equity, diversity, and multicultural education by continually advocating for inclusion. These advocates are not alone in their perspectives and efforts. Even if their goals have not been accomplished yet, proponents of cross-cultural necessities should be encouraged to continue their pursuits. For those still in a process of discovery, this research presents an open invitation to enrich their views. It reinforces the ideas that without cultural diversity, respect, and humility, the values and utility of educational degrees, disciplinary expertise, and scientific

advances are minimized for diverse individuals, minoritized groups, and communities in the U.S., and places where its health professionals serve around the world.

This research also adds value to existing scholarship by:

- Confirming and supporting evidence for some general claims that have been made before.
- Acknowledging the presence and absence of diversity in the DGH, the SPH, and the university.
- Recognizing racial, ethnic, and socio-economic factors causing health disparities.
- Including the experiences and perspectives of different constituent groups such as faculty, staff, and students.
- Shifting the focus from the common and frequent tendency of having members of the dominant population studying and addressing disparities faced by diverse populations and including those targeted populations in the analysis.
- Bringing the perspectives of researched populations into consideration in data collection, action plans, and interventions.
- Beginning cross-ethnoracial and multiple status identity discourses. This decreases potential biases and facilitates racial and ethnic border crossings.
- Adapting data collection instruments previously tested in health-related fields thereby increasing the validity and utility of the results generated.
- Demonstrating the benefits of using varied data collection tools such as surveys, interviews, and observations to triangulate

Many members of minoritized groups living in the U.S. face various kinds of rejection, assimilation, acculturation, and integration that are not experienced by members of the dominant population. These experiences allow minoritized researchers to capture important nuances from

more than one culture as they must learn to be insiders and outsiders at the same time. In research, participants do not necessarily know the racial, ethnic, and other aspects of the cultural background of the researcher when completing surveys. Nonetheless, subtle differences embedded in responses of participants that may not be discerned by majority group researchers can be captured and extrapolated by equally-trained minoritized researchers. This may have been the case in this study since the researcher is a member of a U.S. minoritized group as were some of the participants. This research also increases the potential for addressing issues affecting educational quality and other professional services provided to members of diverse populations.

This study used suggestions by Glesne (2016) and Merriam (2009) for promoting research validity and reliability. The data were triangulated by using multiple collection methods including surveys and interviews, diverse participants, and a verification process to increase accuracy of interpretations. The thick descriptions of the data helped conceptualize the study and enable readers to envision situations in which the research contexts and findings can be transferred or replicated (Merriam, 2009). The investigator regularly checked on her own positionality by doing critical reflections of her assumptions and biases, being mindful of ways in which these factors might affect the study. Limited observations completed in program courses and committee meetings attended in a different school allowed the researcher to gain some insights. The results of these observations, although not included in detail as part of the data analyzed for this study, illustrated some of the questions presented in the survey and interviews. Participant responses were often aligned with previously observed events. The descriptions and integration of quantitative and qualitative data presented are some of the major strengths of the methodological approach used in this study.

Limitations

This study was carefully designed and conducted, yet it has some limitations. These included research location and sample size, self-reported character of the data collected, access to participants, methodology used, and lack of previous research. These limitations could be countered in future research by:

- Increasing the sample size, adding other departments and schools, and completing research in other regions, which would all serve to enhance generalizability of the findings.
- Increasing frequency and opportunities for multiple forms of data collection such as observations, additional testing, and critical reviews of data collection tools. These include revise surveys and guiding interview questions, create observation protocols, and improve processes for the analysis, interpretation, and formulation of the summary of findings, conclusions, and recommendations.
- It would be too ambitious and perhaps unmanageable to attempt to explore the multicultural competence and readiness of all students, staff, and faculty in all health professional schools of this university in a single research project. The focus on a relatively small number of individuals studying and working in only one health profession school and data collection completed during a short timeframe could have provided limited perspectives.
- This study included some participants from all programs offered by the DGH. They provided some insights about the content quality, teaching strategies, classroom environment, and school climate. However, the small size of respondents per program did not allow for capturing the perspectives of all cultural groups present in the institution.
- The length of the study limited the data collected. A one-time survey and one individual interview per participant did not allow for measuring the impact of curricula, faculty and leadership support, and school climate during each stage of the respective programs.

- The length of the study also limited the ability to determine the effects of programs on variations in the development of culturally diverse knowledge and skills of participants while studying or working in the institution and department.
- The accuracy of self-reported perceptions of participants might be over-or-understated. It can be affected by social desirability and acquiescence. In addition, some participants were affiliated with programs outside of the Department of Global Health which might have “contaminated the data,” influenced their responses. Although participants were asked to focus on only the roles they were playing at the DGH, they may not have been able to easily compartmentalize their thoughts, and some of their comments may have been affected by experiences beyond the boundaries of the study.
- The mixed- methods approach used sought to increase accuracy in responses. Despite this effort, the data collected in the survey were inhibited by lack of previous research, and not including modified questions and subsequent interviews after preliminary or early phase data analyses.
- No other studies simultaneously examining perceptions of faculty, staff, and students in a public health program and health professions school have been completed in this institution. This absence limited opportunities to build on existing research.
- The investigator designed the CCQ-DKASA and interview questionnaires. She was the primary instrument of qualitative data collection and analysis. Regardless of conscious effort to monitor biases and subjectivities made by the investigator, responses of participants may have been affected by her presence.
- The positionality and biases of the researcher may have influenced data collection processes regardless of meticulous and mindful steps to prevent it.

- Another potential limitation is the fact that the researcher was also a student in one of the programs offered by the DGH. Participants on the survey and in interviews may have assumed an affinity with her, and thus provided “socially acceptable” responses (i.e. responding as they thought the researcher wished them to).
- Some participants could have reacted adversely by not giving candid responses (if they were not favorable) for fear of insulting the researcher, feeling uncomfortable with the topic, or discrediting programs, the department, and the university. Furthermore, in electronic surveys there are more opportunities to provide less accurate data related to issues that have been historically stigmatized.
- The information provided in the survey and during interviews of this study was not corroborated by extended observations nor by other investigators. The researcher attended some of the same courses as the research participants and interacted with them outside of classroom settings. However, structured and dedicated observations of classroom activities and committee meetings for the purpose of corroborating data collected were not completed at the DGH.

Recommendations for future research and practice

This study suggested some possibilities for future research within health professions education and practice. Related programs, health organizations, and diverse populations served by their graduates could benefit by using findings of this study to continue exploring positive and negative effects of culturally responsive and cross-culturally appropriate health education (or lack thereof) on outcomes of health services and their role in existing health disparities. Additional research could include longitudinal studies in the same department, multiple departments and schools, and other institutions. Longitudinal studies could contribute to the

continued assessment of programs; identifying cross-cultural and interdisciplinary factors beneficial to invigorate curriculum and institutional climate; and maintaining high programmatic quality. In addition to recommendations for future research, immediate actions to strengthen cross-cultural communication could be taken by the department and respective programs. This should include increasing diversity of faculty, students, and staff as well as integrating principles and elements of multicultural education into health care to strengthen and maintain educational quality and enhance professional services and practice of public health professionals. Cross-cultural factors identified by participants in this study and previous scholarship can be integrated in existing curriculum and institutional environment. These factors include those rated by participants in the survey and described by interviewees at their lowest level of knowledge, such as federal, state, and institutional competences and initiatives to prohibit discrimination based on race, color, religion, sex, and national origin including those with limited English proficiency; Connections between historical and contemporary events and health challenges faced by members of diverse populations; institutional policies, initiatives and financial plans to increase diversity, equity, and inclusion (DEI) including, recruitment and retention of members of diverse populations.

- Increased observation in selected departments and schools where participants interact may benefit the process of corroboration of findings and the development of recommendations of future studies.
- A longer study involving a larger number of participants could allow to gather more perspectives and actually observe participants interacting in culturally diverse settings and having consistent cross-cultural communications.
- A longer time period of data collection would have allowed a pseudo-experimental design examining change across time or as the result of specific curricula.

- Increasing the number of participants on surveys and in interviews could be achieved by offering incentives to target populations for their time and continued participation.
- A larger number of interviewees could strengthen and further enhance meaning of survey responses. For students, the development of cross-cultural knowledge, skills, and attitudes could be measured throughout the completion of their selected programs, including selected representatives and complete cohorts.
- The interpretations of multicultural realities studied through observation and interviews could increase the validity and reliability of future qualitative research. It could also help better understand data collected with surveys, avoid misinterpretations oftentimes made about the needs of members of diverse populations, and inform strategies to provide culturally responsive health education and services.
- For faculty and staff, cross-cultural preparation could be measured during periods similar to length of programs offered by the department. For students, additional “shadowing” of faculty and staff could improve their visions of cross-cultural strengths and needs for further educational and practical development.
- Expansion of the study to follow-up with students and graduates during professional practices in the U.S. and other countries could provide more comprehensive insights into the knowledge, attitudes, and skills they have acquired.
- Team-based research could decrease possibilities of individual researcher biases and extend opportunities for interdisciplinary collaborations. Open collaboration and communication including team members from different areas, with various levels of expertise and diverse cultural backgrounds could help create collective intelligence, thus maximizing abilities, knowledge, and skills available to increase services and achieve consensus regarding best approaches to sustain continuous improvement on quality.

- The completion of parallel studies in other training institutions in the same and different regions of the country might generate different findings and/or identify points of similarity. Adding other schools within the university, the city, and other geographic locations could provide additional layers of nuance and depth of findings that would increase generalizability. Researchers could detect changes in cross-cultural characteristics and approaches used by participating institutions, groups, and individuals over selected periods.
- Researchers could also complete comparative studies of effectiveness of cross-cultural education in participating regions.
- Additional studies could explore how increased diversity affects the perspectives of both mainstream and underrepresented minorities (URM); how perceptions of equity change as physical and intellectual diversity increase in programs offered; and effects of more rigorously implemented culturally responsive curriculum and teaching on abilities of health care professionals (HCPs) to appropriately serve members of multicultural societies.
- Other factors to consider for additional research are how implicit bias of university leaders affect abilities of faculty, staff, and students to communicate with diverse individuals and communities; admission, retention, and graduation rates of diverse students, and hiring, retention, and promotion of URM.

The pillar of knowledge in Chapter I includes some factors related to knowledge, awareness, skills, and attitudes essential to developing cross-culturally responsive health professional workforce and increase health equity. The figures and information contained in the Humble and Culturally Responsive Path for Health Professional Schools (Chapter III) illustrates different steps, elements, and components to improve learning and working experiences of health professionals. They show how to create and maintain a continuous flow of elements relevant to the elimination of health disparities. Most of these factors were identified by participants in this

study who endorsed their inclusion in existing curriculum and institutional environments to improve cross-cultural communication and cultural diversity. The following recommendations could help improve health educational practices:

- Cross-cultural communication and culturally responsive education and services should be a regular part of practical experiences. They should not function as one-time interventions when cultural insensitivity and acts of discrimination against members of diverse populations occur.
- Link recruitment and admission of members of diverse populations with wider access efforts, multiple perspectives, and varied expertise.
- Cross-cultural expertise must be included as criteria for recruitment, hiring, promotion, and retention. It should be required for employment and its adequacy assessed during job performance evaluations of faculty and staff, especially those seeking or holding leadership positions.
- Cross-cultural expertise must also be included in criteria for admission of students who can bring diverse experiences and maximize representation of populations served by graduates trained in programs offered by the department.
- Expertise in and recognition of limitations to fully understanding diverse cultures and ethnicities should be a graduation requirement.
- The presence of diverse populations at programmatic and personal levels increases opportunities for cross-cultural interactions; first hand experiences from multiple and diverse stakeholders; and establishment of effective classroom and working environments.

Results of this study could be used to inform curriculum design. Areas of need include curriculum used in the institutional environment, classrooms, meetings, and specialized trainings. Changes must be systematic, integrated, comprehensive and sustained; have longevity,

magnitude, and consistency; and be subjected to continued quality improvement. Specifically, they should demonstrate:

- Strategies to improve the institutional climate such as building strong institutional leadership, intentional planning, allocation of budget to provide adequate resources, and regular assessments to ensure sustainability of DEI plans should support, value, and include individuals of diverse cultural backgrounds; and incorporate and visibly show equitable access for all populations; and comply with zero tolerance of harassment, discrimination, inappropriate comments, and unequal treatments.
- Elimination of hostility and isolation of diverse members by welcoming and increasing receptivity towards education of diverse groups. For example, creating partnerships with ethnic heritage institutions such as Native and historically Black colleges and universities, other institutions with high demographics of people of color, and diverse communities.
- Creating exchange programs for students and faculty, inviting guest speakers, and promoting on-site learning in non-primary White institutions and organizations. The exchange of diverse students with these institutions could be developed in tandem with study abroad and other practical training programs. It could be used as a prelude to international experiences. Local and national exchanges could offer students who have had limited exposure to diversity opportunities to learn how to better interact in cross-cultural settings, understand needs of diverse populations, and provide culturally appropriate services. These exchanges also offer chances for diverse students to learn in institutions with more human resources and technology. Students from the dominant population could benefit from researching and working with immigrant populations at urgent care clinics, health centers, and health departments located in diverse and underserved communities. This training should be completed prior to practicum and research abroad.

- Health education curricula should include specific topics on identity development and cultural values; systems of oppression, governance, and social determinants of health; and how the implementation of principles and elements of multicultural education and culturally responsive teaching, cross cultural communication, and cultural humility affects health equity.
 - Skills such as respect, listening, reflective and critical thinking, and emotional intelligence should be taught to foment positive attitudes.
 - Demonstrate how demographic statistics can be used to analyze relations between health disparities and ethnic, racial, and cultural diversity.
 - Identify how and explore strategies to address political and social factors, including public policy driving resistance to change, poor health outcomes, and racial and ethnic health inequities.

The use of equity pedagogy invites the shifting of existing paradigms in classroom and practical instructions, institutional relationships, campus climate, and health services provided by graduates. Life-long commitments to maintain self-identity, self-critique, and self-reflection increases chances of achieving educational quality, service transformation, and health equity.

A little seed on fertilized ground

This study was deeply influenced by my own journey. Many of my experiences have posed differences and challenges related to social class, ethnicity, patriarchal values, and intellectual turfs. Members of some groups and disciplines often believe their own to be better, more rigorous, and more important. They belittle those who do not fit their ideal image. While navigating issues of power and privilege, hierarchy, and biases, I have often had to develop ways

to increase understanding and collaboration among individuals, social groups, and disciplines. As my knowledge increased, so has my understanding about privileges and obligations.

During my work as a health consultant and in my personal encounters receiving health care, I have experienced and witnessed biases and discrimination. This included lack of knowledge about and sensitivity towards the needs of diverse populations, which caused me to look for additional resources and develop skills to increase the quality of services provided. Initially, I was not familiar with Multicultural Education and Culturally Responsive Pedagogy. However, during my search for a program addressing causes of health inequities, I realized that such a program could help me increase knowledge and develop skills to contribute to improving the quality of health professionals' preparation and delivery of services.

In graduate school, I worked through the sense of separation between my two primary areas of interest—health and education. Even though the university and schools promote interdisciplinary work, unspoken tensions often made me feel as an outsider in both programs. In the School of Public Health, I was often asked where I was housed while in the College of Education some wondered about the “fit” of my interest in improving health education.

Mentors and colleagues supported my work and encouraged me to pursue my interests. Some of them also had experienced challenges receiving inappropriate health services personally or through family members. As a part of my specialization outside of the College of Education, I was supported by the Department of Global Health, the School of Public Health, the School of Medicine, and MEDEX PA program leadership. I felt personally and professionally embraced by many fellow students of the DGH and staff of both schools while completing course work for my Graduate Certificate in Global Health and research for this study.

Thus, for me, exploring these programs further; working to strengthen classroom education and practical experiences about and for cultural diversity in health care; improving

school climate; and better supporting all faculty and staff to understand and engage in culturally responsive interactions to achieve diversity, equity, and inclusion continue to be imperative. This study offers some pathways for these pursuits. It is a little seed that may grow into greater unity, embracing interdisciplinary and holistic perspectives, and changing the status quo of education and healthcare.

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Appendices

APPENDIX A

PERMISSION FOR ADAPTATION OF THE CCCQ

UW Mail - CLINICAL CULTURAL COMPETENCY QUESTIONNAIRE

11/19/18, 11:27 AM



Yris Lance <dyak1@uw.edu>

CLINICAL CULTURAL COMPETENCY QUESTIONNAIRE

Robert Like <like@rwjms.rutgers.edu>
To: Yris Lance <dyak1@uw.edu>, "like@rutgers.edu" <like@rutgers.edu>
Cc: Robert Like <like@rwjms.rutgers.edu>

Thu, Aug 24, 2017 at 1:43 PM

Dear Ms. Lance (Yris):

Good afternoon and thanks for your phone call/email and interest in the CCCQ survey instrument that was used in our previous Aetna Foundation-funded cultural competency/quality improvement study (http://rwjms.rutgers.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html). I appreciated learning about your planned cultural competency doctoral research with the PA program in the Department of Family Medicine at the University of Washington. It's also great to hear about your previous important work with the CLAS Standards.

[RWJMS - Departments and Institutes - Family Medicine](#)

rwjms.rutgers.edu

Grants and Special Projects. Cultural Competency/Quality Improvement Study (Funded by Aetna Foundation) Executive Summary; Patient Request for Services Schedule (pre ...

[RWJMS - Departments and Institutes - Family Medicine](#)

rwjms.rutgers.edu

Grants and Special Projects. Cultural Competency/Quality Improvement Study (Funded by Aetna Foundation) Executive Summary; Patient Request for Services Schedule (pre ...

With regard to your inquiry, it would be fine to make use on a one-time basis of the original or an adapted version of the CCCQ relating to your PhD dissertation study (please note use conditions below). I would just request your inclusion of the following attribution language on the adapted instrument acknowledging the original developers and funding source for the CCCQ:

"This survey has been adapted with permission from the Clinical Cultural Competency Questionnaire (CCCQ) developed by Robert C. Like, MD, MS, Professor and Director of the Center for Healthy Families and Cultural Diversity, Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School. The CCCQ was used in a project entitled, "Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods," funded by the Aetna Foundation (http://rwjms.rutgers.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html)

APPENDIX B

PERMISSION OF ADAPTATION OF MEQ

UW Mail - Purpose of the Multicultural Experiences Questionnaire

11/19/18, 11:29 AM



Yris Lance <dyak1@uw.edu>

Purpose of the Multicultural Experiences Questionnaire

Darcia Narvaez <dnarvaez@nd.edu>
To: Yris Lance <dyak1@uw.edu>

Tue, Nov 21, 2017 at 12:36 PM

Dear Yris,

You are welcome to use the MEQ in your project. You can download it from my website here:
<https://www3.nd.edu/~dnarvaez/Scales.htm>

I'd be pleased to learn your results when you have them.

Best wishes,
D Narvaez

On Tue, Nov 21, 2017 at 12:01 PM, Yris Lance <dyak1@uw.edu> wrote:

Dear Nancy,

I am a PhD candidate at the University of Washington, School of Education-Multicultural Education Curriculum and Instruction Program and Certificate in Global Health program. I am working on the final stages of my programs. Currently, I am completing capstone projects to proceed to prepare for exams and dissertation. To these effects, I created a survey tool to assess perceptions about cross-cultural communication in higher education and health care settings.

My survey includes aspects of tools already used to measure cultural competence in higher education and health care as well as other cross-cultural experiences. I am now in the testing process and I thought it is a good moment to request your permission to use some items of the Multicultural Experiences Questionnaire (MEQ), considering that the guide asks to request permission before publication. I do not know yet whether this study will be published or where. Nonetheless, I would like to learn more about the process to get your authorization for using some items included in questionnaire published in the "Guide for using the Multicultural Experiences Questionnaire (MEQ) For College Students and Adults."

I look forward to hearing from you. I can be contacted by email or feel free to call me at [253-820-7624](tel:253-820-7624).

Respectfully,

Yris Lance, MA
University of Washington

APPENDIX C

IRB Determination

**DETERMINATION OF EXEMPT STATUS**

March 9, 2017

Yris Lance
 2607 Western Av. Seattle, WA unit 301
 Seattle, WA 98121
 yris.lance@gmail.com

Dear Ms. Lance:

On 3/9/2017, the University of Washington Human Subjects Division (HSD) reviewed the following application:

Type of Review:	Initial Study
Title of Study:	Fostering Health Equity by Addressing Power and Privilege in Higher Education
Investigator:	Yris Lance
IRB ID:	STUDY00001648
Funding:	None

Exempt Status

HSD determined that your proposed activity is human subjects research that qualifies for exempt status (Category 1).

- This determination is valid for the duration of your research.
- This means that your research is exempt from the federal human subjects regulations, including the requirement for IRB approval and continuing review.

If you consider changes to this activity in the future and know that the changes will require review (or you are not certain), you may request a review or a new determination by submitting a Modification to this application.

Thank you for your commitment to ethical and responsible research. We wish you great success!

Sincerely,
 Nat Krancus, MA |
 IRB Administrator | Committee D
 206-616-9321
nkrancus@uw.edu

APPENDIX D
CCQ-DKASA Assessment Tool - Validation Summary



CROSS-CULTURAL COMMUNICATION IN HEALTH PROFESSIONAL SCHOOLS
Assessment Tool Validation

Yris T. Lance, MA

Program: PhD Multicultural Education Curriculum and Instruction - Specialization: Health

Advisor: Geneva Gay

ABSTRACT

This research should particularly benefit higher education research aiming to improve cross-cultural communication in health professional schools. It describes the development of an assessment instrument and answers the question:

Does the Cultural Communications Questionnaire-Demographic, Knowledge, Awareness, Skills, and Attitudes (CCQ-DKASA) have the internal consistency, reliability and validity to assess students, staff, and faculty perceptions about their preparedness to interact in cross-cultural settings?

Based on the Standards for Educational and Psychological Testing, the degree of acceptable internal consistency of the instrument and the construct validity tests for the evaluation questionnaire predict the consistency and reliability of the tool.

The analysis of participants' responses confirms the reliability, internal consistency, and construct validity of the CCQ-DKASA to assess participants' perceptions of their readiness to interact with individuals from diverse populations in cross-cultural settings.

ACKNOWLEDGMENT

Data collection, analysis, and report review were possible with the support of members of the UW SPH SDH community, unofficial readers, and my supervisory committee:

Carey Farquhar, MD, MPH. Associate Chair, Academic Programs, DGH.

Douglas Brock, PhD. Emeritus Associate Professor, SoM.

Geneva Gay, PhD. Professor Curriculum and Instruction, Equity Studies, and Multicultural Education, CoE.

Jason Johnson, PhD. Associate Vice Provost Undergraduate Academic Affairs, CoE.

Victoria Gardner, Ed.D. Chief Diversity Officer/Director of Equity, Diversity and Inclusion. SPH.

INTRODUCTION

The Cultural Communications Questionnaire-Demographic, Knowledge, Attitudes, Skills, and Awareness (CCQ-DKASA) explores health professionals' perceptions about their preparedness to interact in cross-cultural settings. It was completed after reviewing Multicultural Education, biases, discrimination, inequities, and other power imbalances scholarship. Particularly scholarship discussing the importance of advancing skills, knowledge, and practices to increase culturally responsive teaching and communication in health education and services. The review also included several instruments created, tested, and validated to assess levels of cultural competency, diversity values, and cross-cultural competence in health and health care (Banks, 2013; Bezruchka, 2010; Boardman, 2015; Boysen, 2012; Gay, 2010; Doorenbos et al, 2005; Endicott et al, 2003; Greenwald, 2011; IOM, 2003; Like, 2011; Lu, 2017; Narvaez et al, 2010; Moskowitz, 2011; Park et al, 2006; Smedley, 2003; Sue et al 2010; Sabin et al. 2009; Sue, 2010; Sue et al., 2009; Stone and Moskowitz, 2011; Staats, 2014; Teal, Gill, Green, and Crandall, 2012; Sukhera and Watling, 2018; van Ryn and Saha, 2011; Smedley et al, 2003).

The CCQ-DKASA seeks to expand outreach from medical providers, social workers, and counselors to other public health professionals. The University of Washington School of Public Health Department of Global Health (UW SPH DGH) students, staff, and faculty completed the CCQ-DKASA and answered a five-items evaluation. Participants' responses helped measure the tool's clarity, relevance, language, and timing to determine how well the instrument measures the intended domains and the degree in which it produces stable and consistent results.

RESEARCH PROBLEM

The socio-economic and political developments impacting the growing diverse populations show a strong disconnect between the idea of equality promoted in the U.S. and current practices of inclusion and equity at almost all levels of its social life, especially in health and health care services provided to members of diverse populations. Regardless of the many and growing scientific advances, health inequities and disparities among diverse populations have been increasing and persisting in the U.S. (Bezruchka, 2010; Foege, 2018; Institute of Medicine [IOM], 2003; Smedley, Stith, and Nelson, 2004, 2003;). Some of the factors contributing to these disparities are health care professionals' lack of cultural competence and awareness about their conscious and unconscious biases, overt discrimination and institutionalized systems of oppression, lack of representation of members of minoritized populations in decision making processes, lack of role models, lack of culturally and linguistically appropriate information and education, and poor access to services and support. (Banaji and Greenwald, 2013; De Chesney and Anderson, 2012; Doorenbos, Schim, Benkert, and Borse, 2005); IOM, 2003; Like, 2001; Sabin, Nosek, Greenwald, and Rivara, 2009; Van Ryn and Saha, 2011; Weinstein, 2017).

Some Health professions schools include in curricular programs, faculty and staff training, and other extracurricular activities information about cultural competence, biases, and cross-cultural communication (Cushman et al., 2015; Doorenbos et al, 2005; Like et al., 2011; Sukhera

and Watling, 2018). However, in the UW no studies assessing students, faculty, and staff perceptions of their readiness to interact with diverse populations in cross-cultural settings have been published.

INSTRUMENTS REVIEWED

The Multicultural Experiences Questionnaire (MEQ); the Clinical Cultural Competence Questionnaire (CCCQ) (MCKAS-R); Multicultural Counseling Knowledge and Awareness Scale (MCKAS); a revised (MCKAS-R); the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS); and Tool for Assessing Cultural Competence Training (TACCT); (Boardman, 2015; Endicott et al, 2003; Like, 2011; Lu, 2017; Narvaez et al, 2010).

QUESTION TO EVALUATE THE INSTRUMENT

Does the Cultural Communications Questionnaire-Demographic, Knowledge, Awareness, Skills, and Attitudes (CCQ-DKASA) have the internal consistency, reliability and validity to assess students, staff, and faculty perceptions about their preparedness to interact in cross-cultural settings?

ITEM CODE and EVALUATION STATEMENTS

- a1 The questions provided appropriate response scales
- a2 The questions were relevant to cross-cultural communication
- a3 The time taken to complete the survey was reasonable
- a4 The questions in each section were clear and easy to understand
- a5 The content was relevant to my communication at school or work

Scale: Strongly Disagree (1) Disagree (2) Somewhat Agree (3) Agree (4) Strongly Agree (5)

Note: Assessment questions were completed immediately after taking the CCQ-DKASA.

POPULATION SAMPLE: TOTAL 669

2017-2018 SPH-DGH STUDENTS					
PhD		MPH		Certificates	
Metrics	11	MPH-First Year	54	Global Health	6
Implementation Sciences	24	MPH-Second Year	48	Global WACH	28
Pathobiology	27	MPH-Continuing students	20	Global HIV/STD's	1
		MPH-2017 Graduates	18		
	TOTAL 62		TOTAL 140	TOTAL	35
SPH-DGH FACULTY			SPH-DGH STAFF		
Core		87		Staff	28
Adjunct, Clinical, and Affiliate		345			

TOTAL 432		TOTAL 28	
STUDY PARTICIPANTS			
STUDENTS		FACULTY	
Program of Study		Classification	
PhD Metrics	3	Core	13
PhD Implementation Sciences	4	Adjunct	13
PhD Pathobiology	7	Clinical	4
MPH-First Year	13	Affiliate	9
MPH-Second Year	11	TOTAL	39
MPH-Continuing	2		
MPH-2017 Graduates	4		
Certificate GH	3	STAFF	
Certificate WCHA	2	Program Staff	27
TOTAL	49	TOTAL	27
TOTAL PARTICIPANTS			115

DATA COLLECTION

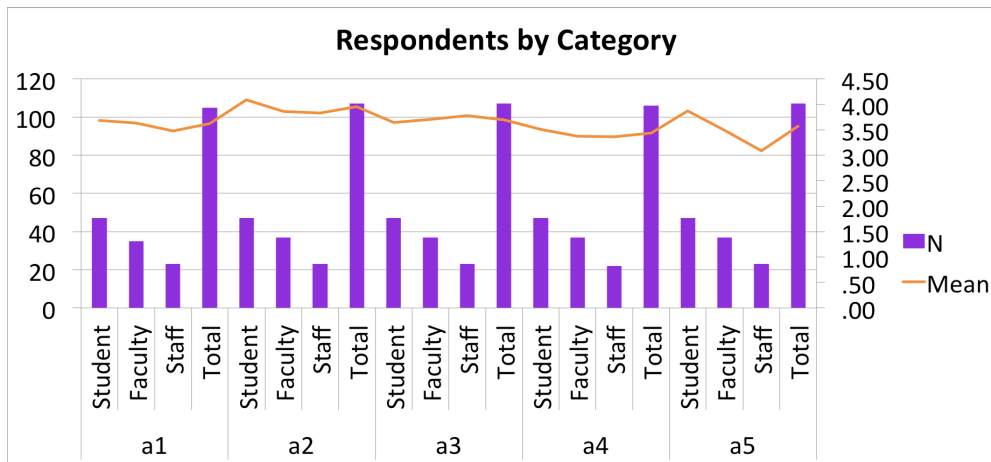
Total population sample received an invitation email with instructions and a link to the survey. Of the total population sample, 115 individuals completed the CCQ-DKASA. Of this group, 105 responded to statement a1, 107 to statements a2 and a3; 106 to statement a4; and 107 responded to statement a5.

DATA ANALYSIS

The following charts and table present an overall assessment of the CCQ-DKASA. It explores its usability and validity to measure the experiences of students, faculty and staff while completing the questionnaire.

The only significant difference in answers of respondents by category was in question a5 in which the Staff mean = 3.09 exhibited a significant lower ($p = 0.007$) difference across groups compared to faculty mean 3.49 and students mean 3.87.

Respondents by Category



Cronbach's Alpha Internal Consistency Estimates for the CCQ-DKASA

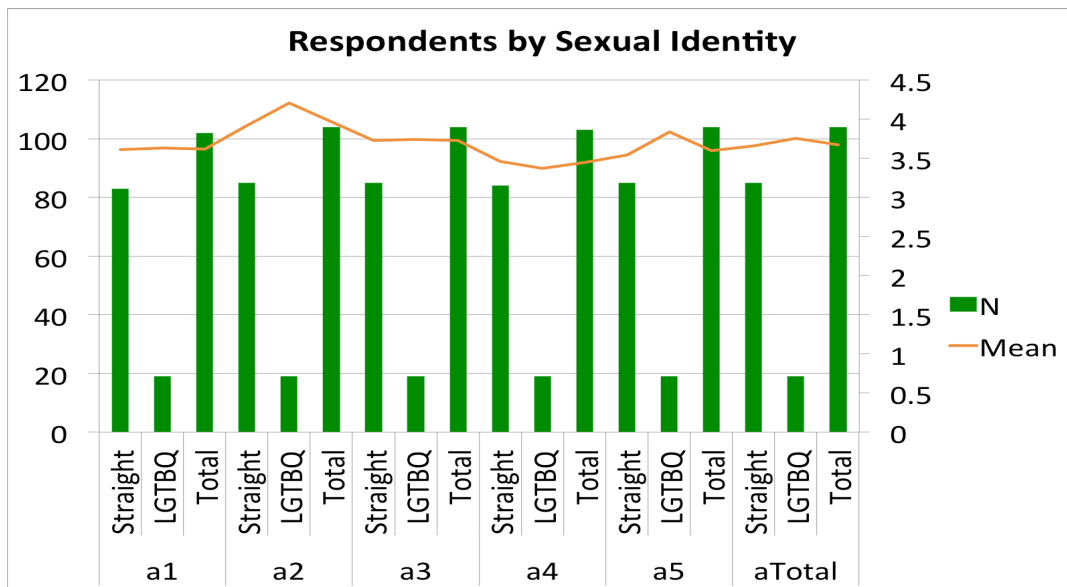
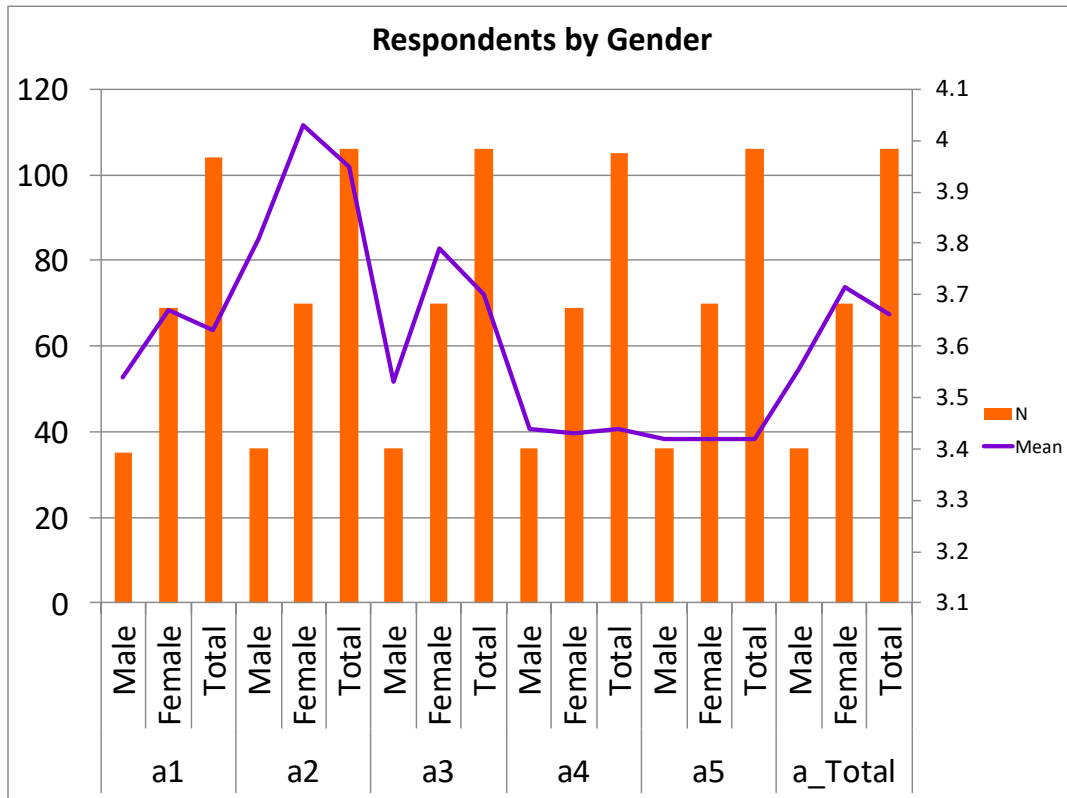
Participants	Items	n	Alpha
All Respondents	5	104	0.76
Students	5	47	0.75
Faculty	5	35	0.77
Staff	5	22	0.79

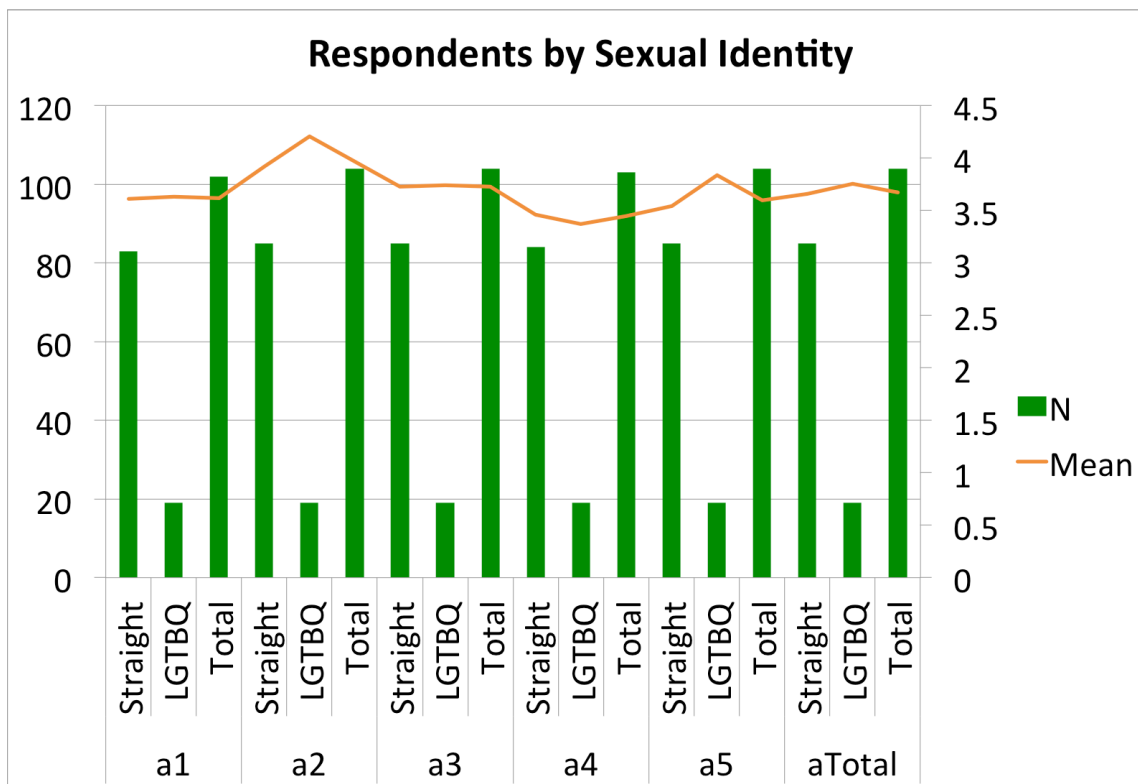
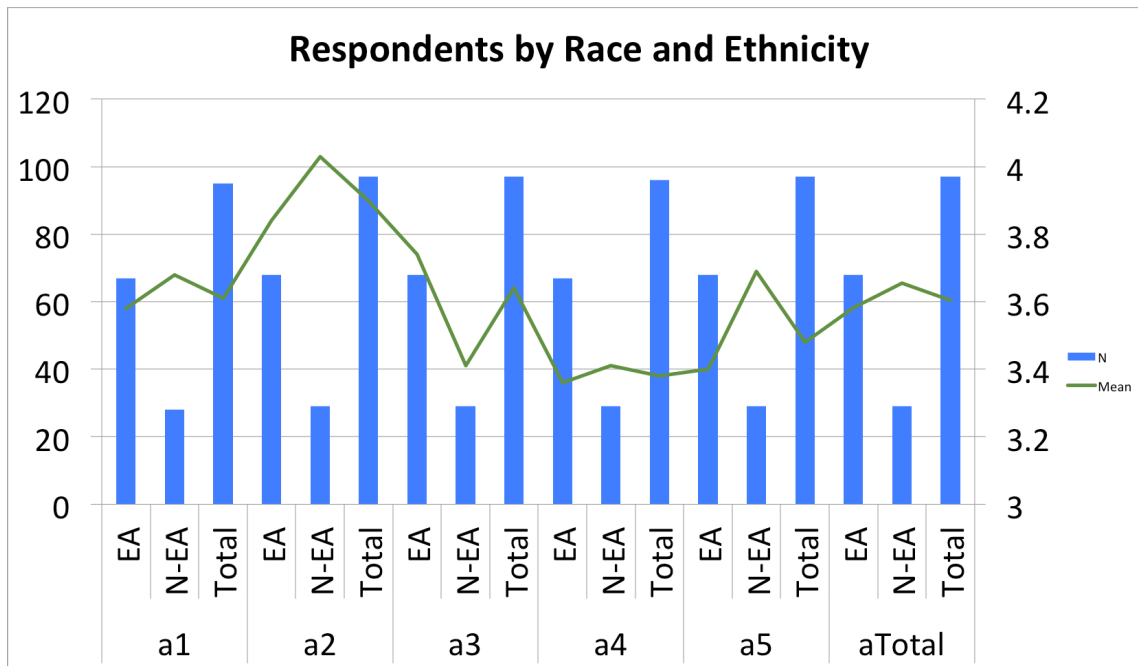
The Cronbach's Alpha estimates show internal consistency with all respondents and with each group. Alpha value ranged between 0.75 to 0.79.

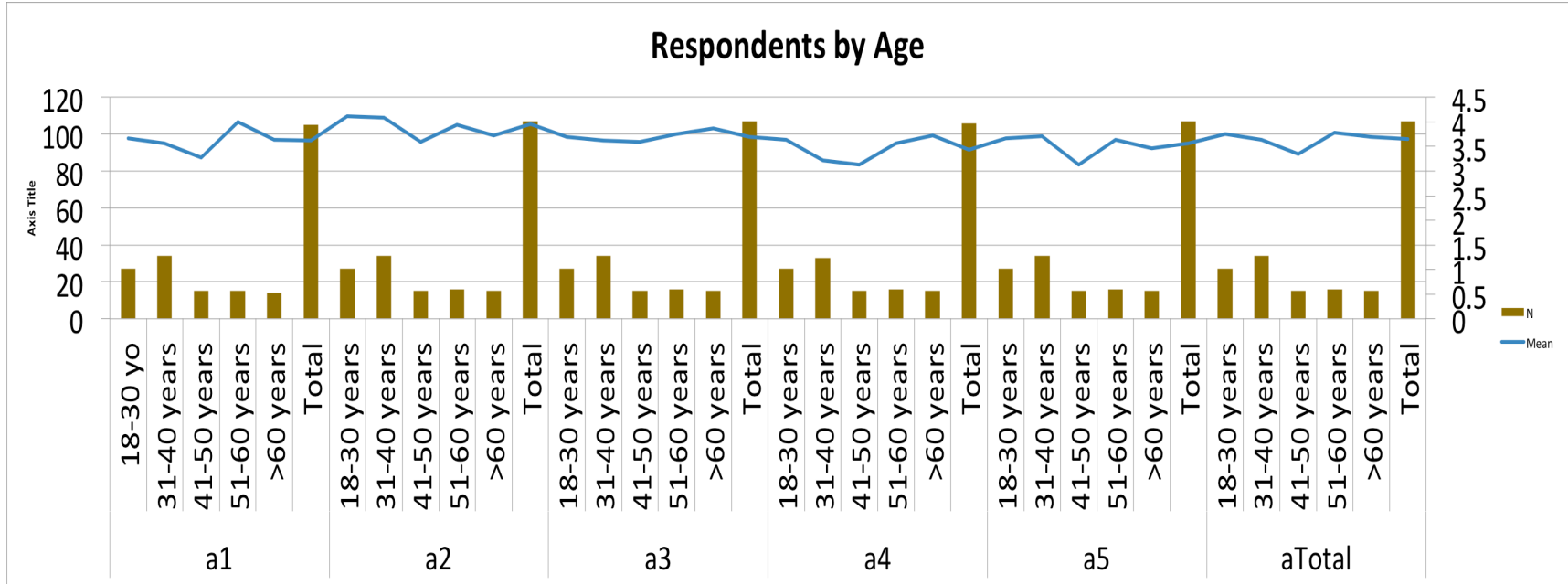
Respondents by Age, Gender, Race and ethnicity, and sexual identity

The following charts and table present an overall assessment of the CCQ-DKASA. It explores its usability and validity to measure the experiences of students, faculty and staff while completing the questionnaire.

Data analysis showed no significant differences by respondents' gender, sexual identity, and racial background. There were no significant relationships (all p s > 0.05) between age and the survey items and their total.







RECOMMENDATIONS

- Analyze CCQ-DKASA items to corroborate the construct validity and reliability of the instrument (Teo, 2013; Messick and Fowler, 1995).
- Explore in depth the significant difference in the staff's responses.
- Conduct interviews with volunteer respondents from all categories to gain in-depth knowledge.
- Develop recommendations for further research and action to address training needs of selected population.

Recommendations

The analyses of all items included in the CCQ-DKASA incorporating discussion of construct validity as defined by Teo (2013) and Messick (1993, 1994) may help corroborate the validity and reliability of the instrument. These measurement and validation criteria have been adopted by the Standards for Educational and Psychological Testing published jointly by the American Educational Research Association (AERA), American Psychological Association (APA), and the National Council on Measurement in Education (NCME).

The only significant difference in the responses demonstrated for the staff could be explored in depth through analyses of the qualitative and quantitative responses provided by the population sample and by conducting interviews with volunteer respondents. Considering that staff members were less likely to agree on the relevance to their work of some items included in the instrument, this variation could be better understood by presenting a richer description of the perceptions of this group. Also conducting interviews with volunteer respondents from all categories can contribute to gain in-depth knowledge and develop additional recommendations for further research and action to address training needs of selected population.

RISKS AND BENEFITS

- No risks were identified during analysis of the evaluation questions.
- The evaluation of the CCQ-DKASA demonstrates the tool's validity and reliability to help identify gaps and strengths in programs, informing improvements to existing curriculum and other trainings provided.

WHAT DID I LEARN

There were no significant differences in responses by age, gender, ethnic, or sexual identity. This is evidence that the utility of the tool is relatively equivalent across groups.

The assessment of internal consistency of the five-item evaluation demonstrated evidence of reliability.

The integrated evaluative judgment of the reliability and validity of the CCQ-DKASA provided preliminary evidence that inferences can be made for the different respondent groups completing the questions.

The combination of responses to the CCQ-DKASA evaluation show the overall quality of the instrument to achieve the project goals.

CONCLUSION

The assessment of internal consistency of the five-item evaluation demonstrated evidence of reliability. When multiple items were combined to form a single scale, an estimate of internal consistency reliability was calculated to provide evidence that the collection of items represent a single construct. These estimates did not vary significantly across different respondent groups. There were no significant differences in responses by age, gender, ethnic, or sexual identity, providing additional evidence that the utility of the tool is relatively equivalent across groups.

The integrated evaluative judgment of the CCQ-DKASA's reliability and validity—including the corresponding correlations between individual items and total scale score provided preliminary evidence that inferences can be made for the different respondent groups completing the CCQ-DKASA.

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APPENDIX E
Electronic Copy of the CCQ-DKASA

CCQ-DKASA

Demographics, Knowledge, Awareness, Skills, and Attitudes

Assessment tool for Cross-cultural Communication

in Health Care – Higher Education

The Cultural Communication Questionnaire-Demographic, Knowledge, Attitudes, Skills and Awareness (CCQ-DKASA) survey assess students, faculty, and staff perceptions about cross-cultural communication in higher education and health care settings. Cross-cultural communication is key to the provision of high quality culturally responsive education and other services. The results of this survey will help identify gaps and strengths of participating programs, informing improvements to existing curriculum and other trainings provided.

The CCQ-DKASA survey has 32 items distributed in the following five sections.

Section A. DEMOGRAPHIC DATA	Items 1 to 16
Section B. KNOWLEDGE:	Items 17 to 19
Section C. AWARENESS:	Items 20 to 25
Section D. SKILLS:	Items 26 to 27
Section E. ATTITUDES.	Items 28 to 32

The survey takes approximately 15 minutes to complete. Your participation is voluntary and by completing the survey you are agreeing for your responses to be included as part of a doctoral training and a Global Health Certificate project.

The project investigator will analyze survey responses only in aggregate with the rest of the responders from each group. Individual responses will be anonymous and kept strictly confidential. No students, faculty or staff member of the Department of Global Health will have access to any data that could possibly be used to identify an individual. The University of Washington Institutional Review Board (IRB) has approved all aspects of this study.

For the purpose of this project, **Cultural Groups** is defined as a number of people who share language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits. **Cultural background** is defined as individual's language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.

At the end of the survey, you will have the opportunity to provide comments and feedback about the DKASA survey tool. To participate, please respond to Item 33. Item 34 is an invitation to participate in randomly selected interviews. In these interviews, you will have an opportunity to expand survey responses and add additional information relevant to your cross-cultural communication experience. To participate, please include your contact information in the space provided. Only the project investigator will have access to this individual information. Individual identification provided will be kept secure and strictly confidential. The report presented will only include de-identified data.

If you have any questions regarding the survey or how the data will be used please contact dyak1@uw.edu.

Item 1.**Section A. DEMOGRAPHIC DATA Items 1 to 16**

Select the role that best describes your current status.

First year MPH-GH student

Second year MPH-GH student

Continuing MPH-GH student

2017 MPH-GH graduate

PhD in GH Metrics student

PhD in GH Implementation Science student

PhD in Pathobiology student

Graduate Certificate in Global Health student

Graduate Certificate in HIV and STIs student

Graduate Certificate in Global Injury and Violence Prevention student

Graduate Certificate in Global Health of Women, Children, and Adolescents student

GH Core Faculty

GH Adjunct Faculty

GH Clinical Faculty

GH Affiliate Faculty

GH Department Staff

Item 2.

As a faculty or staff, have you taught, supervised or advised MPH-GH students during the years 2015, 2016 or 2017?

Yes

No

Item 3.

Have you participated in undergraduate or graduate studies outside the U.S. during one (1) or more quarters? If yes, please indicate the main language spoken.

Yes

No

Language spoken:

Item 4.

Select **ALL cultural groups you most frequently encounter** during your current educational or professional situation.

European Ancestry

American Indian or Alaska Native

African Ancestry

Asian Ancestry

Native Hawaiian or other Pacific Islander Ancestry

Other race

Mixed race

Hispanic or Latino

Other ethnicity

Mixed ethnicity

Male

Female

Straight

Gay or lesbian

Bisexual

Transgender/transsexual

Genderqueer

Low level socioeconomic status

Middle level socioeconomic status

High level socioeconomic status

People with disabilities

Item 5.

Add cultural groups you most frequently encounter if they are not included above.

Item 6.

Select **ALL** of the environments in which you have had practicum or clinical training.

Urban

Suburban

Rural

Underserved

N/A

Other:

Item 7.

Have you lived or worked in a community where you were not part of the majority racial or ethnic group for more than six (6) months?

Yes

No

Item 8.

Have you lived in countries outside of the U.S. for more than six (6) months?

Yes, lived in one country outside of the U.S.

Yes, lived in two or more countries outside of the U.S.

No, I have not lived outside of the U.S.

Item 9.

What languages other than English do you speak? List each language in the box provided. You can also write N/A.

Item 10.

If you listed additional languages you speak, in the same order listed, please select your level of proficiency using the following scale.

Rows

Language 1

Language 2

Language 3

Language 4

Language 5

Beginner

Intermediate

Advanced

Native or Bilingual

Item 11.

How much training in cultural diversity, cross-cultural communication and biases have you had:

Rows

As a first year MPH-GH student

As a second MPH-GH student

As a Continuing MPH-GH student

As a 2017 MPH-GH graduate

As a PhD in GH-Metrics student

As a PhD in GH-Implementation Science student

As a PhD in GH-Pathobiology student

As a Graduate Certificate in Global Health student

As a Graduate Certificate in HIV and STIs student

As a Graduate Certificate in Global Injury and Violence Prevention student

As a Graduate Certificate in Global Health of Women, Children, and Adolescents student

As Faculty

As Staff

No Training

A Little Training

Some Training

Moderate Training

Lots of Training

N/A

Item 12.

The training in cultural diversity, cross-cultural communication and biases I have received while in my program at the Department of Global Health was:

Required

Elective

Offered by my current school or program

Taken at the UW outside of my school or program

Taken outside of the UW

Other:

Item 13.

Select the range applicable to your age:

18-30 years

31-40 years

41-50 years

51-60 years

> 60 years

Item 14.

Select the gender identity you identify with:

Male

Female

Transgender/ Transsexual

Genderqueer /non-conforming

Prefer not to disclose

Different identity:

Item 15.

Select the sexual identity you identify with:

Straight

Gay or lesbian

Bisexual

Prefer not to disclose

Different identity:

Item 16.

Select ALL options of racial and ethnic background that apply to you.

European Ancestry

American Indian or Alaska Native

Asian Ancestry

African Ancestry

Native Hawaiian or other Pacific Islander Ancestry

Other race

Mixed race

Hispanic or Latino

Other ethnicity

Mixed ethnicities

Prefer not to disclose

Item 17.

Section B. KNOWLEDGE:

Items 17 to 19

How **KNOWLEDGEABLE** are you about cross-cultural issues impacting the following topics?

Rows

Health Promotion/Disease Prevention

Reproductive Health/Pregnancy

Child Health

Adolescent Health

Adult Health

Geriatrics Health

Women's Health

Not at all

A Little

Somewhat

Moderately

Very Much

Item 18.

How **KNOWLEDGEABLE** are you about the following topics?

ROWS

Demographics of culturally diverse populations you most frequently encounter

Social characteristics of culturally diverse populations you most frequently encounter

Stereotypes of culturally diverse populations you most frequently encounter

Health risks experienced by culturally diverse populations you most frequently encounter

Challenges experienced by diverse populations to receive their preferred forms of services or treatments

Historical and contemporary impacts of racism, bias, prejudice and discrimination in health care experienced by culturally diverse groups in the U.S.

Different cultural healing traditions (e.g., Ayurvedic Medicine, Traditional Chinese Medicine)

Ethnopharmacology (i.e., variations in medication responses in racial and ethnic populations)

Potential challenges to integrating cross-cultural training in health care services and clinical practice

Not at All

A Little

Somewhat

Moderately

Very Much

Item 19.

How **KNOWLEDGEABLE** are you about the following topics?

Rows

Civil rights policy prohibiting discrimination against individuals based on race, color, religion, sex, and national origin including those with limited English proficiency

Federal requirements to provide culturally and linguistically appropriate services in health services and health care

Council on Education for Public Health (CEPH) Competencies

U.S. Department of Health and Human Services Initiative to Eliminate Racial and Ethnic Disparities in Health

Not at All

A Little

Somewhat

Moderately

Very Much

Item 20.**Section C. AWARENESS:****Items 20 to 24**

How **AWARE** I am about:

Rows

My own racial, ethnic, and cultural identity

My own racial, ethnic, and cultural stereotypes

My own biases and prejudices

Not Aware

A Little Aware

Somewhat Aware

Moderately Aware

Very Aware

Item 21.

To what extent do you agree or disagree with the following statements.

ROWS

Prejudices and biases impact my interactions with people who have professional and/or cultural-racial-ethnic backgrounds different than my own

Discussing issues of discrimination, racism and oppression makes me uncomfortable

My cultural background or orientation can influence my ability to effectively communicate with people who have cultural backgrounds or orientations different from my own

Systematic and institutionalized racism, poverty, and prejudice negatively impact members of minorities, racial and ethnic populations

Strongly Disagree

Disagree

Somewhat Agree

Agree

Strongly Agree

Item 22.

I have **OBSERVED** or personally **BEEN MADE AWARE** of the following:

ROWS

Biases or prejudices of a member(s) of my program towards other member(s) or client(s) who have cultural backgrounds or orientations different from their own

The way in which a member(s) of my program believe that their cultural backgrounds or orientations may influence their effectiveness

Discomfort experienced by a member(s) of my program when discussing issues of discrimination, racism, or oppression

Strongly Disagree

Disagree

Somewhat Agree

Agree

Strongly Agree

Item 23.

If you would like to include issues you have observed or been made aware of that are not included in the item above, please use the following box to write one sentence per each issue.

Item 24.

My current program has the following:

Rows

Mission, vision, and goals committed to promote diversity, cultural competency, cross-cultural communication and responsive educational and other services

An advisory committee composed of faculty, students, and staff to addresses issues of biases, cross-cultural competency and cross-cultural communication

Instructional materials (e.g. lectures, films/videos, books, etc) representing diverse cultural groups you most frequently encounter

Racially and ethnically diverse staff

Racially and ethnically diverse student body

Racially and ethnically diverse faculty body

Curriculum that prepares students with sufficient knowledge to interact in cross-cultural settings

Curriculum that prepares students with sufficient practical experiences to work in cross-cultural settings

Curriculum that prepares students, faculty and staff to provide high quality culturally responsive education and other services

Strongly Disagree

Disagree

Somewhat Agree

Agree

Strongly Agree

Item 25.

My current program has the following:

Rows

Appointed directors to address issues of cross-cultural competency, communication, and biases

Strategic plan implementing clear diversity, cultural competency, cross-cultural communication strategies promoting appropriate services to all populations

Strongly Disagree

Disagree

Somewhat Agree

Agree

Strongly Agree

Item 26.
Section D. SKILLS

Items 26 to 27

How **SKILLED** are you at the following?

Rows

Greeting people with different cultural backgrounds in a culturally sensitive manner

Eliciting perspective about learning or communication styles

Eliciting and discussing information about the use of folk remedies and/or other alternative healing modalities

Eliciting and discussing information about use of folk healers and/or other alternative practitioners

Developing culturally sensitive examinations, needs assessments, or intervention plans

Performing culturally sensitive examinations, needs assessments, or intervention plans

Providing high quality culturally responsive education, advising, or other services

Working with language interpreters

Assessing health literacy

Not Skilled

A Little Skilled

Somewhat Skilled

Moderately Skilled

Very Skilled

N/A

Item 27.

How **SKILLED** are you in **dealing with** the following socio and cross-cultural situations?

Rows

Conflicts relating to interventions, diagnosis or treatment caused by cultural beliefs

Adherence/compliance problems caused by cultural beliefs

Ethical conflicts caused by cultural beliefs

Apologizing for errors and comments based on personal biases, prejudice or lack of knowledge, and resolving the issues

Interacting with individuals from cultural, racial, and ethnic backgrounds different than your own

Interacting with individuals with limited English proficiency and language accent

Interacting with individuals who insist on using, seeking, learning about and supporting folk healers and alternative therapies

Identifying beliefs that are not expressed by individuals but might interfere with outcomes of your services

Being attentive to nonverbal cues or gestures that might have different meanings in different cultures

Interpreting different cultural expressions of pain, distress, and suffering

Advising others to change behaviors or practices related to cultural beliefs that impair one's communication in a culturally sensitive way

Not Skilled

A Little Skilled

Somewhat Skilled

Moderately Skilled

Very Skilled

Item 28.

Section E. ATTITUDES.

Items 28 to 32

How **IMPORTANT** do you believe the following factors are in contributing to health disparities?

Rows

Genetics

Lifestyle

Environment

Poverty

Educational Status

Illiteracy

Ageism

Sexism

Racism

Classism

Ableism

Homophobia
 Socioeconomic status
 Access to healthy food
 Access to Health care
 Social Support
 Language access
 Social Discrimination
 Institutional discrimination

Not Important

A Little Important

Somewhat important

Moderately

Important

Very Important

Item 29.

Are there any other **IMPORTANT** factors not already listed above you believe are contributing to disparities in the cultural groups you most frequently encounter?

Item 30.

How **IMPORTANT** do you believe racial, ethnic and cultural differences are in your interactions with:

Rows

Patients/clients

Health and other professional colleagues

Students

Staff

Faculty

Not Important

A Little Important

Somewhat important

Moderately Important

Very Important

Item 31.

How **IMPORTANT** is it for you to:

Rows

Receive training in biases, cultural diversity multicultural health care, and cross-cultural communication

Understand the individual needs of the people you serve

Understand equity and cultural sensitivity to address existing educational and health disparities

Understand and be “in tune” with the meaning of ethnic dispositions, behaviors, and experiences

Not Important

A Little Important

Somewhat important

Moderately Important

Very Important

Item 32.

How **COMFORTABLE** do you feel doing the following?

Rows

Caring for individuals with racial, ethnic and cultural background different than your own

Caring for individuals with limited English proficiency

Working with peers and colleagues with cultural backgrounds or orientations different than your own

Working with peers and colleagues who make derogatory comments about serving individuals with cultural backgrounds or orientations different than their own

Working with or serving individuals who make derogatory comments about your cultural background or members of your group

Not Comfortable

A Little Comfortable

Somewhat Comfortable

Moderately Comfortable

Very Comfortable

THANK YOU FOR YOUR TIME AND PARTICIPATION!

You have completed the CCQ-DKASA survey.

About the survey:

The CCQ-DKASA was developed using existing as a base existing tools. These tools were adapted with permission of their developers. The Clinical Cultural Competency Questionnaire (CCCQ) developed by Robert C. Like, MD, MS, Professor and Director of the Center for Healthy Families and Cultural Diversity, Department of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School. The CCCQ was used in a project entitled, "Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods," funded by the Aetna Foundation (http://rwjms.rutgers.edu/departments_institutes/family_medicine/chfcd/grants_projects/aetna.html). The MEQ was developed by Darcia Narvaez Professor at Center for Ethical Education of the University of Notre Dame. The CCQ-DKASA might have also influenced by aspects of the Tool for Assessing Cultural Competence Training (TACCT).

Item 33.

Survey Evaluation: Please provide feedback on the survey Tool.

Please provide feedback on the DKASA survey tool:

Rows

The questions provided appropriate response scales.

The questions were relevant to cross-cultural communication.

The time taken to complete the survey was reasonable.

The questions in each section were clear and easy to understand.

The content was relevant to my communication at school or work.

Strongly Disagree

Disagree

Somewhat Agree

Agree

Strongly Agree

Item 34.

Interviews:

You are INVITED to participate in interviews. Members of each group indicating interest in participating in interviews will be randomly selected. Interviews will take between 30 to 60 minutes. You will have the opportunity to expand responses provided on the DKASA survey and add additional comments, thoughts and perspectives. Your responses will be kept secure and strictly confidential. Personal identifiers will not be revealed during the analysis and summary of findings without your authorization.

Your participation will be a valuable addition to this research and findings could lead to greater understanding of cross-cultural communication issues in our field. Please provide:

Questions or comments?
Contact us or email catalysthelp@uw.edu

APPENDIX F

Informed Consent Form for research

Please read the Information below and sign to indicate agreement with the conditions. If you have any questions, please ask the researcher before signing the form. If you decide to participate, you will be given a copy of this Consent Form to keep and refer to at any time.

Study Title: Cross-Culturally Responsive Communication in Health Professional Schools

Principal Investigator: Yris T. Lance

University of Washington

College of Education: Multicultural Education Curriculum and Instruction-PhD Program

School of Public Health: Department of Global Health-Global Health Certificate

Purpose of the Study: The purpose of this study is to explore perceptions of students, faculty, and staff about their cross-cultural education preparedness and implementation of concepts learned in theory and practice. It intends to identify where they have taken their cross-cultural communication and equity training and describe the impact of equity, race and cross-cultural training taken in and outside of college curriculum. It will also help identify strengths and gaps on current courses and workshops available in and administrative support for diversity, equity, and inclusion.

Benefits of the Study

This cross-cultural and intercultural communication study seeks the advancement of interdisciplinary and diverse perspectives to achieve equity; inform practical interventions; and enhance curriculum, content, and the written and unwritten policies dominating the environment in health profession schools. It may contribute to understanding student, staff and faculty views about acquired training, perceived gaps, and effects of their ability to learn, teach, and provide quality services in cross-cultural settings to culturally diverse clientele. This study uses evidence from individuals' experiences to provide recommendations necessary for the development of further interventions. It may help improve institutional climate, quality, and professional development by fostering intercultural learning, respect, ethical work, and mutual understanding.

Risks, Stress, or Discomfort

During the interview participants might feel some emotional stress or discomfort, especially if he/she/they have been subject of traumas related to the topic addressed by the study. Interviewee might feel emotional, uncomfortable, or vulnerable given the minimal risk of unauthorized persons discovering their identity, regardless of confidentiality protection measures.

Condition of participation

- My participation in this interview and overall study is voluntary and I am free to withdraw anytime.
- My interview will be recorded, included in reports, and published as part of a doctoral dissertation and a Global Health Certificate project.
- The investigator of this study can contact me in the future to invite me to participate in follow-up studies.
- I will review the interview transcript, provide feedback, and agree on information to be included.
- My identity will remain confidential and all my identifiers will be removed in any publication developed with information provided for this study.
- All de-identified data may be used by others for future research.

- Schedule phone/in-person interview of approximately 60-minute in length during provided timeframe.
- Interview will be strictly confidential,
- Audio recording and transcripts will be reviewed in the months immediate after the interview.
- If interviewee names any individuals during the interview, names provided will be replaced with pseudonyms.
- Interviewee may choose not to answer any interview question.

Participant's Statement

- I have read and understand what the study involves and the conditions for participation.
- I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researcher involved and withdraw immediately.
- I consent to the processing of my personal information for the purposes of this study.
- I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.
- I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.
- I agree that there will not be any financial compensation for my participation.
- By signing this form, I am freely giving my consent to participate.

APPENDIX G

Exploratory Interview Protocol Form-Students, Staff, Faculty

Study: Equity and Cross-Culturally Responsive Communication in the Health Professional Schools

Date _____ **Time** _____ **Location** _____
Interviewer _____ **Interviewee** _____ **Provided Consent:** _____

Information for interviewee: Mr/Ms. XXXXX Thank you for meeting with me. The input provided in this interview will contribute with the research referred in the project title. It seeks to assess the perceptions of participants about their readiness to provide culturally responsive services to diverse populations and interact in cross-cultural settings. The information you provide will help identify the DGH strengths and gaps and provide recommendations to increase sensitivity, humility, and responsiveness to cultural diversity. However, any response that you wish to maintain private will remain confidential.

Length and type of the interview: 60-90 minutes One-on-one audio recorded.

Interview Structure: Open-ended questions

Purpose of the Study: The purpose of this study is to explore perceptions of students, faculty, and staff about their cross-cultural education preparedness and implementation of concepts learned in theory and practice. It intends to identify where they have taken their cross-cultural communication and equity training and describe the impact of equity, race and cross-cultural training taken in and outside of college curriculum. It will also help identify strengths and gaps on current courses and workshops available in and administrative support for diversity, equity, and inclusion.

Purpose of the interview: This interview is designed to gain in-depth insights into participants' experiences and sense of readiness to interact with diverse populations before and after becoming members of their respective programs, completing voluntary or required studies and practices, and interacting in cross-cultural settings.

Definitions for the purpose of this project: Cultural Groups is defined as a number of people who share language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.

Cultural background is defined as individual's language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.

Interviewer used Guiding Questions: Demographic-Knowledge-Awareness-Skills-Attitudes

Final steps

- 1) Reflection by Interviewer
It is good to learn about your perspectives about and experiences interacting with individuals of diverse backgrounds. Are there any other comments you would like to add?
- 2) Words from interviewer to close the interview:
 - a) Thank you to interviewee: I appreciate the time you have taken to speak with me today.
 - b) Reassure confidentiality: As I mentioned at the beginning of our meeting, your contact information will remain confidential. You will have the opportunity to review the transcript of this interview and let me know if there is any shared information you would like to keep confidential.
 - c) Indicate interest and ask for permission to follow-up: Let me know if it will be ok to contact you in the future to share or obtain additional information as I continue working on this topic.

APPENDIX H

PI Invitation to Participate in the Study

Dear Department of Global Health students, faculty, and staff:

I invite you to take the **Cultural Communication Questionnaire-Demographic, Knowledge, Attitudes, Skills and Awareness (CCQ-DKASA)** survey, which assesses perceptions about cross-cultural communication in higher education and health care settings.

This project is part of my doctoral Multicultural Education training and Global Health Certificate. The survey aims to identify gaps and strengths within departments, informing improvements to existing curriculum and extracurricular training. It seeks to ensure that students, faculty and staff interact in a high-quality cross-cultural learning environment and graduates enter the job market with the knowledge and skills needed to work in cross-cultural settings.

The CCQ-DKASA survey takes approximately 15 minutes to complete. Your participation is voluntary. Individual responses are anonymous and confidential. The project investigator will analyze survey responses only in aggregate with the rest of the responders from each group.

At the end of the survey you will have an opportunity to provide your contact information to participate in interviews to expand survey responses and add additional information. Individual responses will be kept secure and strictly confidential. All reports presented will only contain de-identified data. No students, faculty or staff member of the Department of Global Health will have access to any data that could possibly be used to identify an individual.

Please follow the link to complete the survey by **XXXX**.

Thank you in advance for your participation. If you have any questions regarding the survey or how the data will be used please contact dyak1@uw.edu.

Yris T. Lance, MA
University of Washington
PhD Candidate, College of Education, Multicultural Education-Curriculum and Instruction Program
Global Health Certificate Program
Email – dyak1@uw.edu

APPENDIX I**DGH Leadership Support
Invitation to the Participate in the Study**

Carey Farquhar <cfarq@uw.edu> wrote:

Dear DGH students, staff and faculty,

I'm writing to request your participation in a survey being conducted by Yris Lance, a doctoral student in the College of Education and also a Global Health Certificate student and member of our MPH Curriculum Development Committee.

The survey is a cross-cultural survey that Yris will be using for her dissertation, but will also be useful for us as a department to guide discussion in this area. It has received IRB approval.

I'd appreciate if you would take the time to complete this survey – additional info about the survey can be found below, and on the survey link.

Many thanks,
Carey

~~~~~  
Carey Farquhar, MD, MPH  
Professor, Departments of Global Health, Medicine and Epidemiology  
Associate Chair, Academic Programs, Department of Global Health  
Director, International AIDS Research and Training Program  
Director, Afya Bora Consortium Fellowship in Global Health Leadership  
University of Washington

Phone: 1-206-543-4278  
Fax: 1-206-543-4818  
Address: Ninth and Jefferson Building, 13<sup>th</sup> floor #1347, Seattle WA 98104  
~~~~~

APPENDIX J**Recruitment Letter for Interviews
Survey Takers**

RE: Study:
Equity and Cross-Culturally Responsive Communication in Health Professional Schools.

Dear [Name]

You are invited to participate in a one-on-one interview to discuss your cross-cultural experiences. Thank you for completing the Cultural Competence Questionnaire-Demographic, Knowledge, Awareness, Skills, and Attitudes (CCQ-DKASA). Interviews take approximately 60 to 90 minutes. If you agree to participate, I will be asking you about your cross-cultural communication education and experiences in the UW and in organizations where you might have had practical required or elective training as part of your program.

By accepting this invitation, you are agreeing for your responses to be included in a doctoral dissertation and a Global Health Certificate project. Your responses will be anonymous and kept strictly confidential. The University of Washington Institutional Review Board (IRB) has approved all aspects of this study. No students, faculty or staff member of the DGH, SPH, or UW will have access to any data that could possibly be used to identify an individual. Your participation in this interview and in the study is entirely voluntary and optional. You are free to withdraw at any time without any consequences.

Please send me your availability between XXX and XXX to conduct the interview, indicating:

- 1) Available dates and times:
- 2) In-Person: yes_____ Preferred location: no_____ Phone/video: _____

Thank you in advance for your time and support!

APPENDIX K**Recruitment Letter for Interviews****Non-Survey Takers**

RE: Study:
Equity and Cross-Culturally Responsive Communication in Health Professional Schools.

Dear

You are invited to participate in a one-on-one interview. I will be asking you to share about your cross-cultural communication education and experiences in the DGH, SPH, the UW. Interviews take approximately 60 minutes.

By accepting this invitation, you are agreeing for your responses to be included in a doctoral dissertation and a Global Health Certificate project. Your responses will be anonymous and kept strictly confidential. The University of Washington Institutional Review Board (IRB) has approved all aspects of this study. No students, faculty or staff member of the DGH, SPH, or UW will have access to any data that could possibly be used to identify an individual. Your participation in this interview and in the study is entirely voluntary and optional. You are free to withdraw at any time without any consequences.

In-person interviews are preferred but if you find it necessary, we could set it up as a video conference. Please provide your earliest availability between XXX and XXX. We could meet at a place and time convenient for you, including evenings.

Thank you in advance for your time and support!

APPENDIX L**Letter to Schedule Interviews with Volunteers
Survey Takers**

RE: Study:

Equity and Cross-Culturally Responsive Communication in Health Professional Schools.

Dear [Name]

Thank you for volunteering to participate in the upcoming interviews to continue discussing your cross-cultural communication experiences. I appreciate the time you took to complete the Cultural Competence Questionnaire-Demographic, Knowledge, Awareness, Skills, and Attitudes (CCQ-DKASA).

Our one-on-one Interview will take approximately 60 minutes. I will be asking you to share more about your cross-cultural communication education and experiences in the DGH, SPH, the UW, and with members of organizations where you might have had practical required or elective training as a part of your program.

Interviews will be scheduled between **XXX and XXX** at a place and time convenient for you. In-Person interviews are preferred but if you find it necessary, we could set up a video conference interview. Please let me know:

3) Available dates and times: _____

4) In person Preferred location: _____

Thank you in advance for your time and contribution to this study!

APPENDIX M

Students Interview Questionnaire

Primary question: How do students, staff, and faculty in the UW SPH DGH program describe their (training) preparation, skills and readiness to work in cross-cultural settings?

- Describe training pertinent to cross-cultural communication offered by the UW, SPH, DGH
- Describe how received training or lack of impact students, staff, and faculty knowledge, awareness, skills, attitudes, and behaviors towards diverse cultural groups (DCG).
- Describe participant perception of their preparation to effectively work in cross-cultural settings and with members of DCG.
- Identify participants' perceived CD/CCRC training/practice strengths and gaps.

DEI: Diversity Equity and Inclusion - CG: Cultural Groups

Brief Definitions: CD, DCG, CCRC, CH.

- **Cultural diversity:** "[Culture] is that complex whole which includes knowledge, beliefs, arts, morals, laws, customs, and any other capabilities and habits acquired by [a human] as a member of society" (UN Educational, Scientific and Cultural Organization,n.d.).
- **Diverse Cultural Groups:** number of people who share language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **CD training:** Training developed to increase participants' awareness, knowledge, and skills to communicate with and interpret information relevant to a broad range of cultural groups.
- **Cultural background** is defined as individual's language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **Humility:** quality of being modest and humble, having a low view of one's self-importance.
- **Cultural humility:** abilities to elicit information and relate to members of diverse populations. A lifelong learning process that includes critical self-reflection, the ability to recognize and change power imbalances, develop mutually beneficial partnerships, and promote institutional accountability.

Icebreaker Introductory 5 minutes

- What gender pronoun would you like me to use to address you? _____
- How long have you been part of the DGH: _____
- In what program: _____
- In what capacity? Please select below your current primary and then secondary role.
- Faculty only: _____ faculty/student _____ faculty/staff: _____ Faculty Lead: _____
- What areas of study do you teach?
- With what cultural groups you identify with? _____
- What are the predominant cultural groups in your department, school, and institution?
- What is the level of representation of these groups among students, faculty, and staff?
- Has this composition changed since you entered your program? If so, How?
- How has your identity impacted your teaching experiences and other interactions in the DGH SPH and UW?

Main Questions 50 minutes

1. Remembering the time before you started studying in the DGH, describe your experiences taking training specific to cultural diversity and cross-cultural responsive communication (CD/CCRC).
 - a. Was the training specific CD/CCRC or was it embedded within other training topics?
 - b. Was the training elective or required?

- c. Was the training taken as student, employee, or both?
 - d. What teaching strategies or content was more helpful?
2. Using a 1-5 scale, rate your level of understanding of CD, describe how you used, if at all, your CD knowledge and skills to effectively interact with people from DCG.
 3. Describe your experiences taking training specific to CD/CCRC while in your current program. Particularly what aspects, including teaching strategies and content might have impacted your understanding of cultural values and experiences of individuals with cultural background different than our own?

Follow up if not included in narrative:

- a. Was the training specific to CD/CCRC embedded within other training topics?
 - b. Was the training offered by your program or taken in a different school or institution?
 - c. Was the training elective or required?
 - d. What teaching strategies were most helpful to you: readings, practical activities, videos, group or pair discussions, writing, etc?
4. How, if at all did discussions about the history of members of cultural groups different than your own increase your understanding of their experiences?
 5. How, if at all, was the term cultural humility described in your CD training?
 6. Provide some examples of situations in which **you used** your CD/CCRC **knowledge and skills** to interact with classmates, faculty, and staff?
 7. Thinking about learning as a continuous process and using a 1-5 scale, today, how would rate your level of cultural knowledge and skills to effectively interact with people from DCG. Describe how you feel about your ability to use it?
 8. In your opinion what are some of the most important skills students, faculty, and staff must develop to serve DCG?
 9. **As a future public health practitioner, you have been interacting with and will be working with information relevant to a broad range of cultural groups. What additional knowledge, skills, and resources, if any, would you consider relevant to help you develop mutually beneficial communication with members of DCG.**
 10. Describe any cross-cultural interactions **where you or any of your classmates** have successfully addressed difficult classroom situations or tensions, including dynamics of power and privilege?
 11. Describe any cross-cultural interactions **where you or any of your instructors** have successfully addressed difficult classroom situations or tensions, including dynamics of power and privilege?
 12. Provide examples of ways in which **your instructors** have helped you better understand issues impacting cultural groups different than your own?
 13. Provide examples of ways in which **leadership** in your department has helped you better understand issues impacting cultural groups different than your own.
 14. Describe any other **experienced or observed situations** in which dynamics of power and privilege impacted learning, teaching, or working relations of members at the DGH.

15. How, if at all, have **issues of academic and professional diversity**, equity, and inclusion (DEI) been **incorporated in your training**?
16. How, if at all, did you learn about the following initiatives and policies?
 - a. Federal requirements and initiatives to eliminate racial and ethnic disparities, such as the Culturally and Linguistically Appropriate Services (CLAS) standards.
 - b. Competencies required by the Council on Education for Public Health.
 - c. Institutional, school and department policies to improve DEI.
17. How relevant do you believe these policies and initiatives are to improve actions addressing inequities in your program, school, and community?
 - a. Do you believe most students, faculty and staff in your department have received sufficient knowledge about and guidance to follow these initiatives, competencies, and policies?
 - b. If not, should the UW, SPH and DGH improve this situation? If so how?
18. Provide some examples of how your current program, if at all, has prepared you to understand and address issues impacting public health practice, including systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices against members of DCG.
19. How has studying in a predominantly White institution impacted your learning experiences?
 - a. Describe one way in which the diversity of the staff your department has impacted your learning experiences? Provide examples.
 - b. Describe one way in which the diversity of the student body your department has impacted your learning experiences? Provide examples.
 - c. Describe how the diversity of the faculty body your department has impacted your learning experiences?
20. Describe any current departmental, school and institutional efforts to increase DEI and promote cultural humility in the work place—non-academic and academic roles?

Closing 5 minutes

21. What other aspects in your personal and professional journey might be relevant to your cross-cultural interactions? What have impacted your levels of cultural communication and humility when interacting with members of DCH?

Cultural Diversity | United Nations Educational, Scientific and Cultural Organization. (n.d.). Retrieved August 17, 2019, from <http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/cultural-diversity/>

APPENDIX N

Staff Interview Questionnaire

Primary question: How do students, staff, and faculty in the UW SPH DGH program describe their (training) preparation, skills and readiness to work in cross-cultural settings?

- Describe training pertinent to cross-cultural communication offered by the UW, SPH, DGH
- Describe how received training or lack of impact students, staff, and faculty knowledge, awareness, skills, attitudes, and behaviors towards diverse cultural groups (DCG).
- Describe participant perception of their preparation to effectively work in cross-cultural settings and with members of DCG.
- Identify participants' perceived CD/CCRC training/practice strengths and gaps.

DEI: Diversity Equity and Inclusion - CG: Cultural Groups

Acronyms and Brief Definitions

- **Cultural diversity:** "[Culture] is that complex whole which includes knowledge, beliefs, arts, morals, laws, customs, and any other capabilities and habits acquired by [a human] as a member of society" (UN Educational, Scientific and Cultural Organization, n.d.).
- **Diverse Cultural Groups (DCG):** number of people who share language, religion, practices, knowledge, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **CD training (CDT):** Training developed to increase participants' awareness, knowledge, and skills to communicate with and interpret information relevant to a broad range of cultural groups.
- **Cultural background (CB)** is defined as individual's language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **Humility:** quality of being modest and humble, having a low view of one's self-importance.
- **Cultural humility (CH):** abilities to elicit information and relate to members of diverse populations. A lifelong learning process that includes critical self-reflection, the ability to recognize and change power imbalances, develop mutually beneficial partnerships, and promote institutional accountability.

Icebreaker Introductory 5 minutes

- What gender pronoun would you like me to use to address you? _____
- How long have you been part of the DGH: _____
- In what program: _____
- In what capacity? Please select below your current primary and then secondary role.
- Staff only: _____ Staff/student: _____ Staff support: _____ Staff Lead: _____
- What areas of work?
- With what cultural groups you identify with? _____
- What are the predominant cultural groups in your department, school, and institution?
- What is the level of representation of these groups among students, faculty, and staff?
- Has this composition changed since you entered your program? If so, How?
- How has your identity impacted your working experiences and other interactions in the DGH SPH and UW?

Main Questions 50 minutes

1. Remembering the time before you started working in the DGH, describe your experiences taking training specific to cultural diversity and cross-cultural responsive communication (CD/CCRC).
 1. Was the training specific CD/CCRC or was it embedded within other training topics?
 2. Was the training elective or required?
 3. Was the training taken as student, employee, or both?
 4. What teaching strategies or content was more helpful?
2. Rate 1-10 to describe your level of understanding of CD and use examples to briefly describe how you used, if at all, the acquired knowledge and skills?

5 minutes each/total 45

3. Describe your experiences **taking training** specific to CD/CCRC after you started working in the DGH, particularly what aspects, including teaching strategies and content might have impacted your understanding of cultural values and experiences of individuals with cultural backgrounds different than your own?

Follow up questions, if information is not included in narrative:

- a. Was the training specific to CD/CCRC embedded within other training topics?
 - b. Was the training offered by your program or taken in a different school or institution?
 - c. Was the training elective or required?
 - d. What teaching strategies were most helpful to you: readings, practical activities, videos, group or pair discussions, writing, etc?
4. How, if at all did discussions about the history of members of cultural groups different than your own increase your understanding of their experiences?
 5. How, if at all, was the term cultural humility described in your CD training?
 6. Provide some examples of situations in which **you used** your CD/CCRC **knowledge and skills** to interact with students, faculty, and other staff?
 7. Thinking about learning as a continuous process and using a 1-10 scale, today, how would rate your level of cultural knowledge and skills to effectively interact with people from DCG. Describe how confident do you feel about your ability to use it?
 8. In your opinion what are some of the most important skills students, faculty, and staff must develop to serve DCG?
 9. **As staff, you have been interacting with and working with information relevant to a broad range of cultural groups. Describe what additional resources you would consider relevant to help you develop mutually beneficial communication with members of DCG?**
 10. Describe any cross-cultural interactions where **you or any of your colleagues** have **successfully addressed** difficult working situations or tensions, including dynamics of power and privilege?

11. Provide examples of ways in which **leadership** in your department has helped you better understand issues impacting cultural groups different than your own.
12. Describe any other **experienced or observed situations** in which dynamics of power and privilege impacted learning, teaching, or working relations of members of the DGH.
13. How, if at all, have **issues of academic and professional diversity**, equity, and inclusion (DEI) been **incorporated in your training**?
14. How, if at all, did you learn about the following initiatives and policies?
 - a. Federal requirements and initiatives to eliminate racial and ethnic disparities, such as the Culturally and Linguistically Appropriate Services (CLAS) standards.
 - b. Competencies required by the Council on Education for Public Health.
 - c. Institutional, school and department policies to improve DEI.
15. How relevant do you believe these policies and initiatives are to improve actions addressing inequities in your program, school, and community?
 - a. Do you believe most students, faculty and staff in your department have received sufficient knowledge about and guidance to follow these initiatives, competencies, and policies?
 - b. If not, should the UW, SPH and DGH improve this situation? If so how?
16. Provide some examples of how your CD training, if at all, has prepared you to **understand and address issues** impacting DEI, including systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices against members of DCG.
17. How has working in a predominantly White institution impacted your working experiences?
 - a. Describe one way in which the diversity of the staff in your department has impacted your experiences? Provide examples.
 - b. Describe one way in which the diversity of the student body your department has impacted your experiences? Provide examples.
 - c. Describe how the diversity of the faculty body your department has impacted your experiences?
18. Describe any current departmental, school and institutional efforts to increase DEI and promote cultural humility in the work place—non-academic and academic roles?

Closing 5 minutes

19. What other aspects in your personal and professional journey might be relevant to your cross-cultural interactions? What have impacted the levels of cultural communication and humility when interacting with members of DCH?

Cultural Diversity | United Nations Educational, Scientific and Cultural Organization. (n.d.). Retrieved August 17, 2019, from <http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/cultural-diversity/>

APPENDIX O

Faculty Interview Questionnaire

Primary question: How do students, staff, and faculty in the UW SPH DGH program describe their (training) preparation, skills and readiness to work in cross-cultural settings?

- Describe training pertinent to cross-cultural communication offered by the UW, SPH, DGH
- Describe how received training or lack of impact students, staff, and faculty knowledge, awareness, skills, attitudes, and behaviors towards diverse cultural groups (DCG).
- Describe participant perception of their preparation to effectively work in cross-cultural settings and with members of DCG.
- Identify participants' perceived CD/CCRC training/practice strengths and gaps.

DEI: Diversity Equity and Inclusion - CG: Cultural Groups

Acronyms and Brief Definitions

- **Cultural diversity:** "[Culture] is that complex whole which includes knowledge, beliefs, arts, morals, laws, customs, and any other capabilities and habits acquired by [a human] as a member of society" (UN Educational, Scientific and Cultural Organization, n.d.).
- **Diverse Cultural Groups (DCG):** number of people who share language, religion, practices, knowledge, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **CD training (CDT):** Training developed to increase participants' awareness, knowledge, and skills to communicate with and interpret information relevant to a broad range of cultural groups.
- **Cultural background (CB)** is defined as individual's language, religion, knowledge, practices, beliefs, attitudes, behaviors, ancestry, genetics, physical or social traits.
- **Humility:** quality of being modest and humble, having a low view of one's self-importance.
- **Cultural humility (CH):** abilities to elicit information and relate to members of diverse populations. A lifelong learning process that includes critical self-reflection, the ability to recognize and change power imbalances, develop mutually beneficial partnerships, and promote institutional accountability.

Icebreaker Introductory 5 minutes

- What gender pronoun would you like me to use to address you? _____
- How long have you been part of the DGH: _____
- In what program: _____
- In what capacity? Please select below your current primary and then secondary role.
- Faculty only: _____ faculty/student _____ faculty/staff: _____ Faculty Lead: _____
- What areas of study do you teach?
- With what cultural groups you identify with? _____
- What are the predominant cultural groups in your department, school, and institution?
- What is the level of representation of these groups among students, faculty, and staff?
- Has this composition changed since you entered your program? If so, How?
- How has your identity impacted your teaching experiences and other interactions in the DGH SPH and UW?

Main Questions 50 minutes

1. Remembering the time before you started teaching in the DGH, describe your experiences taking training specific to cultural diversity and cross-cultural responsive communication (CD/CCRC).
 - a. Was the training specific CD/CCRC or was it embedded within other training topics?
 - b. Was the training elective or required?
 - c. Was the training taken as student, employee, or both?
 - d. What teaching strategies or content was more helpful?
2. Using a 1-10 scale, rate your level of understanding of CD, describe how you used, if at all, your CD knowledge and skills to effectively interact with people from DCG.

5 minutes each/total 45

3. Describe your experiences taking training specific to CD/CCRC while in current program. Particularly what aspects, including teaching strategies and content might have impacted your understanding of cultural values and experiences of individuals with cultural background different than our own?

Follow up questions, if information is not included in narrative:

- a. Was the training specific to CD/CCRC embedded within other training topics?
 - b. Was the training offered by your program or taken in a different school or institution?
 - c. Was the training elective or required?
 - d. What teaching strategies were most helpful to you: readings, practical activities, videos, group or pair discussions, writing, etc.
4. How, if at all did discussions about the history of members of cultural groups different than your own increase your understanding of their experiences?
 5. How, if at all, was the term cultural humility described in your CD training?
 6. Provide some examples of situations in which **you used** your CD/CCRC **knowledge and skills** to interact with students, colleagues, and staff?
 7. Thinking about learning as a continuous process and using a 1-5 scale, today, how would rate your level of cultural knowledge and skills to effectively interact with people from DCG. Describe how you feel about your ability to use it?
 8. In your opinion what are some of the most important skills students, faculty, and staff must develop to serve DCG?
 9. **As faculty, you have been interacting with and working with information relevant to a broad range of cultural groups. What additional knowledge, skills, and resources, if any, would you consider relevant to help you develop mutually beneficial communication with members of DCG?**
 10. Describe any cross-cultural interactions **where you or any of your students** have successfully addressed difficult classroom situations or tensions, including dynamics of power and privilege.

11. Describe any cross-cultural interactions **where you any of your colleagues** have successfully addressed difficult working situations or tensions, including dynamics of power and privilege.
12. Provide examples of ways in which **leadership** in your department has helped you better understand issues impacting cultural groups different than your own.
13. Describe any other **experienced or observed situations** in which dynamics of power and privilege impacted learning, teaching, or working relations of members at the DGH.
14. How, if at all, have **issues of academic and professional diversity**, equity, and inclusion (DEI) been **incorporated in your training**?
15. How, if at all, did you learn about the following initiatives and policies?
 - a. Federal requirements and initiatives to eliminate racial and ethnic disparities, such as the Culturally and Linguistically Appropriate Services (CLAS) standards.
 - b. Competencies required by the Council on Education for Public Health.
 - c. Institutional, school and department policies to improve DEI.
16. How relevant do you believe these policies and initiatives are to improve actions addressing inequities in your program, school, and community?
 - a. Do you believe most students, faculty and staff in your department have received sufficient knowledge about and guidance to follow these initiatives, competencies, and policies?
 - b. If not, should the UW, SPH and DGH improve this situation? If so how?
17. Provide some examples of how your current program, if at all, has prepared you to understand and address issues impacting public health practice, including systematic and institutionalized discrimination, conscious and unconscious biases, and other prejudices against members of DCG.
18. How has working in a predominantly White institution impacted your teaching experiences?
 - a. Describe one way in which the diversity of the staff in your department has impacted your teaching experiences? Provide examples.
 - b. Describe one way in which the diversity of the student body your department has impacted your teaching experiences? Provide examples.
 - c. Describe how the diversity of the faculty body your department has impacted your working experiences?
19. Describe any current departmental, school and institutional efforts to increase DEI and promote cultural humility in the workplace—non-academic and academic roles?

Closing 5 minutes

20. What other aspects in your personal and professional journey might be relevant to your cross-cultural interactions? What have impacted the levels of cultural communication and humility when interacting with members of DCH?

Cultural Diversity | United Nations Educational, Scientific and Cultural Organization. (n.d.). Retrieved August 17, 2019, from <http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/cultural-diversity/>

APPENDIX P
CURRICULUM VITAE

Yris T. Lance

Seattle, WA August 2019

Yris.lance@gmail.com**EDUCATION**

Doctor of Philosophy	University of Washington-Seattle, WA	
Education - Curriculum and Instruction		Expected
Multicultural Ed./Health specialization		August 2019
M.A. Interdisciplinary Arts and Sciences	University of Washington-Tacoma, WA	August 2007
Interdisciplinary Studies: Health and Education		
B.A. Interdisciplinary Arts and Sciences	University of Washington-Tacoma, WA	June 2006
Global Studies - Minors: Human Rights/ Hispanic Studies/Nonprofit management		
Administration - Industrial Relations	Pedro Emilio Coll College-Maracaibo, Vzla	June 1995

CERTIFICATIONS

Graduate Certificate on Global Health	University of Washington-Seattle	Spring 2019
Certified Non-Profit Manager	University of Washington-Tacoma	Spring 2006
Certified Medical Service Interpreter	WA Department of Social Health Services	2004
Certified Social Service Interpreter	WA Department of Social Health Services	2004

LANGUAGES

Spanish (native speaker), English (fluent), and French (basic).

ADDITIONAL TRAININGS

Washington State Department of Health

- Contract Management
- Diversity and Cultural Competency
- Medical Home
- Telehealth
- Leadership, management, and supervision
- Community development
- Legislation-public policy development
- Advanced Quality improvement
- Social Justice Community development
- LEAN practitioner

PROFESSIONAL EXPERIENCE

WA Department of Health- Tumwater

Nov 2007-Dec 2016

CLAS Project Manager Governors' Council on Health Disparities Sept 2013-Aug 2015

- Led efforts on the development, adoption, implementation, and promotion of Cultural and Linguistically Appropriate Services (CLAS) standards policies and practices in State agencies and organizations.
- Worked with at least seven state agencies, 4 professional associations, three community health plans, and one Federal agency.
- Led a team of health educators on the development of CLAS training curriculum.
- Provided training and presentations at regional/state conferences and local organizations.
- Recognized statewide as an important resource of expertise in CLAS, diversity & inclusion, community outreach, and community development.

Community Relations Liaison Governors' Council on Health Disparities Nov 2010-Aug 2013

- Developed partnerships/collaborations with more than 100 organizations serving Washington's diverse communities, especially racial/ethnic and disadvantaged populations.
- Lead Community Outreach Roundtable. Approximately 120 individuals from more than 40 organizations received training and improved their outreach and communication strategies.
- Partnered the Washington State Ethnic Commissions and several non-profit and private organizations to serve vulnerable populations across the state.
- Supported 200+ events that provided information & free screenings to 25,000+ individuals living in underserved communities, including those with limited English proficiency.

Project Coordinator WA DOH-Division of Maternal and Child Health Nov 2007-Aug 2010

- Worked with ten national multidisciplinary quality improvement teams to increase the quality of care for children, youth, and young adults with special health care needs.
- Led the WA State team in the 2008-2010 National Learning Collaborative to improve health access for children with special health care needs. Members included three specialty and primary care facilities, two school nurse administrators serving several schools, two local health departments, four family support organizations, and more than 250 families.
- Served in more than six conference-planning committees, increasing access to continuing education for hundreds of health professionals, including those working in rural areas.

HONORS AND AWARDS: 2015 ICSEW Excellence in Service and Leadership.

2015 Molina Community service award-Latino Promoting good health

2013 ICSEW Outstanding performance award

2013 ICSEW Valuable contributions on policy development award

2004 to 2006 UW High Scholarship Annual and Quarterly Dean Lists

SELECTED VOLUNTEER EXPERIENCE**American Educational Research Association (AERA)** Peer reviewer

Summer-2019

UW Global Health Student Association (GHSA) Oct 2018-June 2019
 Founding member / Co-President

UW DGH Curriculum Development Caucus - Member Jan 2017-Sept 2018

UW DGH Curriculum Development Working Group

- Coordinate and facilitate Caucus meetings
- Data collection and stakeholder analysis
- Peer mentoring
- Development of evidence-based curriculum proposal

Interagency Com. State Employed Women -ICSEW Jun. 2013-2015
 Conference Committee Chair

- Lead planning, promotion, and fundraising strategies of the ICSEW annual conference.
- Increased size of the 2014 annual leadership conference from 150 to 400 attendees.
- Developed a public-private sponsorship system, recruiting 9 sponsors at levels up to \$3,000.
- Served in their Legislative and Policy subcommittee, contributing to the development of two Executive orders signed by the Governor.

Washington State Individual Review Board-WA IRB Mar. 2012-2016
 Board member

Protected the rights and welfare of human subjects while promoting, equity and inclusion.

Latinos Promoting Good Health (LPGH) 2010-2015
 Founding Member

Organized and convened family health and safety fairs throughout the state of Washington in partnership with representatives from community based and for-profit organizations, federal, state and local health and safety agencies, and local medical and pharmacy students.

Susan G. Komen – 2010-2013
 Grant reviewer

Reviewed grant applications and awards

PREVIOUS AND CURRENT MEMBERSHIPS:

2018- present DGH Global health Student Association (Co-President/Advisor)

2017-2018 UW SoM Diversity Committee

2007-present Golden Key International Honor Society.

2013-2016 Chair of the ICSEW Conference committee

2010-2016 Franciscan Health System Family Advisory Committee

2010-2014 Susan G. Komen Grant Review Committee

2011-2016 Washington State Individual Review Board

2010-2013 Members of the Washington State Hispanic Health Fairs Planning committee

2009-2010 Seattle Children's Pediatric Neurology Conference Planning Committee

2007-2010 Seattle Children's Hospital Duncan Seminar Planning Committee

2008-2010 The Olympian newspaper Diversity Panel

2003-2010 St. Frances Cabrini Church Hispanic Community Outreach and Education

SELECTED PUBLICATIONS:

Lance, Y., (2009, October 16). Taking time to better understand epilepsy worth effort, The Olympian.

Lance Y., (2009, August 7). Sotomayor is good step in gaining equal representation, The Olympian.

Lance Y., (2009, May 29). We must chart our own course and learn from mistakes, The Olympian.

Lance Y., (2009, March 19). We all must promote mutual respect, understanding in our communities, The Olympian.

Lance Y., (2008, December 18). If ever there were a time to find simplicity, this would be it. The Olympian.

Lance Y., (2008, October 10). Counter an unconscious bias against other accents. The Olympian.

Lance Y., (2008, July 30). Motivated employees key to productive environment, The Olympian.

Lance Y., (2008, May 23) Parents need to take responsibility for their family's health. The Olympian

Lance Y., (2008, March 14). State needs to provide health care to all of its children. The Olympian.

Lance, Y. (2007) Mexican Americans from Mexico to Washington State: Discrimination and Segregation in the Memory of One Witness. University of Washington. Oral History

Lance, Y. (2007). *Closing the achievement gap of Hispanics in Washington State through quality education, equal treatment, and justice*. University of Washington, Tacoma.

Federal reports:

2013-2015: Governor's Interagency Council. State Partnership Grant to Improve Minority Health: Implementing CLAS Standards in Washington State. Quarterly and Annual Reports

2010-2013: Governor's Interagency Council. Fostering Health Equity Partnerships. Quarterly and Annual Reports.

2008 WA Department of Health. Epilepsia en Washington - Needs Assessment.

2007-2010: WA Department of Health. Epilepsia en Washington. Quarterly and Annual Reports.

SELECTED PRESENTATIONS / TRAININGS / WORKSHOPS:

Lance, Y. and Mehan K., (June 2015). Washington State Department of Ecology. CLAS Standards Overview. Olympia, WA.

Lance, Y. and Mehan K., (June 2015). Washington State Department of Ecology. CLAS Standards: Governance, Leadership and Workforce. Olympia, WA.

Lance, Y. and Mehan K., (June 2015). Washington State Department of Ecology. CLAS Standards: Communication and Language Assistance. Olympia, WA.

Lance, Y. and Mehan K., (June 2015). Washington State Department of Ecology. CLAS Standards: Engagement, Continued Improvement and Accountability. Olympia, WA.

Lance, Y. and Mehan K., (June 2015). Washington State Department of Ecology. CLAS Standards: Integrating CLAS into Policy and Practice. Olympia, WA.

- Lance, Y. and Swory S., (June 2015). Health Champions Reducing Disease to Improve Health Conference. Community Health Workers and other Champions: Opportunities and Challenges. Granger, WA.
- Lance, Y., and Mehan K. (May 2015). Department of Early Learning. CLAS Standards, Education and Health.
- Lance, Y., (March 2015). Northwest Rural Health Conference. Implementing National Class Standards in Rural Washington. Spokane, WA.
- Lance, Y., (February 2015). Northwest Regional Primary Care Association Conference. CLAS-y Washington: Providing Culturally and Linguistically Appropriate Services. Seattle, WA.
- Lance, Y., (February 2015). Northwest Regional Primary Care Association Conference. CLAS-y Washington: Providing Culturally and Linguistically Appropriate Services. San Jose, Texas.
- Lance, Y. (February 2015). Improving Health Outcomes Through Community Based Outreach. Seattle, WA.
- Lance, Y. and Mehan K., (November 2014). Premera. Implementing National CLAS Standards in Washington State. Seattle, WA.
- Lance, Y., Alanis, P, Valenzuela, M, Rubio, A, and Salazar, L., (October 2014). Washington State Public Health Association Annual Conference. Diversity Awareness, Equity and Community Engagement in Healthcare. Seattle, WA.
- Lance, Y. and Mehan K. (October 2014). Health Care Authority. Integrating CLAS Into Policy and Practice Health Care Authority. Olympia, WA.
- Lance, Y., (October 2014). Washington State Public Health Association Annual Conference. Reducing Health Disparities in Washington State: Fostering Health Equity Partnerships. Seattle, WA.
- Lance, Y., (September 2014). Interagency Committee State Employee Women Conference. CLAS Standards in Government Agencies. Olympia, WA.
- Lance, Y., (June 2014). Washington State Department of Agriculture. Developing and Adopting CLAS Standards. Olympia, WA.
- Lance, Y. and Martin, D., (April 2014). Health Care Authority. Developing and Adopting CLAS Standards. Olympia, WA.
- Lance, Y. and Martin, D. (March 2014). Office of the Superintendent of Public Instruction. Development, Adoption and Implementation of CLAS Standards. Olympia, WA.
- Lance, Y., (April 2014). Washington State Coalition for Language Access Conference. National Class Standards, Languages, Interpretations and Translations, WA.
- Lance, Y. and Martin, M., (March 2014). Northwest Rural Health Conference. National Class Standards and Rural Health. Spokane, WA.
- Lance, Y., (June 2013). Latina Health Forum. Partnerships for Improving Latina Health in Washington State. Seattle, WA.
- Lance, Y., (April 2012). City of Bellevue. Cultural Conversations. Culture and Health. Bellevue, WA
- Lance, Y. and Chodon T., (December 2011). Epilepsy-Quality Improvement Tools. 15th Annual Multiracial and Multicultural Health Conference. Memphis, Tennessee.
- Lance, Y and Collin, M., (November 19-21, 2009). Epilepsy-Provider-Patient Communication, 19th Annual Midwest Stream Farmworker Health Forum. Texas,

- Lance, Y. (May 2009). Epilepsia en Washington. Presentation for Educators. Infant and Early Childhood Conference. Tacoma, WA.
- Lance, Y. (April 2009). Recursos Locales para Familias con Niños con Epilepsia. Epic Resource Fair. Yakima, WA
- Lance, Y., (March, 2009). Incrementando Acceso a Servicios de Salud en la Comunidad Hispana. Hispanic Conference Yakima, WA.
- Lance, Y. and Stahlnecker, L., (February 2009). Evidence-Based Practice: Update for Nurses in School and Ambulatory Care Settings. Research and Presentation. Seattle Children's Hospital. Seattle, WA.
- Lance, Y. (November 2008) Epilepsy and Ethnic Outreach. Presentation for Public Health Consultants. Kennewick, WA.
- Lance, Y., (October 2008). Project Access: Epilepsia en Washington. Presentation for Parent Support Organizations.
- Lance, Y., (November, 2008). Epilepsia y la Familia Hispana. Parent's presentation. Tricities, WA
- Lance, Y., and Barnhart, L., (September 2008). Epilepsy, Care Coordination and Medical Home.
- Lance, Y., (September 2008). Epilepsia en Washington. Migrant Council. Presentation for Health Consultants.
- Lance, Y. and Barnhart, L. (August 2008). Epilepsy, Care Coordination and Medical Home.
- Lance, Y., (July 2008). Hispanics and Epilepsy. Migrant and Community Health Care Centers Promotoras Training, Yakima, WA.
- Lance, Y., (July 2008). Health Districts. Using Needs Assessment to Promote Health Equity. Central Region Meeting. Seattle, WA.
- Lance, Y., (April 2008). Project Access and Epilepsia. Spanish. Focus Groups in local communities. Pasco, WA.
- Lance, Y., (April 2008). Epilepsy and Ethnic Outreach (Spanish). Washington Association of Community and Migrant Health Centers. Promotoras Training. Yakima, WA.
- Lance, Y., (2008). Project Access and Epilepsia. Spanish. Focus Groups in local communities. March, Yakima, WA. 2008 Lance. Yris. Epilepsia y la Comunidad Hispana. Yakima Valley - Hispanic Conference.
- Lance, Y., (February 2008). Venezuela and Human Rights. Annual Undergraduate Research Symposium. University of Washington. June. 2006.
- Lance, Y., (June 2006). Affirmative Action and I-200 Research and presentation. University of Washington. Seattle, WA.