PUBLIC HEALTH PERSPECTIVES OF CULTURAL COMPETENCE

by

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DEDICATION

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ABSTRACT

Racial health disparities and social injustices[1] in health care continue in the United States (US) despite decades of research, policies, and programs dedicated to their elimination (Feagin & Bennefield, 2014). Cultural competency education[2] of health care providers has been one way purported to help sensitize professionals to these inequities, thus seeking to address racial bias, unequal treatment, and misunderstandings of minority populations (Office of Minority Health, 2001). Such education can begin when students enter academia to commence their health care education, and certainly occurs as a student moves on through their academic career, particularly as they enter their post-graduate level studies. Investigating the required cultural competency course of a Master of Public Health (MPH) program through the perspectives of faculty, current students, and alumni for its ability to develop culturally sensitive health care practitioners was the aim of this case study.

Document analysis and direct observation of the one cultural competency course required for all concentrations in one MPH program was undertaken. This was a semester-long course and was offered face-to-face and online; both were observed. In-depth interviews of faculty, current students, and alumni of the same program were also conducted. Using the public health critical race (PHCR) praxis theoretical framework (Ford & Airhihenbuwa, 2010b), data was analyzed to determine how, and to what extent, faculty teach cultural competency, students internalize this instruction, and alumni put this education into practice.

By using a critical theoretical framework designed for public health program development, this study found that such a framework has effective utility as a curriculum

evaluative tool – this framework could be used to increase students understanding of racial issues that impact health and health care. Data also revealed a schematic believed, by faculty, students, and alumni, to be important for the development of cultural competence.

The findings also point to the importance of creating space in the classroom for both minority and majority voices to feel free to express difficult issues without repercussions of stereo-typing and name-calling; and for faculty to be able to effectively deal with such discourse. Curriculum that addresses issues of health disparities and social justice, classroom praxis, and faculty role-modeling can be combined to create the institutional environment where culturally sensitive and socially just health care practitioners may emerge.

CHAPTER 1: INTRODUCTION

> I had come to Merced, California, …because I had heard that there were some strange misunderstandings going on at the county hospital between its Hmong patients [refugees] and its medical staff. One doctor called them "collisions," which made it sound as if two different kinds of people had rammed into each other, head on, to the accompaniment of squealing brakes and breaking glass. As it turned out, the encounters were messy but rarely frontal. Both sides were wounded, but neither side seemed to know what had hit it or how to avoid another crash. (Fadiman, 1997, p. *viii*)

Anne Fadiman relates this sentiment in her preface to "The Spirit Catches You and You Fall Down." This book is her first-person investigative account of a Hmong family whose young daughter was plagued with a severe case of epilepsy and their tragic encounters with health care professionals. The story encapsulates the struggle between predominantly white health care practitioners and their non-white patients, be they United States (US) citizens, refugees, or undocumented immigrants. Attention to this struggle has resulted in the recommendation to improve the cultural competency of health care practitioners in an attempt to decrease the social, cultural, and communication gaps between these professionals and their patients (Office of Minority Health, 2001). Cultural competency has been defined as "the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds" (Betancourt & Green, 2010, p. 583). This study investigated how cultural competency education of public health professionals is taught by faculty and "caught" (internalized, practiced) by students in a case study of one Master of Public Health

(MPH) program, using in-depth interviews, document analysis, and classroom observation to analyze attitudes and beliefs about cultural competency in health care based on faculty, student, and alumni perspectives. The objective of this study was to illuminate pedagogical practices that might influence students' views about and practice of culturally sensitive health care and to provide recommendations for teaching this topic.

Cultural Competency

From the earliest research on language barriers between majority health care providers and minority patient populations (Saha, Beach, & Cooper, 2008) to the disparities in health care access, treatment, and outcomes between majority and minority populations in the US, (Dilworth-Anderson, Pierre, & Hilliard, 2012), cultural competency has been viewed as a way to improve health care treatment and outcomes for minority populations (Haughton & George, 2008; Kardong-Edgren & Campinha-Bacote, 2008; O'Connell, Rickles, Sias, & Korner, 2009; Smedley, Stith, & Nelson, 2003). Indeed, a sampling of statistics reveal the stark truth about such disparities: the mortality rate of infants born to American Indian/Alaskan Native women is 1.5 times higher than for infants born to white women and the mortality rate of infants born to black women is 2.3 times higher than for infants born to white women; non-Hispanic blacks have a hypertension rate of 56% while for whites it is 38%; the rate of potentially preventable hospitalizations for non-Hispanic blacks is double that of non-Hispanic whites (Centers for Disease Control, 2013); and the rates of diabetes by race are non-Hispanic whites 7.6%, Asian-American 9%, Hispanics 12.8%, non-Hispanic blacks 13.2%, and American Indian/Alaska Natives 15.9% (Centers for Disease Control, 2014). Finding ways to decrease such disparities has become an important topic in medicine and cultural

competency education is one way purported to do just that. Exposing students to (a) the historical background of diverse populations and their often harmful medical contacts - e.g. the Tuskegee syphilis study (Washington, 2006) and the Willowbrook State School experiment (Kirschner, 2006); (b) the current lived experiences of diverse populations - economically, nutritionally, socially (Seeleman, Suurmond, & Stronks, 2009); and (c) to students' own biases and prejudices before they treat individuals from cultures other than their own (Westberg, Bumgardner, & Lind, 2005), have all been shown to enhance medical interactions between students and patients (Shoultz, Fongwa, Tanner, Noone, & Philion, 2006), improve the cultural attitudes, knowledge, and skills of students (Calvillo, Clark, Ballantyne, Pacquiao, Purnell, & Villarruel, 2009; Doutrich & Storey, 2004), as well as improve health outcomes for patients (Kattelmann, Conti, & Ren, 2009).

The promotion of culturally competent health care practitioners is particularly important when one considers the race/ethnicity of our health care workforce compared to the race/ethnicity of the US population. Despite the fact that African-Americans, Hispanic/Latinos, and American Indians/Alaska Natives combined make up more than thirty percent of the US population (US Census Bureau, 2014), they represent only 11.5% of physicians, 9.5% of dentists, 10.1% of pharmacist, and 16.5% of registered nurses (US Department of Health & Human Services, 2015). In the field of public health the percentage of African-American graduates in 2002-2003 equaled the percentage of adult African-Americans in the population, however seven percent of public health graduates were Hispanic/Latino compared to an adult population of eleven percent (Perlino, 2006). To examine these inequalities in the health care professions, the Sullivan Commission toured the country collecting data from a variety of sources about the state of our health

care (Sullivan Commission, 2004). This Commission made recommendations to increase representation of minority groups in the health care professions, an ideal echoed by many (Bodin, 2007; Haughton & George, 2008; Mitchell & Lassiter, 2006).

While the US health care workforce is predominantly white, the population is becoming ever more diverse. According to the US Census Bureau (Day, 1995), by 2050 non-Hispanic whites will comprise about 50% of the population, with 16% black, 23% Hispanic, 10% Asian and Pacific Islander, and about 1% American Indian, Eskimo, and Aleut. Immigrant and refugee populations more than tripled from 1960-2015 (Migration Policy Institute, n.d.) and are expected to continue to rise (Haub, 2008). Groups that define their racial, ethnic, and/or cultural lives as different from the dominant race/culture have very different ideas about disease, health, and treatment (Garrett, Dickson, Lis-Young, Whelan, & Roberto-Forero, 2008; Garrison, 2007; Ingram, McClelland, Martin, Caballero, Mayorga, & Gillespie, 2010). By ignoring this aspect of the medical encounter, health outcomes (e.g., access, treatment, morbidity, and mortality) for minority patients can suffer (Fadiman, 1997; Smedley, Stith, & Nelson, 2003). This means that health care professionals will need the knowledge, attitude, and skills to best treat individuals within this increasingly racially, ethnically, and culturally diverse population. To provide the highest quality of care, health care professionals will need to be able to work *with* patients in the context of their lived experiences, i.e., their culture (Betancourt, 2004).

Improving the cultural competence of health care workers is seen by many researchers as a way to improve the care and treatment of minority populations, even to the point of decreasing health disparities that have been reported across the country;

disparities that exist even when insurance status and income are controlled (Smedley, Stith, & Nelson, 2003). A lack of cultural competence on the part of a health care practitioner has been described in many ways. Some of these may include: the inability to communicate effectively with patients due to language barriers; inadequate knowledge about a patient's culture and its influence on health; attitudes of indifference or disrespect about a patient's cultural beliefs and health habits; and/or organizational/institutional factors that do not support respect for patient's language, culture, or health beliefs and habits (Truong, Paradies, & Priest, 2014). In fact, Congress charged the Institute of Medicine (IOM) to study the differences in access and quality of care between minority and majority populations, determine the causes of these differences, and make recommendations to eliminate disparities discovered (Smedley, Stith, & Nelson, 2003). This IOM report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (Smedley, Stith, & Nelson, 2003), included a very comprehensive review of the literature on this topic, as well as data from work groups, interviews, and focus groups with health care leaders, practitioners, researchers, and patients. What this report found shocked the medical community as it revealed blatant areas of discrimination, prejudice, and bias on the part of practitioners and mistrust and refusal of treatment on the part of minority populations due to historical mistreatment of such groups (Geiger, 2008). Based on their findings, the IOM committee writing the report made many recommendations. Among them: (a) strengthening doctor-patient relationships via improved cultural competency education and increasing the number of minorities in health care professions; (b) decreasing financial incentives that promote disparities; (c) using professional interpretation services in health care settings for patients with limited

or non-English speaking abilities; (d) promoting multidisciplinary care teams and patient education on how to access care; and (e) promoting further research that addresses health care disparities, improved treatment for minority populations, and progress in the area of decreasing health disparities. Since this report was published, the number of articles related to health disparities has increased significantly. Indeed, a literature search performed using the terms "health care," "disparities," and "United States" from 1950 to 2003 returned 400 results, while in the five years just after this IOM report, 2003 to 2008, the search returned 1,416 results. For the entire period of 2003 to 2015 this search returned 5,034 results.

Reviewing this literature for the impact of culturally competent health care practitioners on the health outcomes of minority populations, reveals many articles reflecting health care interventions with specific populations (e.g., Kattelmann, Conti, & Ren, 2009) and limited success with improving outcomes (e.g., Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2010). Thus, the literature has not been viewed by the health care field as generalizable nor the interventions studied fully successful. Part of these limitations, however, may be that such research does not go far enough to explicate the underlying issues surrounding the gaps between majority health care workers and minority patient populations. Due to this limitation, more recent research has looked at what may limit health care professionals from practicing in culturally responsive ways. Such research has related these limitations to the idea of social justice, claiming that as practitioners learn more about the underlying disparities, what they stem from, and how to openly, honestly view their own role in addressing such disparities, these health care workers may then begin to practice in more culturally responsive, socially just ways

(Beadle & Graham, 2011; Dilworth-Anderson, Pierre, & Hilliard, 2012; Taboada, 2011). These researchers predict that not only culturally competent, but racially aware, health care workers could function in ways that provide the greatest positive impact to those who now bear the greatest burden of ill health – minority populations (Beach, et al., 2005; Brach & Fraserirector, 2000; Chin, Alexander-Young, & Burnet, 2009). Thus, effective education of health care professionals is critical.

Standards for promoting cultural sensitivity have been developed, which target health care organizations, practicing professionals within each health care discipline, and higher education institutions which train future health professionals (American Dietetic Association, 2011; American Physical Therapy Association, 2008; Association of Schools of Public Health, n.d.; Betancourt, Green, Carrillo, & Park, 2005; Betancourt & Lopez, 1993; Gilbert, 2002; Munoz, DoBroka, & Mohammad, 2009; The Joint Commission, 2010; Williams, 2006). Studies addressing the effectiveness of such educational programs for physicians, dentists, and nurses are readily available, but studies on medical subspecialties are less plentiful. Since the majority of health care professionals are still non-Hispanic whites (Sullivan & Mittman, 2011) and chronic health issues disproportionally affect minority populations (Bastos, Celeste, Faerstein, & Barros, 2010; Woolf, Johnson, Fryer, Rust, & Satcher, 2004), the long term effectiveness of these education programs in all health specialties is an important issue. Focusing, however, on one subspecialty, public health professionals, may help illuminate the effectiveness of culturally competent education practices.

Due to their expansive geographic coverage (urban, rural, State, county, and local health offices, for example) and the fact that public health professionals are often the first

or primary health care workers and educators seen by minority populations (Gebbie, Rosenstock, & Hernandez, 2003), public health professionals as a subspecialty within medicine, make a sound study population. Additionally, the origins of public health involve social justice issues (Rosen, 1993) and public health's focus on population-level health issues (Association of Schools and Programs of Public Health, n.d.) makes studying the education programs of public health students fitting since looking at variation between and among two or more racially/ethnically and culturally diverse populations is at the heart of cultural competency instruction. Furthermore, another IOM report, "Who Will Keep the Public Healthy?" (Gebbie, Rosenstock, & Hernandez, 2003), aimed at developing a framework for the 21st century education of public health professionals, defined a public health professional as "a person educated in public health or a related discipline who is employed to improve health through a population focus" (p. 1). This report delineated eight new areas critical for the public health professional knowledge base that should be included in MPH graduate programs. These eight areas are "informatics, genomics, communication, *cultural competence*, community-based participatory research, policy and law, global health, and ethics" (p. 17, emphasis added). The Association of Schools and Programs of Public Health (ASPPH) recently came out with their report on the core elements of a MPH program. These core elements included taking into account the cultural components of populations and individuals and practicing in culturally competent ways (ASPPH, 2014). Thus, with a mandate to include cultural competency education within MPH programs, analyzing how and to what extent such education has been included can be instructive for administrators of these programs as well as for other medical subspecialties.

In addition, past President of the American Public Health Association (APHA), Carol Easley Allen, stated that public health practitioners must establish health equity as a priority in programs and policies; that the elimination of health disparities is simply the just and right thing to do (Allen, 2001). Academia is an appropriate institution to examine whether or not health equity is a priority, for it is when educating future health care professionals that the creation of culturally competent, socially just practitioners can occur. In her article about education for social justice, Hytten (2006) states that cultural studies should engage in research that impacts people's lives, that brings about "democracy and social justice" for those who are oppressed. She adds that such studies can be seen:

> . . . as a political, interventionist, and transformative approach to exploring, critiquing, and creating knowledge. Among its goals are to understand the relationship between power and knowledge, to look at how power gets symbolically and representationally reproduced, to challenge disem-powering social practices, and to provide resources for resistance and social transformation. (p. 234)

Are academic institutions that confer the MPH engaged in such pedagogy through their cultural competency programs? This study set out to examine this question.

Statement of the Problem

Although studies of the cultural competency curriculum and education have been done on some medical professions, there are very few studies looking at the cultural competency education in MPH programs. While the percentage of white students in MPH programs has fallen below 50% (Association of Schools of Public Health, 2011), this

group still represents the largest race/ethnicity in MPH programs. Because of the greater likelihood of public health workers contact with minority populations, this racial/ethnic divide should be more fully evaluated at the curriculum level and, looking beyond the classroom, to alumni practicing in the field to assess how their education prepares them to practice in culturally competent ways, or to reveal gaps in the education when looking at actual practice, particularly as it relates to issues of correcting social injustices in health care and decreasing health disparities.

In addition, because racially related health disparities continue despite years of attention (Green, Lewis, & Bediako, 2005; Keppel, Pearcy, & Heron, 2010; Trivedi, Grebla, Wright, & Washington, 2011), looking at the issue from a more critical perspective at the classroom level, and how this classroom experience impacts students as future practitioners, may illuminate additional problems not yet addressed in previous studies. Indeed, Ford and Airhihenbuwa (2010b) claim that early public health research based on dominant class scientific norms, i.e., the scientific method as defined by white, middle-class men, did not address the underlying social and racial contexts of health disparities, thus did not, and could not, truly improve unhealthy conditions for some populations. These authors state that connecting critical theoretical standards used in racial scholarship since the 1980's to public health research can help "move [researchers] beyond merely documenting health inequities toward understanding and challenging the power hierarchies that undergird them" (p. 1390). When the subject of racial identity and white privilege is openly discussed in medical education, growth in the area of cultural competency is seen in students with provocative and instructive results (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2005). Perceived racial privilege hurts all

racial groups in terms of health, thus it should be an area of inquiry when looking at cultural competency education (Fujishiro, 2009). Commenting on her experience as a Latina student in a MPH program, Taboada (2011) stated:

> While many of the classmates I remain in contact with have indeed gone into public health practice, it is unclear whether our classroom CSL [Community Service Learning] experience allowed us to draw the connections between racism, health outcomes, and our own cultural competency, and hence prepared us to combat racial/ethnic health disparities in the field. (pp. 378-379)

Clearly, more research into cultural competency education and its potential impact on students' actual practice, leading to decreases in racial/ethnic health disparities and more race-conscious/socially just practice, is needed.

Purpose and Audience

Based on the above research, the goal of this case study was to analyze the cultural competency perspectives of faculty, students, and alumni from one MPH granting institution. This case study is best described as a discourse analysis embedded within a curriculum investigation. By qualitatively analyzing the discourse around cultural competency teaching, learning, and practice, this study proved illustrative and added depth and richness to the literature on the education of future practitioners in the area of cultural competency and health-related race and ethnic disparities. Looking at this topic through a critical lens, asking questions about "whiteness," privilege, attitudes, and power, from the perspective of these three populations of the same MPH program provided instructive practices on teaching and learning cultural competency. Asking

these questions as they related to racial/ethnic health disparities and social justice as a part of cultural competency also provided insight to improve such teaching and learning and opened new avenues of study not yet addressed.

Findings of this study are particularly important for administrators and faculty of MPH granting institutions, but students and alumni of MPH programs can also learn a great deal from these findings. In addition, administrators, faculty, students, and alumni of other health care professions may find this study enlightening and administrators and faculty can adapt the methodology and theoretical framework to their own programs, helping to create curriculum that is more critical in nature; curriculum that may open the space for discourse to occur that can lead to the development of more culturally sensitive, socially just practitioners in all health care fields.

Methodology

To investigate the cultural competency education of MPH students, I performed document analysis, direct classroom observation of a semester-long required cultural competency course, and in-depth interviews with (a) faculty who teach, or have taught, cultural competency courses, (b) current students over the course of a semester in a required cultural competency class, and (c) alumni of this same program who are now practicing within populations different from their own, to examine how faculty taught, and students "caught" (internalized, practice), such teaching. This course was taught face-to-face as well as online and I observed both classes. I analyzed the discourse surrounding cultural competency, health disparities, and social justice issues from the perspectives of these three populations.

I used a critical race theory-based (CRT) framework, the public health critical

race (PHCR) praxis (Ford & Airhihenbuwa, 2010b), to ground this study, since my objective was to see how, and to what extent, cultural competency education led to perspectives that exhibited a health equity and social justice disposition. Critical research is designed to reveal dominant hegemonic views (in this case the educational pedagogy based on historically white perspectives – socially, culturally, ideologically) versus marginalized views (perspectives from groups who have less power in a society – socially, culturally, ideologically). This framework, therefore, was appropriate since acknowledgement of such a dichotomy is needed before change in the status quo (dominant ideology) can occur through praxis. I first analyzed the data according to narratives (representing dominant viewpoints) and counter-narratives (representing marginalized viewpoints) based on the four focuses of the PHCR framework, then further analyzed the data against the ten principles of this framework.

Organization of the Study

Chapter one of this six chapter dissertation includes an overview of the study as a whole; a brief background that situates the study and its rationale as well as the study highlights. Chapter two presents a literature review that encompasses a more extensive historical background of cultural competency in health care, as well as explaining the theoretical framework for this study. This particular chapter describes the foundation of the primary theory used in this study, the public health critical race (PHCR) praxis, its intended purpose based on its authors' commentary, and how this framework was used in this study. This explanation is particularly important since I chose to use this framework in a new way – to evaluate a curriculum rather than a health program.

Chapter three establishes the research questions, then describes my positionality.

In qualitative studies, particularly critical ones, the positionality of the researcher is important since it impacts all aspects of a study. Thus, my positionality prefaces the data collection populations and methods, definitions of the four focuses and ten principles of the PHCR framework, and the review of how analysis was carried out; principally how the analysis was done against the specifics of the theoretical framework. This chapter concludes by addressing the validity and limitations of the study.

Chapters four and five delineate the findings. Chapter four provides the first phase analysis of this study: narrative and counter-narrative themes found when examining the data against the four focuses of the PHCR framework; while chapter five portrays the second phase of analysis: evaluating these themes against the ten principles of the theoretical framework. The study findings are presented in this way due to the nature of the framework; I used the basic critical research process of developing narrative and counter-narrative themes, but wanted to go further with this analysis and the expanded ten principles of the PHCR framework helped contextualize the data, providing a richer, even more critical analysis than what I observed in the first phase of the analysis. This second phase analysis also revealed how well the framework could be employed to evaluate a curriculum.

Chapter six concludes this dissertation with a brief overview of the study and research questions to re-establish the rationale of the study, then moves on to provide a summary of the findings with implications for future research and practice. I end this chapter with a few concluding remarks.

CHAPTER 2: LITERATURE REVIEW

Despite the fact that the US has long been a multi-racial, multi-ethnic nation, the concept of cultural competence in health care writings did not emerge regularly until the 1990's (Saha, Beach, & Cooper, 2008). In fact, the term "cultural competence" was not used in indexing medical literature until 2008 (K. Douglas, personal communication, June 13, 2012). Over the years, however, the idea of cultural competence in health care has been refined and is generally accepted to mean:

> … the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds; aspects of diversity include – but go beyond – race, ethnicity, gender, sexual orientation, religion, and country of origin. (Betancourt & Green, 2010, p. 583)

With this definition in mind, the following represents a summary of how cultural competence became an important concept in the health care field and traces three eras that reflect the changing focus of cultural competency literature.

History of Cultural Competence in Health Care

Public health as a field has often been involved with populations considered under-resourced (Rosen, 1993), but the concept of being culturally competent as a health care provider is relatively new (Yee & Weaver, 1994). Looking at the cultural competency in health care literature, approaches to the topic can be broken down into three historical eras. The following will present these eras.

Era One: Language and Perceptions

From the late 1960's, when the term patient-centered care was coined by Balint

(1969) to the early 1990's, early efforts at addressing barriers to health care due to cultural differences between majority (health care providers) and minority (patients) groups focused on language barriers (Saha, Beach, & Cooper, 2008). The emphasis was on how these largely immigrant populations perceived health and illness differently than the majority population and how these inherent differences could negatively impact health care (Berlin & Fowkes, 1983). Anne Fadiman (1997) illustrated this aspect of health care poignantly in "The Spirit Catches You and You Fall Down." Through this story of a Hmong family and their little girl who had a severe form of epilepsy, Fadiman captures the trials and tribulations of the Hmong family, as well as the health care system and professionals, because of the cultural chasm between the two worlds. This book is considered a classic and used by many health care educators to illustrate the need for culturally competent care (DasGupta, 2006; Spector, 2009). This early work created interest in the topic, but also revealed (a) the impossibilities of having health care professionals learn a great deal about every culture with which they might come in contact and (b) the possibility that professionals might stereotype groups in ways that would create negative health care encounters (Campinha-Bacote, 2002; Hill, Fortenberry, & Stein, 1990). Literature to support medical professionals' education on cultural competence to address these two issues then became more frequent (Bobo, Womeodu, & Knox, 1991). The importance of recognizing that both the patient and the provider bring culture to the medical interaction was also a part of this early research (Saha, Beach, & Cooper, 2008).

Era Two: Expansion of Cultural Competency Description

The growth of research dealing with culturally responsive care broadened in the

1990's representing a second era that extended into the early 2000's. Populations included within the concept of culture were enlarged to include not only immigrant groups, but all minority groups, and the idea of racial disparities in health care became more prominent in this literature (Betancourt, 2004; Saha, Beach, & Cooper, 2008; Woolf, Johnson, Fryer, Rust, & Satcher, 2004). It was at the end of this decade and the beginning of the 21st century that the IOM reports mentioned previously were published (Gebbie, Rosenstock, & Hernandez, 2003; Smedley, Stith, & Nelson, 2003). These reports helped to launch much more research on the topics of cultural competence and health disparities.

In addition to articles on patient populations, literature during this time also focused on including cultural competence in educational endeavors for health care providers. This early body of work primarily endorsed the development of health care professionals' knowledge, attitudes, and skills for providing care to populations different than their own (Campinha-Bacote, 2009; Crandall, George, Marion, & Davis, 2003; Paul, Devries, Fliegel, Cleave, & Kish, 2008). Literature focused on education to improve not only knowledge, skills, and attitudes, but was also aimed at addressing the realities of health disparities (Bull & Miller, 2008). Campinha-Bacote (2011), a prolific writer on the subject of cultural competence in nursing, emphasized the process of becoming culturally competent. Her contribution to the subject was not only her model of culturally competent care, but also the fact that she stressed the difference between *being* culturally competent and *becoming* culturally competent. Campinha-Bacote explains this difference as one in which a health care provider is actively involved in cultural awareness, learning about the cultures with which they work, and integrating all they learn into their practice

of care with patients, becoming much more adept and effective as they care for patients whose lives may be very different from their own. This distinction is very important since experience with patients over the course of time may alter aspects of how a student recalls their academic education and how they currently practice (Daley, 1999), thus cultural competence may change over time as well. Because experience in the field is an aspect of this study, Campinha-Bacote's perspective is important.

Although sprinkled throughout the history of this literature, it was during this time that the issue of the predominantly white health care workforce and its contribution to the issues of health disparities was more prominently addressed (Bichsel & Mallinckrodt, 2001; Cooper-Patrick, et al., 1999; Lopez, Lopez, & Fong, 1991; Perez-Stable, Napoles-Springer, & Miramontes, 1997). In fact, during this time the IOM released "In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce," not only to address the significant imbalance of racial/ethnic diversity within the health care professions, compared to the population as a whole, but also to make recommendations for improving this imbalance by increasing the number of underrepresented groups in the health care professions (Smedley, Butler, & Bristow, 2004). This report discussed the evidence that improved health care outcomes do occur when there is more congruence between the racial/ethnic background and/or culture of the health care provider and that of the patient:

> This evidence . . . demonstrates that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-clinician communication. . . . Indirectly, evidence suggests that

> greater diversity can improve the cultural competence of health professionals and health systems, and that such improvements may be associated with better health-care outcomes. In addition, greater diversity among health professionals has the potential to improve the clinical research enterprise and to lead to new developments and improvements in health care and how care is delivered. (p. 29)

The IOM report also addressed not only disparities, but provided recommendations to increase access to higher education for underrepresented groups within health care programs.

The focus of this research began to address more critically the nature of health disparities from a more comprehensive perspective, including inequalities of resources, health care providers and access, and policies and power; the very systems which impact health (Beadle & Graham, 2011; Betancourt & Green, 2010; Betancourt, Green, Carrillo, & Park, 2005; Green, Lewis, & Bediako, 2005). Such research alluded to the social justice aspects of cultural competence and health disparities, defining the third era, which is the subject of the next section.

Era Three: Cultural Competency, Health Disparities, and Social Justice

This era began after the 2003 IOM report mentioned above and continues to the present day. Due to the continuing health disparities among racial/ethnic population groups despite (a) years of addressing these issues, (b) development of recommendations for higher education institutions to increase students from underrepresented groups in health care professional programs, and (c) adoption of cultural competence standards for health care professions and organizations, many authors see the issue of racial/ethnic

health disparities as a social justice issue. Their contribution to this literature is in making the connections between systemic racial/ethnic issues and a call to action to dismantle such systems so that truly equitable health care for all can be attained (Braveman, et al., 2011; Saha, Beach, & Cooper, 2008). These authors make the observation that:

> Most of the American healthcare infrastructure was developed in the pre-Civil Rights era and is therefore at risk of propagating "institutionalized" discrimination against people of color. Even modern health systems were largely designed with the majority population in mind. These realities, coupled with the increasing racial and ethnic diversity in the United States, have made changing health systems to accommodate the preferences and values of diverse populations an essential part of the cultural competence agenda. (Saha, Beach, & Cooper, 2008, p. 18)

A sampling of the innovative approaches to addressing health disparities and decreasing social injustice follows. Such examples help situate the importance of the historical research in this field and the advancements made by addressing the majority-minority gap in health care.

Historically, minorities have been used in medical experimentation as objects, not humans, and have not always been helped by the medical research they are willing or unwilling participants of (Rogers & Kelly, 2011; Washington, 2006). Using feminist intersectionality principles as described by Crenshaw (1991) that explicate the ways that individuals can be multiply oppressed when they self-identify in ways oppositional to the dominant white male cultural hegemony, e.g., being female *and* lesbian *and* African-American. Rogers and Kelly (2011) explain some of the ways that health disparities

contribute to social injustice. They describe how those affected by such injustice are often affected not by just one category of "minority status," but by several, e.g., female versus male, black versus white, low income versus high income. These varying identities, particularly when many are subordinate to the dominant societal group, each have their own negative aspect of less than ideal health provision or beneficence from health research, but when occurring together they produce even higher rates of social injustice than any one alone. There have been specific incidences where multiple categories of "vulnerable population" impact not only "who gets studied and why," but also how such research may indicate multiple risks for the individual, but not actually provide testing or treatment for such risks during the study for which the person is a subject (Rogers & Kelly, 2011). These authors assert that "power hierarchies between researchers and participants enable researchers to interpret and use data for their own agendas (e.g., social, economic, and political)" (p. 400). They promote an intersectional approach to health research to protect and serve underrepresented groups and help promote social justice within the health care system. One such approach is community-based participatory research (CBPR). Not only do these authors promote this as a more just form of health research, but CBPR is becoming a hallmark of public health research (Levy & Sidel, 2006).

Community-based participatory research is particularly suited to public health since public health practitioners focus on community and population health issues (APHA, n.d.). By more fully engaging the community in the research, often as co-investigators, CBPR can be viewed as a form of socially just research (Rogers & Kelly, 2011; Thomas, Quinn, Butler, Fryer, & Garza, 2011). To reveal the depth and breadth of

such research, some examples of CBPR include working with Native American communities on youth wellness (Teufel-Shone, Siyuja, Watahomigie, & Irwin, 2006), looking at depression care among African-American women (Nicolaidis, et al., 2010), and evaluating cancer rates in rural Appalachian populations, one with and one without mountaintop coal mining (Hendryx, Wolfe, Luo, & Webb, 2012). Teufel-Shone, Siyuja, Watahomigie, and Irwin (2006) further describe CBPR as coming from an emic, or insider's, perspective, rather than the typical etic, or outsider's, view which simply promotes the paternalistic tendencies health care professionals have toward minority populations and the marginalization of such populations in past research. Wallerstein and Duran (2010) call CBPR translational intervention research because CBPR gives voice to community members, allowing them to have input into analysis, results, and discussions of such research. These authors state that "as a core concept, CBPR has been framed as an orientation and overall research approach, which equalizes power relationships between academic and community research partners" (p. S42). This equalizing power of research and knowledge production is a good example of this third era of cultural competence work that addresses health disparities in ways that can lead toward social justice in the health care field. This example of emic-oriented research that grew out of the social sciences (Lewin, 1946) has been used in health research since the late 1980's and early 1990's (Holter & Schwartz-Barcott, 1993), and indicates that public health is a good place to focus on academic education as a way of preparing more culturally competent, socially conscious practitioners; assessing not only if such principles are taught, but also if they are "caught" (internalized) by students, then translated to practice by alumni. Further, lessons learned from the academic setting may prove instructional for

other health-related professions that have not historically been as culturally or socially focused.

Bergsma (2004) lauds the emancipatory function of community-based health research; that by allowing members of a community to be involved in every aspect of a health promotion program, from inception, to diagnosis of problems, to solution development, enactment, and evaluation, the community members become more empowered to "critically analyze their sociopolitical environment, and create mutual support systems" (p. 155). Bergsma's article adds the dimension of empowerment education as a vehicle to elevate underrepresented groups' voices within the health care paradigm. Bergsma discusses the theoretical underpinnings of Freire's empowerment education in her work with media literacy and health promotion as a way to increase participants' critical thinking skills, which enables them to resist messages that promote unhealthy choices and worthless consumerism. Since these issues are systemic, they must be solved at the systemic level, but face considerable opposition. She states:

> In public health, there is constant tension with the dominant system of the medical model that focuses on individual disease or deficiency. The medical model employs a simple triadic credo: (a) the problem is you, (b) the resolution of your problem is my professional control, and (c) my control is your help. (p. 158)

This ideology reveals the core of why health disparities research and the ideals of social justice have become interconnected and why dismantling hierarchies of power within the health care system through such research, education, and training may ultimately "result in healthier citizens able to think critically and act collectively" (Bergsma, 2004, p. 161),

the ultimate goal of socially responsible action within any institution.

As the ideals of cultural competence, health equality, and social justice have continued to gain attention, research focus, and funding, the theoretical underpinnings and actual practice of such ideals have also gained attention (Livingood, et al., 2011; Munoz, DoBroka, & Mohammad, 2009). Livingood, et al. (2011) provide compelling arguments for "the development and application of applied approaches to the social and behavioral health sciences" (p. 525). They regard this approach as one that moves from the "research to practice paradigm" to a paradigm that "integrates research and practice" (p. 525). These authors claim that addressing the complexities of health in terms of social, economic, environmental, and behavioral contexts for individuals, families, and communities, rather than generalizing health messages based on diagnoses which ignore such complexities, is where health care research should move next. Their example of the success in decreasing tobacco use is fitting: while small tobacco-cessation programs could quantify reductions in tobacco use and are certainly intervention science, it was really community-wide, societal, and policy changes that were responsible for the large decline in tobacco use in the US. Yet because these larger influences do not fit into the "randomized, controlled study" paradigm of the "linear scientific method," they are often ignored in scientific literature; but information from such interventions is extremely useful for policymakers, program planners, and health advocates. They further argue that such narrow thinking serves to promote individualistic, costly programs to the detriment of minority populations due to cost and recruitment barriers. To train future health care providers who remain flexible enough to deal with the ever-changing social constructs of health and health care, these authors state:

> Rather than practitioners who dutifully and blindly apply the discoveries of science 'with fidelity' in their practice, we need experimenting practitioners and applied scientists who have acquired the reflective habits of mind that enable them to apply numerous sources of evidence, principles, and theories to each unique community, spanning both research and practice. (p. 529)

To remain committed to the idea of "generalizability" in research is to promote the status quo of health care, thus to have little impact on health promotion, disease prevention, and health disparities (Livingood, et al., 2011). Thus health care practitioners well-versed in the cultural landscape of varying minority populations, who use new methodology based on such knowledge, can allow new, more positive, culturally-relevant research and practice to emerge.

These various concepts and authors reveal a shift in public health promotion to more effectively address health issues in the population from a culturally competent, socially just standpoint. From the preceding research, it is evident that this shift is occurring within health programs, professional organizations, and educational institutions that train future health care providers, but to what extent? By analyzing if, and to what extent, students internalize culturally competent principles and enact these principles in their practice; instructional recommendations for such teaching may be illuminated.

Cultural Competency Education

The previous review reveals a representative example of the body of work that has been done on this subject, but the fact that so much research that interconnects cultural competence, health disparities, and social justice has been, and still is, being

done speaks to the notion that there is a powerful hierarchy within health care that has barred advances in decreasing such inequities. In fact, the editor-in-chief of the American Journal of Public Health, Mary Northridge, in the April 2012 issue, applauded the Occupy Wall Street movement for bringing economic injustice, which reflects racial inequality in business, education, and health, into the public discourse. She states:

> In other words, Occupy Wall Street has accomplished what until recently has eluded public health advocates and scientists: it has crystallized a message around the social determinants of health that resonates with broad segments of the population, both domestically and abroad. (p. 585).

Making visible these inequalities can occur at any level and in any institution, but education is often the vanguard of such work (Apple, 2004a; Apple & Buras, 2006; Delgado & Stefancic, 2012; Lea & Helfand, 2007; Wink, 2011). Looking at changes in educating college students in any field, and specifically in the health care field, from a social justice standpoint begins with the idea of critical pedagogy because "critical pedagogues argue that schooling should fundamentally be about individual growth and social transformation; what we do in classrooms should be connected to efforts to challenge social inequalities and to build a better society" (Hytten, 2006, p. 222). Thus, this section provides background on this subject as the foundation for the theoretical framework underlying this study.

Apple's research on whose knowledge is "official" (Apple, 1990) and "of worth" (Apple, 2004b) is particularly salient here. Apple's work introduces the concept that there is an ideology behind the curriculum in schools that reproduces the dominant society's

values while rendering minority values invisible. Thus, the status quo of society (culture, business, achievement, etc.) is maintained at the expense of silencing minority voices. This concept fits with the idea of education in culturally appropriate care for health professionals since the point of this education is to give voice to the "other;" to have those in power actually give up some of their power in the relationship and listen, to be able to provide the best care. Apple's research also points to the larger question of who decides what exactly cultural competence is. What definitions are used and who determines these definitions? There is also the issue of the hidden curriculum in medical education that values the hierarchical nature of medicine through role modeling of teachers as preceptors of normal behavior and that effectively represses critique of this structure (DasGupta, et al., 2006). DasGupta, et al., go on to caution medical educators that to teach students a "socially conscious professionalism, we have to be critically conscious of our power as teachers" (p. 249). There is evidence in the value of community work, having medical students actually encounter the social, economic, and environmental challenges faced by minority groups or by having them act "as if" they were the individuals in need of health care under the same conditions their minority patients experience. Such experiences allow students to see the world from a different, less privileged perspective. Indeed:

> De-privileging our own authority as educators can contribute to real cultural change in our profession, modeling non-hierarchical and respectful relationships that trainees can then translate into their clinical care. In this way, ideals of social justice can be operationalized for both learners and teachers toward broader goals of social critique and change. (DasGupta,

et al., 2006, p. 251)

Despite this call for such educational reformation in 2006, "pedagogy for health disparities education is still in its infancy and has received limited acceptance and implementation into undergraduate and graduate medical education curricula" (Ross, et al., 2010, p. S160). This "limited acceptance and implementation" could be due to the difficulties of dismantling a system that so fully benefits, or is invisible to, those in power (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2005; Ross, 2009).

Addressing these difficulties can be done at the individual level, the institutional level, or the policy level. Examples of such research that has addressed what happens when issues of racism and social justice are made transparent follow. Resistance to racism education for marriage and family therapists in a specific institution revealed that such resistance on the part of white students was easily seen by minority students, but not by white students, revealing that education does tend to maintain dominant hierarchies. This particular program, however, did allow resistance discourse by non-white students against such dominance (McDowell, 2004). Allowing open classroom discussions of racism and inequalities can lead to "emancipatory and counterhegemonic" education for all students (McDowell, 2004). Looking at this issue from an organizational and institutional perspective, change will not occur until the very root causes of such inequalities at this level are challenged and changed, something termed "dismantling racism" (Griffith, Yonas, Mason, & Havens, 2010) . This approach is based on accountability for organizational policies, practices, and procedures, toward improving equity, but includes individual accountability as well. Policy makers at the institutional level are exhorted to use dismantling racism approaches to make foundational changes.

Intersectionality paradigms have been used in nursing research (Van Herk, Smith, & Andrew, 2011). These paradigms conclude that "people's experiences are simultaneously the product of how they identify themselves, how they are seen by others, and how they interact with others" (Chow, Pederson, Haworth-Brockman, & Bernier, 2009, p. 163). By using such paradigms in nursing practice, education, research, and policy, the privilege-oppression binary that exists in health care can be openly revealed and examined by all, with the ultimate goal of seeing the world as it truly is, thus opening up opportunities to right social wrongs within health care.

One last example clearly illustrates the connections between education and theory: CBPR, mentioned above, is a way of viewing minority groups as having capital, rather than viewing them from a deficit standpoint (Valentine, 1969). This practical application of theory echoes such practice in education. Yosso (2005) describes this same approach when looking at communities of color as having "community cultural wealth" (p. 70). Yosso describes several forms of this capital, briefly defined here: aspirational – the ability to dream of success in a world where success for minorities is difficult to achieve due to the dominance of white racial ideology; navigational – the ability to handle and succeed in institutions whose rules and regulations are based on a white racial frame and are not intuitive, or even friendly, to non-white individuals; social – those networks of family and friends who can provide support, information, and knowledge to navigate dominant institutions; linguistic – the ability to communicate in more than one language, socially, intellectually, and culturally; familial – the strong family and community ties that provide strength "of caring, coping and providing (educacion), which inform our emotional, moral, educational and occupational consciousness" (p. 70); and

resistant – the ability and strength to recognize and oppose racial inequities and injustices. Yosso goes on to describe that this type of wealth is not what is valued by the dominant society, thus is not recognized as wealth; rather communities of color continue to be viewed from a deficit standpoint. This review brings this discussion back to where it began with Apple's (1990 & 2004b; Apple & Buras, 2006) contention that who's knowledge has value or is of worth, is foundational to the concept of social justice; whether in education or in health care.

Summary of Literature Review

Taking the preceding research as a whole, it is interesting to note the progression of research on cultural competency to health disparities to social justice. It is apparent that such an evolution of study would occur since, as noted, health disparities such as less access to health care, less optimal treatment, and higher incidence of chronic diseases for minorities, continue to exist despite decades of research attention, regulations, and professional standards to address such disparities. Another theoretical step in this evolution has been critical race theory, since the heart of this theoretical stance is in "challenging and making white supremacy and institutional racism visible" (Twine & Gallagher, 2008, p. 10). Thus, it is with this background and theoretical lens that the current study was framed.

Theoretical Framework: Critical Race Theory and Public Health Critical Race Praxis

Critical race theory (CRT) and public health critical race praxis (PHCR) formed the theoretical frameworks for this study. CRT is the foundation upon which PHCR is built. Originally, CRT was used to explain institutionalized racism, marginalization, and

social inequalities that exist and impact the legal profession and criminal justice system (Delgado, 2009; Delgado & Stefancic, 2012) while PHCR was developed to explain these same aspects within the health care system (Ford & Airhihenbuwa, 2010a). CRT has been adopted by scholars to explain institutionalized racism, marginalization, and social inequalities that exist within the educational system (Aguirre, 2010; Gilborn, 2005; Powers, 2007; Stanton-Salazar, 1997), among various underrepresented groups (Butler, 1994; Han, 2008; Jain, 2010; Plummer, 2005), and within other non-legal institutions (Lee & Skrentny, 2010; McClure, 2010; Preston & Chadderton, 2012). This review will focus on the history of CRT as used in higher education literature, how CRT paved the way for PHCR, and how CRT and PHCR formed the theoretical framework for this study. It will also include the concept of "whiteness" research (Cabrera, 2012; Cabrera, 2014a; Twine & Gallagher, 2008) since this philosophy moves CRT forward into the realm that PHCR seeks to inhabit. This review also includes work by critical theorists of race as such work helps situate white racial ideology within our US culture and the health care system.

Critical Race Theory (CRT) and Race Studies

CRT's development was based on the idea that it is the system, rather than individuals, that creates social inequalities. These systems maintain the majorities' privileged position without the consent of minorities and often without the knowledge of either group. CRT sought to open the discourse about such systems, exposing the reality of such discrimination for both majority and minority populations to see, and thus hopefully, change (Bell, 1973; Delgado, 2009). CRT has thus been used within education in several ways: to expose the conditions that maintain the academic achievement gap

between whites and non-whites (Aleman, 2009; Love, 2004; Taylor, 2006); to reveal the "hidden curriculum" that maintains majority knowledge as "official knowledge" (Apple, 2004b; Kress, 2011); to discuss the experience of scholars of color within academe (Burden, Harrison, & Hodge, 2005; Dowdy, Givens, Murillo, Shenoy, & Vellenas, 2000; Hughes & Giles, 2010); and to address issues of affirmative action (Aguirre, 2000; Holmes, 2007; Morfin, Perez, Parker, Lynn, & Arrona, 2006; Teranishi & Briscoe, 2008), including the idea of "reverse discrimination" espoused by whites (Cabrera, 2014a; Cabrera, 2014b) .

The body of literature using CRT to study the educational system is considerable. With the introduction of CRT to the field of education in 1995 (Ladsen-Billings & Tate), power hierarchies, structural racism, and the ideology of curriculum began to be analyzed and voiced. Within this scholarship, criticism of the structures of the educational system which thwart upward mobility and truly equal opportunity for minority populations from kindergarten through graduate school have revealed many areas of racism and injustice (Apple, 2004b; Powers, 2007; Stovall, 2006; Wink, 2011; Yosso, 2005). This body of work has also provided hope for change within these structures, although change comes slowly due to the power hierarchies in place and majority members' blindness to these hierarchies (Apple, 2006; Fischman & McCLaren, 2005; Kress, 2011; Lea & Helfand, 2007). CRT studies and "whiteness," or critical whiteness studies (CWS), interconnect to reveal these hierarchies to both minority and majority players within an institution (Cabrera, 2012; Feagin & Bennefield, 2014; Spanierman & Cabrera, 2015; Twine & Gallagher, 2008). By analyzing and reporting on such phenomena as (a) barriers minorities experience that whites do not experience (e.g., white privileges;

microaggressions toward minorities), (b) the lasting negative health and wealth effects of historical trauma on minorities, and (c) the direct negative results of racism on minorities (e.g., educational attainment), CRT, critical theorists of race, and CWS can reveal these hierarchies. Cabrera (2012) and Spanierman & Cabrera (2015) describe the lack of praxis in many whiteness studies and how such neglect of practical recommendations for action to redress issues revealed in CRT, "whiteness", and CWS research can create frustration on the part of whites who are trying to positively address race issues. It is only through praxis that change can occur. These authors also describe the emotions whites experience as they confront issues of white privilege, how to come to terms with this privilege, and then what whites can actually do to become racial justice allies as opposed to anti-racist allies. Cabrera's (2012) description of this important difference and how it can push racial justice movements forward is an important perspective to the study of social justice and racial inequities since racial justice ally reveals what a person is *for* rather than what a person is *against*, as in anti-racist ally. Feagin and Bennefield (2014) speak directly to the systemic racism found throughout the history of US health care. They state that by using "weak individualistic concepts such as 'bias', 'prejudice', and 'cultural competence'" (p. 8) systemic racism within health care is allowed to continue. They argue that by not using critical studies for examining health disparities, research in health care misses the mark by not definitively stating the white racial framing and advantages of health care "norms" that create disparities in physician-patient contacts, in resource allocation to people of color, in maintaining white dominance among medical practitioners, and in individual-level up through system-level discrimination experienced by people of color. Twine and Gallagher (2008) trace the history of whiteness studies

from W.E.B. Dubois through critical race theorists to today's, what they term "third wave whiteness" scholars. This historical view of race studies, and CRT in particular, is compelling when one looks at various institutions that have been analyzed with a critical lens; it is not just enough to recognize and reveal injustices based on power differentials between majority and minority populations, but to allow dominant members' perceptions to be opened, thus together, society as a whole can move toward eliminating these hierarchical structures. Twine and Gallagher (2008) state:

> Third wave whiteness makes these contradictions [between white privilege in wealthy settings versus white privilege in poor settings] explicit by acknowledging the relational, contextual and situational ways in which white privilege can be at the same time a taken-for-granted entitlement, a desired social status, a perceived source of victimization and a tenuous situational identity. It is these white inflections, the nuanced and locally specific ways in which whiteness as a form of power is defined, deployed, performed, policed, and reinvented that is the central focus of third wave whiteness. (p. 7)

Ultimately, the goal of third wave whiteness/critical whiteness research is to go beyond CRT and to break down racial hierarchies so that just and equal practices become the norm. Thus, in the context of this study, public health critical race (PHCR) praxis theory is a form of third wave whiteness-based research.

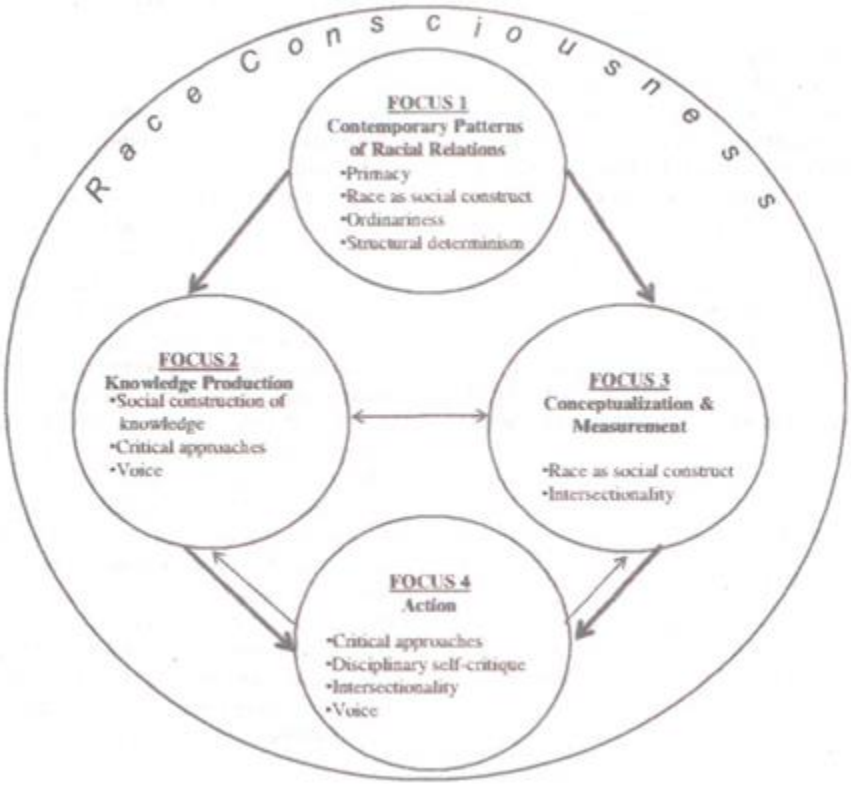
Public Health Critical Race (PHCR) Praxis

The public health critical race praxis (PHCR) model for public health practitioners based on CRT was introduced to address the racial and ethnic disparities in

health care (Ford and Airhihenbuwa, 2010b). While designed to be utilized in population studies, this model was appropriate to look at the education of future public health practitioners as well. The model was used to evaluate if, in what ways, and to what extent critical theoretical principles were being taught by faculty, learned by students, and then incorporated into practice by alumni of a MPH program. Ford and Airhihenbuwa (2010b) proclaimed that if the "disconnect" between CRT and public health practice were eliminated, explanations of racial health disparities would be more complete and lead to improved practice – a third wave whiteness principle as described above. Further, Airhihenbuwa (2007) stated, "There is no distinction between theorization and intervention. We regard all theorization as political intervention and all intervention as theoretically motivated" (p. 34).

The PHCR praxis model as described by Ford and Airhihenbuwa (2010b) has four focuses and ten principles. A schematic of the process is illustrated in Figure 1. Race consciousness backgrounds the entire PHCR praxis model because, "To understand the causes of racial health inequities requires solid understandings of the salience of racialization in society and in one's personal life" (p. 1392). The four focuses are (a) contemporary racial relations – how racism operates within the time period under study; (b) knowledge production – how racialization affects the trajectory of a project and vice versa, how the project may reify racially constructed beliefs; (c) conceptualization and measurement – how "race- or racism-related constructs" are defined and/or operationalized and how "the hypothesized relations between constructs, and the social contexts in which the constructs and relationships exist" (p. 1393) are defined; and (d) action–using the study results to "disrupt one or more causes of the inequities" (p. 1393).

Figure 1. Schematic of the Public Health Critical Race (PHCR) praxis model (from Ford & Airhihenbuwa, 2010b)



Although the model shows the flow of the process moving from one to four, there are lighter arrows which reveal how the process of a study moves fluidly back and forth among the different focuses. The ten principles of this model also overlap and intersect as some principles exist within two different focuses. A definition of each of the ten principles and which focus it fits within and an example of the conventional public health (PH) and the PHCR research approach indicated by each principle, are listed in Table 1. Although meant for use in population and intervention style studies, the PHCR model was used in this study by remaining attentive to the researcher's and subjects' race consciousness throughout the study, developing interview questions based on the focuses and principles, and analyzing the data through the PHCR model's focuses and principles.

Table 1

PHCR principles, associated foci, definitions, and examples of the conventional public health(PH) and PHCR research approach (adapted from Ford & Airhihenbuwa, 2010b)

Principle	Associated Focus	Definition	Conventional PH Approach	PHCR Approach
1. Race consciousness	All	Deep awareness of one's racial position; awareness of racial stratification processes operating in colorblind contexts	Colorblindness-belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors (e.g. SES)	A researcher clarifies her racial biases before beginning research within a diverse community
2. Primacy of racialization	Focus 1	The fundamental contribution of racial stratification to societal problems; the central focus of CRT scholarship on explaining racial phenomena	Tendency to attribute effects to race rather than to racialization or racism	A study on neighborhood characteristics includes factors hypothesized to reflect structural racism
3. Race as social construct	Focus 1 Focus 3	Significance that derives from social, political and historical factors	Biological determinism – the belief that race is meaningful because it provides insights about one's biology and propensities	A study assesses race not as a risk factor but to identify a population at risk for specific racism exposures
4. Ordinariness of racism	Focus 1	Racism is embedded in the social fabric of society	Racial exceptionalism – defines racism as rare, discreet and overtly egregious incidents	A study on racism and health operationalizes racism as routine exposures (e.g. being followed while shopping)
5. Structural determinism	Focus 1	The fundamental role of macro-level forces in driving and sustaining inequities across time and contexts; the tendency of dominant group members and institutions to make decisions or take actions that preserve existing power hierarchies	Emphasizing individual or interpersonal factors	A multilevel study considers policy factors that may promote residential segregation
6. Social construction of knowledge	Focus 2	The claim that established knowledge within a discipline can be re-evaluated using anti-racism modes of analysis	The belief that empirical research carried out properly is impermeable to social influences	A disparities-related literature review compares articles published in minority vs. majority journals
7. Critical approaches	Focus 2 Focus 4	To dig beneath the surface; to develop a comprehensive understanding of one's biases	To accept phenomena or explanations at face value	A researcher considers alternative explanations for findings than those previously posited
8. Intersectionality	Focus 3 Focus 4	The interlocking nature of co-occurring social categories (e.g. race and gender) and the forms of social stratification that maintain them	Additive model of co-occurring social categories (e.g. race and gender)	Example: Efforts to reduce HIV risk behaviors among diverse men who have sex with men address racial stereotypes
9. Disciplinary self-critique	Focus 4	The systematic examination by members of a discipline of its conventions and impacts on the broader society	Limited critical examination of how a discipline's norms might influence the knowledge on a topic	Researchers examine implications for research of using "health inequities" vs. "health disparities" vs. "health inequalities"
10. Voice	Focus 2 Focus 4	Prioritizing the perspectives of marginalized persons; privileging the experiential knowledge of outsiders within	Routine privileging of majority perspective	Responses of skepticism or anger when outsiders within speak truth to power

Since the end result of utilizing PHCR is praxis, it was theorized that teaching future

practitioners based upon this framework should lead to a more race-conscious, culturally-sensitive, and socially responsible curriculum, presumably creating more culturally responsive and socially just public health practitioners.

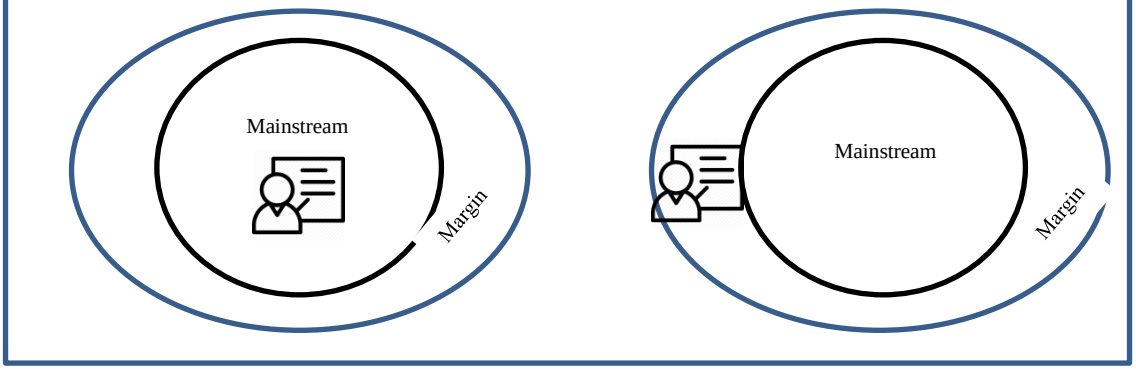
Using the PHCR Framework

Since the PHCR framework was developed to be used in program development, not teaching and curriculum investigation, adaptation for this study was important. Based on its critical race foundation, narrative and counter-narrative themes were determined from the data; a hallmark of critical research. This step was considered a first sifting of the data. Since the PHCR framework includes a comparison of the conventional public health approach versus the PHCR approach for each of the ten principles of PHCR (Table 1), this aspect of the framework became a second sifting of the data. The following paragraphs explain this strategy.

In a 2014 talk to the Center for Health Equity and Urban Science Education of Columbia University, Ford explains that in critical research there is the "mainstream" and the "margin." The mainstream is representative of the dominant hegemony, the white racial framing that exists in the US, specifically in health care, and the margin represents those ideas and peoples marginalized, or dismissed, by this dominant ideology. She states that our social position informs the viewpoints that we have, which often keep us unaware of the racial hierarchies that exist within our world; this difference between the mainstream and the margin. She contends that as we begin to become aware of this division between the mainstream and the margin, we intentionally ground our work as critical researchers in the viewpoints of those marginalized by society and we thus, "center in the margins" – give voice to those who typically have no voice in our society.

This practice of centering in the margins is a tool critical race theorists use to "explain and undo racism by using the tools of our discipline" (Ford, 2014). Figure 2 illustrates this idea of either doing research within the mainstream or doing research from within the margin. This tenet of critical race theory is contextualized as (a) narratives – stories that reinforce the status quo, or dominant ideology and (b) counter-narratives – stories that oppose the status quo and give voice to those marginalized by the dominant society.

Figure 2: PHCR framework: Working within the mainstream or working within the margin in research (adapted from Ford, 2014)



For this study, the narrative and counter-narrative themes helped ground the data, while evaluating this first sifting of the data against the ten principles of PHCR using the conventional public health approach (mainstream) versus a PHCR approach (margin) provided a richness and depth not seen in the first sifting. This ten principle part of the PHCR theoretical framework was seen not only as an extension of the narrative (mainstream) and counter-narrative (margin) critical race aspect, but also as a specific public health disciplinary critique. Thus this theoretical framework proved quite useful in analyzing the data and providing insight into the teaching, internalizing, and practice of culturally competent health care.

CHAPTER 3: METHODOLOGY

This qualitative case study is best described as a discourse analysis imbedded within a curriculum investigation (Creswell, 2003; Rymes, 2009; Stake, 1995). This research included classroom observation, document analysis, and in-depth interview data. The case was one Master of Public Health (MPH) program – its cultural competency education as viewed by faculty, students, and alumni. A case study was chosen since case studies "emphasize episodes of nuance, the sequentiality of happenings in context, the wholeness of the individual" (Stake, 1995, p. xii). Specifically, the one cultural competency course required by all students in the MPH program, regardless of concentration specialty, was observed and evaluated. This course was offered online as well as face-to-face; both were observed in one semester. Analysis of the data utilized critical race theory (CRT) methods including analyzing master narratives and examining stories embedded within the data against a critical race theory framework – public health critical race praxis (PHCR) as described by Ford and Airhihenbuwa (2010b). This section begins with the research questions; describes my positionality as the researcher, since my own perspectives influence data collection and analysis; then describes the data collection and analysis. This chapter concludes with a description of the validity and limitations of this study.

Research Questions

This study was designed to answer the following research questions:

1. To what extent do faculty members teach cultural competency in a MPH program?

Sub-question (a) To what extent do faculty members address racial/ethnic health disparities and issues of social justice as a part of cultural competency education?

Sub-question (b) To what extent do faculty reflect on their own race consciousness?

2. How do students perceive the importance of cultural competency in future practice?

Sub-question (a) To what extent do students' attitudes about cultural competency change over the course of a semester in a class that teaches cultural competency?

Sub-question (b) To what extent do students see racial/ethnic health disparities as a part of cultural competency and an issue they need to address as future practitioners?

Sub-question (c) To what extent do students perceive the field of public health as a field that promotes social justice?

3. What do alumni from the same program say about cultural competency in practice?

Sub-question (a) To what extent do alumni express that the curriculum in their program prepared them effectively for practice with minority groups?

Sub-question (b) To what extent do alumni see any connections between cultural competency and racial/ethnic health disparities or issues of social justice?

Sub-question (c) To what extent has alumni's work experience influenced their perspectives on these issues – has practice reified their long-held beliefs or has their academic education changed these beliefs?

Approach and Rationale

This study was designed to analyze a specific education component – cultural competency - of a MPH program to make recommendations that may improve that education from a health equity and social justice standpoint – reducing health disparities by improving cultural competence education as recommended in the literature. This was a case study because it involved an in-depth exploration of one institution's program over the course of a semester, with longer time-bound periods being represented by practicing alumni (Stake, 1995). I was eager to examine the nuances of cultural competence education and how students react to the subject over the course of a semester, as well as how faculty members teach this topic. This study specifically included observation of a course required by the MPH program that directly addresses the very issues this study set out to examine – cultural competence.

Approval by the University's Institution Review Board (IRB) was sought by completing an extensive application packet. IRB reviewed the packet and I received an email in October 2012 that the study was considered a program investigation, therefore exempt from approval. Although exempt, I still felt it was very necessary to maintain consenting practices and confidentiality of the participants and followed standard procedures to do that.

A hallmark of qualitative research is that it acknowledges the relationship of the researcher to the data, and the possible biases and influences that may come with that

relationship (Milner, 2007). Since that relationship and potential biases affect everything from topic selection to data collection and analysis to final conclusions, my positionality is presented first. In discussing this positionality, however, I also recognize the strengths that come with my relationship to the subject matter of the research.

Positionality

It is important to firmly establish the researcher within the context of the study to bring a level of honesty and transparency to the research, particularly in qualitative research of this nature (Ulin, Robinson, & Tolley, 2005). The positionality of the researcher affects every aspect of a study: from topic selection, to design, to analysis, and finally, interpretation of the findings. It is critical to recognize the bias the researcher brings to the research. To that end, I present my own positionality.

As I reflect on why I chose this topic and the theoretical framework, it is easy to see where the choice came from. As a dietitian working in the field for over 30 years now, I have learned a great deal from experience and from my professional association. I was not, however, quite prepared for what I would learn in the coursework for this dual degree program. My MPH and Higher Education coursework exposed me to historical, sociological, and anthropological works that were not only eye-opening, but life-changing. The whole idea of social justice as it relates to education and to health was, sadly, new to me.

Being exposed to this new information challenged what I had learned and what I believed about educational and health opportunities: availability, access, retention, promotion. These themes echoed one another in the courses and readings from both degree programs and caused me to question my own experience as white and privileged.

It also made me question my own cultural competency as I have worked primarily with Native American and Latino populations throughout my career. The fact that this information was not part of my own academic foundation, nor professional continuing education, made me wonder how this topic is being taught currently, particularly as it relates to decreasing health disparities. While cultural competency is now being mentioned in professional journal articles, this has been a new development since the beginning of my current academic degree pursuits. I saw many parallels between what is being done in the field of higher education to address racial/ethnic disparities in education and wanted to know what was being done in the health care realm.

Believing that a MPH program provides a more culturally sensitive approach to this topic than perhaps, dietetics or pharmacy programs (whose programs may provide little, if any, cultural competency education), and because that is where I found my own "social conscience," I decided that studying how it is done and looking at the perspectives of faculty, students, and alumni from the field of public health, would teach me about the roots of such education within a program. I could also see if others, like me, had eye-opening and life-changing experiences as they were confronted with new and difficult knowledge. I thus hoped that through this study I would see ways that such education "works" to increase a sense of social justice and responsibility for such knowledge as students move on to become practitioners. If this were the case, the findings would then agree with the argument that teaching cultural competency does help to decrease health disparities.

While these were my hopes, strengths, and biases, however, my main goal for studying such a topic was to find out how others were perceiving and enacting a socially

aware sense of cultural competence. Regardless of where that exploration took me, to listen attentively and as objectively as I possibly could, remained critical to learning more about this topic. To allow the data to guide the analysis was also critical for making recommendations about cultural competency education that were honest and effective. I utilized the PHCR framework repeatedly during this study to continue taking me back to critical concepts and critical ways of viewing the world and my work. Throughout the time of data collection and continued reading of the literature, this topic became an even greater area of interest to me. My desire to analyze and present this information grew to the point where I also began to think about reproducing this study, or something very similar, within my own dietetics profession, because the topic is so important. By recognizing and voicing my own positionality, and by having others review my analysis, I was able to open the door to this honesty more widely. This study has also not only taught me about concepts such as racial justice allies, but has increased my desire to work as a racial justice ally in my own health care practice and personal life.

Data Collection

Site

To insure a broad-based sample of responses, a MPH granting institution with faculty and student diversity was desired. An institution with close ties to alumni practicing in the field was also needed. Due to these requirements the MPH program at South West College of Public Health (SWCOPH) at the South West University (SWU) was chosen for this study. SWCOPH and SWU are pseudonyms for the research site.

SWCOPH does have a reputation for advancing the cause of social justice and health equity as evidenced by their faculty research interests and their annual Social

Justice symposium (personal observation). They are also a leader in culturally sensitive research practices with Native American, Immigrant, and Border populations (Ingram, McClelland, Martin, Caballero, Mayorga, & Gillespie, 2010; Teufel-Shone, Siyuja, Watahomigie, & Irwin, 2006).

According to the most recent report from the Association of Schools of Public Health (2011), which reviewed all 46 accredited public health schools in the nation, SWCOPH's student population by gender is consistent with other colleges (about 20-35% male, rest female); foreign nationals comprise about 6% of the student population (lower end of the range for schools); race/ethnicity is 14.7% Hispanic/Latino (fifth out of 46), 8.1% American Indian/Alaskan Native (second only to Oklahoma), 8.5% Asian (falls in the middle of the group), 5.9% black or African-American (toward the bottom of the spectrum), 0% Native Hawaiian/Pacific Islander (only 15 of the 46 schools have any students in this category), and 61.4% white (falls in the middle to lower end of the group). These statistics show that from a diversity standpoint, SWCOPH is about as diverse as most other colleges of public health.

Participants

Introduction. The participants for this study included faculty that teach at SWCOPH; students enrolled in the "Sociocultural and Behavioral Aspects of Public Health" required course offered in the Fall of 2013 at SWCOPH (one was face-to-face; the other was online); and graduates of SWCOPH who have been practicing in the field of public health. This course is offered as the one cultural competency course required by all MPH students. The objective of this course is that students "will have developed a foundation of skills and knowledge that will enhance their ability to work in the field of

public health and assist in the development of culturally appropriate health promotion" (syllabi from courses). Use of three different populations was chosen to provide a more comprehensive look at teaching, learning, and practice dimensions of cultural competency and how this topic might, or has, affected practice as it relates to reducing racial/ethnic disparities and impacting subjects' views of social justice in the health care field.

Students enrolled in the required class were observed during the Fall 2013 semester and interviews with each of these three different participant population groups were conducted. Table 2 provides simplified demographic information of the participants who provided formal interviews. Document analysis of course materials was also used as data. Rationale for why each participant group was chosen is presented next, followed by details of data collection for document analysis, observation, and interviews.

Faculty. Faculty teaching the face-to-face and online course "Sociocultural and Behavioral Aspects of Public Health" (Dr. Z and Dr. Y, respective pseudonyms used for these face-to-face and online professors), as well as other current faculty in the college of public health who teach or have taught cultural competency courses, provided the faculty data for this study. Faculty members represented several concentrations, genders, and some diversity of race/ethnicity (Table 2).

Current Students. Students enrolled in the online and face-to-face classes during Fall 2013 were observed and were also asked to participate in in-depth interviews relating to the topic of cultural competency. The online course began with 45 students and ended the semester with 39 students. The face-to-face course began the semester with 50 students and ended the semester with 44 students. While I could not get specific

Table 2

Simplified demographic information of interview participants & length of interview

Faculty (F)/ Current Students (CS)/ Alumni (A)	Self-identified Race/ Ethnicity	Gender Female (F)/ Male (M)	Public Health Concentration	Previous Experience with Cultures other than own	Length of interview (minutes)
F	Caucasian	F	Environmental Health	Yes	Email
F	Caucasian	F	Biostatistics	Yes	Email
F	African-American	F	Health Behavior/ Health Promotion	Yes	60
F	Caucasian	F	Health Behavior/ Health Promotion	Yes	30
F	Caucasian	M	Community, Environment, and Policy	Yes	45
F	Caucasian	F	Epidemiology & Biostatistics	Yes	45
F	Caucasian	F	Health Behavior/ Health Promotion	Yes	60
F	Caucasian	M	Community, Environment and Policy	Yes	40
F	Caucasian	M	Community, Environment, and Policy	Yes	20
F	Asian-American	F	Health Behavior/ Health Promotion	Yes	Email
Total number of faculty interviews - 10					
CS	Mexican	F	Health Behavior/ Health Promotion	Yes	60
CS	Caucasian	F	Policy & Management	Yes	60
CS	Caucasian	F	Policy & Management	Yes	Email
CS	Caucasian	F	Global Family & Child Health	Yes	Email
CS	Caucasian	M	Biostatistics	No	Email
CS	Iranian-American	M	Global Family & Child Health	Yes	Email
CS	Caucasian	M	Health Behavior/ Health Promotion	Yes	Email
CS	Caucasian	M	Health Behavior/ Health Promotion	Yes	Email
Total number of current student interviews - 8					
A	Hispanic	F	Maternal & Child Health	Yes	Email
A	Caucasian	F	Community Health & Assessment	Yes	Email
A	Caucasian	F	Community Programming	Yes	Email
A	Caucasian	F	Community Health Practice	Yes	Email
A	Caucasian	F	Community Health Practice	Yes	Email
A	Caucasian	F	Health Behavior/Health Promotion	Yes	Email
A	Mexican-American	F	Health Behavior/Health Promotion	Yes	Email
A	Caucasian	F	Health Behavior/Health Promotion	Yes	Email
Total number of alumni interviews - 8					

demographics of each class, the online students presented an introduction of themselves to one another and so I observed that the class was about equally divided between white and non-white students. Participation in interviews was voluntary, but diversity among participants was a high priority, and was so indicated during the recruitment process when I introduced myself and what I was doing. This introduction was also to get ascension to my "observing" the semester. No student indicated any overt negativity with my presence, nor did either professor tell me of any negative student responses they received privately that I would not have observed in the class, thus observations began. Without a diversity of participating students in interviews, it is evident that some voices were not heard, but with voluntary participation there was no guarantee of diversity in the study participants. My goal was to have at least an equal number of minority as majority interviewees, but this did not occur as indicated by Table 2. Having an equal number of minority and majority interviews rather than only 25% of the interviews from minority voices would have provided a better impression of minority students' experiences in and perspectives of the course. Fortunately the online course requirement of three discussion contributions per week did provide an avenue for minority voices to come forward.

Alumni. Alumni of the MPH program of SWCOPH were recruited via the SWCOPH maintained alumni lists, by phone, letter and/or email, and by invitation at a SWCOPH event to take the analysis a step further and see the results of the coursework on the actual professional practice of alumni. Simplified demographics of those who responded are indicated in Table 2. I had planned to obtain data from graduates who had been in practice for approximately 1 year, 3 years, and 5 years, but with limited participation, any and all alumni willing to provide their opinions and perspectives were

accepted. Participating alumni had practiced in the field from 2 years up to 15 years (1 participant at 2 years, 2 at 3 years, 1 at 7 years, 2 at 12 years, 1 at 14 years, and 1 at 15 years). Various years in practice were desired to obtain feedback on not only how the graduates' coursework affected their practice as it relates to cultural sensitivity and competency and how they see this practice in relation to health disparities and social justice, but also how experience has changed them and their practice as it relates to these issues. It was interesting to get the perspectives of those in the field greater than a decade as they have seen many changes regarding cultural competency requirements of practitioners during this time.

Documents

Syllabi, handouts, required and supplementary readings assigned, assignments, discussion questions prepared by faculty, classroom and online videos, and exam preparation tip sheets provided one aspect of data collection in this study. Documents from the "Sociocultural and Behavioral Aspects of Public Health" (CPH 577) class, as mentioned above were reviewed. Since this is the one required cultural competency course for all MPH students at SWCOPH it was selected as the course to analyze in this study. While there are other courses that address cultural competency in each concentration, e.g., "Health Behavior Health Promotion," "Public Health Policy and Management," the course chosen is the *one* cultural competency course required by *every* concentration.

Curriculum for courses in this MPH program is determined by each faculty member according to national criteria set by the Association of Schools and Programs of Public Health (Calhoun, Ramiah, Weist, & Shortell, 2008). Thus, document analysis

revealed how each professor operationalized these criteria according to their own understandings and experiences. Analyzing course documents against the PHCR framework in connection with the other forms of data added a second layer of depth to the analysis.

Observations

Due to IRB approval in October of 2012, the online course, which is a Fall offering only, could not be observed until Fall 2013. Attempt was made to observe the Spring 2013 face-to-face course, but faculty teaching at that time refused admittance. Fall 2013 faculty of the face-to-face course did allow my observation and faculty of the Fall 2013 online course also agreed.

Informal discussions with students in the face-to-face class during classroom activities and breaks aided in understanding attitudes and perspectives of current students, while the extensive required discussions of the online course provided an enormous amount of data to review and revealed attitudes and opinions among the class students. Although recording the face-to-face class was desired, faculty stated that this was prohibited by her and the college. Note-taking of discussions and final paper submissions was done for each "meeting" of the online class. Current students' views, comments, and interactions in the classroom, over the course of a semester, aided in analyzing changing attitudes of culture, cultural sensitivity, and cultural competency as it related to future practice, health disparities, and social justice.

Positive as well as negative responses during observation were instructive as majority population students confronted difficult material and heard stories of historical injustices against minority populations. Minority population students', as well as foreign

students', viewpoints regarding these topics were enlightening. Analyzing classroom discourse and online discussion "chats" helped delineate who spoke, whose "voice" was heard and whose was silent during classroom discussions, and how faculty members dealt with sometimes difficult, sensitive topics. This aspect of the study helped, to some degree, narrow gaps that occurred within the self-selected students who chose to do interviews versus those who did not. Particularly helpful was the fact that a requirement for the online course was that each student had to add comments to other students' discussion comments as they all answered questions posed by the professor each week; thus *all* online students' voices were represented. How much each student chose to reveal during their contributions was less clear, but at least each was represented.

Looking at this data from a critical perspective helped reveal pedagogical ideologies. Indeed, Rymes (2009) advocates looking at classroom discourse from the social, interactional, and individual agency contexts which help the researcher notice not only what is being said, but what is not being said, and how space within the classroom affects discourse. Apple (2004b) expands upon this idea as he states,

> that our very taken for granted perceptions mislead us here and that this is a rather grave limitation on our thought and action. That is, anything is a good deal more than it appears, especially when one is dealing with complex and interrelated institutions including the school. It is this very point that will enable us to make progress in even further uncovering some of the ideological functions of educational language. (p. 125)

Indeed, as the researcher, my own biases could not be ignored as I observed discourse among students and faculty; what did I pick up on, what did I miss due to my own

limitations? These are important considerations and an important aspect of critical race theory research (Ford & Airhihenbuwa, 2010b). My own biases were also made apparent by comments provided to me from my committee members as well as an Asian-American friend familiar with CRT, but not public health, who reviewed early drafts of my findings chapters. Such feedback, as mentioned in my positionality, helped me gain back some degree of objectivity and control, at least somewhat, for my biases (Morse, 2015).

My committee, too, helped me take a broader view of my research that helped me accept my own biases and re-look at my data more objectively. Indeed, Honeychurch (1996) states that "Knowledge does not emerge in a cultural vacuum" (p. 343). He goes on to discuss how, as a researcher, our own biases that emerge from the culture we live in, as well as our own identities in relation to the theoretical framework and participants we've chosen, "slant and fashion the research process in its entirety" (p. 346). As a white woman, using a critical race praxis framework, my own whiteness, as well as my own race conscious-increasing journey directly impacted my own perceptions and expectations of the data. By confronting these issues with the help of others' comments, I hope that I have, as Honeychurch goes on to say, decreased my own objectivism, yet increased my own objectivity to the study.

Interviews

Interviews of current students (8), alumni (8), and faculty (10) were done face-to-face or via asynchronous email (Mann & Stewart, 2000). These numbers represent approximately 10% of the students enrolled in CPH577 in Fall 2013, about 10% of the number of standardly mailed (US Postal Service) invitations to participate sent to alumni, and about 14% of all SWCOPH faculty. The simplified (to increase confidentiality of

participants) demographic background information is presented in Table 2 above. The process of recruitment for interviews proved much more arduous a task than I anticipated as outlined in Table 3 and detailed in this section.

Table 3

Data collection time-frame and resultant responses

Time-frame	Action	Result
October 2012	IRB Approval	Began study
	Current Students	
Nov/Dec. 2012	Asked faculty permission to observe Spring 2013 face-to-face course	Denied
May 2013	Asked faculty permission to observe Fall 2013 face-to-face and online courses	Both approved
August 2013	Sent reminder email of my presence to instructors and online students; short presentation to face-to-face students on first day	One participant agreed to recorded interview
October 2013	Another request to students in class for interviews	No participants
December 2013	Provided snacks and handouts with questions during final exam for face-to-face class	Three participants
April 2014	Short presentation at Spring MPH Conference about study requesting participants	Four participants
	Faculty	
February 2013	Short presentation at Faculty meeting about study requesting participants	No participants
April 2013	Mass email to faculty inviting participation	One participant
May 2013	Mass email to faculty inviting participation	No participants
December 2013	Paper/card invitation to faculty to participate	One participant
February 2013	Short presentation at Faculty meeting about study requesting participants	No participants
February-March 2014	Researcher went door-to-door asking faculty who were in their office to participate	Eight participants (7 face-to-face; 1 via email)
	Alumni	
August 2013	Mass email to alumni via Assistant Dean of Student & Alumni Affairs	No participants
Spring 2014	Mass email to alumni via Assistant Dean of Student & Alumni Affairs	No participants
March 2014	Eighty invitations to participate in study were mailed to alumni via Assistant Dean of Students & Alumni Affairs	Four participants
April 2014	Short presentation at Spring MPH Conference about study requesting participants	Four participants

Participants for interviews were self-selected; no coercive tactics in procurement

were used. However, the importance and high priority of having a diverse group of subjects was emphasized during recruitment. In-depth interviewing is used in qualitative studies because it:

- Fosters interactivity with participants
- Elicits in-depth, context-rich personal accounts, perceptions, and perspectives
- Data are collected in their natural setting
- Interviews can be unstructured, structured, or semistructured
- Explains and describes complex interactions and processes
- Facilitates discovery of nuances in culture
- Notes or verbatim transcriptions are used to document the interview

(Bloomberg & Volpe, 2008, p. 195)

I had hoped to interview at least 15 current students, 15 faculty members and 20-25 alumni. Due to inadequate participation, in-depth interviewing was modified to include fewer questions that would still evoke important data from subjects. Due to an increasingly difficult time garnering participants as the Fall 2013 semester was coming to an end, and even into the next semester, and not knowing exactly why I was experiencing such difficulties, I chose not only to decrease the number of questions, but to eliminate any possible barriers I could think of to participation. These barriers included the gold standard of recording interviews. I was concerned about audio recording as a barrier due to the nature of the topic, but also because it appeared that I was not getting subjects because people felt they were too busy to participate. By removing the recording of their interviews and cutting down on the estimated time commitment of interviews, I hoped to get participation. I opted to recruit interviewees with only a 30 minute time commitment

(although those few who provided interviews did provide longer time frames once we got started; Table 2), at their location of choice (which was always the option available), and with extensive note-taking during the interview. I reviewed these notes directly after the interview with the interviewee to fill in any missing points, to make the notes more complete, and to make sure I accurately represented what the participant had stated. Then as soon as I left the location, I reviewed my notes again, adding additional comments I wanted to remember to make these more thorough, then went home and typed up the notes. I had created business cards with my contact information to hand out at faculty meetings and at the beginning of the semester when asking for interviewees; then in December of 2013 I created an invitation card to place in the office mailboxes of 40 faculty members. When these resulted in only one participant, I then decided to go door-to-door introducing myself and my study and asking for just 15 minutes of the professor's time. While this process may appear somewhat aggressive, I was very diplomatic – if the faculty member did not have time at that moment, I planned to ask if we could set up a more convenient time. Luckily, every faculty member invited me in and once I began asking questions, they were interested enough in the subject to give me more than 15 minutes of their time (Table 2). I also recruited participants from the Spring 2014 MPH Conference where faculty, current students, and alumni were present. Non-face-to-face interviews were done via email. Due to scheduling constraints, asynchronous email interviews were done (Mann & Stewart, 2000). Face-to-face interviews were semi-structured, using simple main, follow-up, and probing questions to allow for a more conversational tone and interactivity between subject and researcher (Ulin, Robinson, & Tolley, 2005). Questions posed to each group of subjects are listed in Appendix A.

As mentioned, participant recruitment proved quite difficult for this study and so deserves further explanation. Recruitment materials are shown in Appendix B.

Faculty. After obtaining permission from the Dean of the college, I attended a faculty meeting in February of 2013 to announce the study and ask for interviewees. Contact business cards were handed out and faculty were encouraged to take several for any professors not in attendance at that time. When no participants were obtained from this method, I received permission from the Dean of the college to send out an email to all faculty explaining the study and asking for participants in April of 2013. One faculty member responded to this method. A second attempt at an all-faculty email was made near the end of the Spring 2013 semester with no responses. I then created an invitation card for faculty participation and placed an invitation in the wall-mounted mailbox directly outside of each faculty members' office at the end of the Fall 2013 semester. This method of recruitment netted one response. Since faculty perspectives were so important to this study, I attempted one more time to garner faculty participation via a short announcement at a faculty meeting in February 2014, then decided that it was time to try to catch faculty in their offices to obtain data. A shortened version of the questions was created to try to keep interview length to about 15 minutes, a time I felt was reasonable for busy faculty, and I spent one day a week for several weeks attempting to do short interviews with faculty in Spring 2014. This method netted face-to-face interviews and an additional email interview. Total interviews achieved by these recruitment efforts were ten.

Current Students. Before the approved semester started, I contacted the face-to-face and online faculty responsible for delivering the course to remind them of my

presence and the purpose for the study. Ascent was obtained from both professors. At the very beginning of the semester I made a short speech regarding my presence and purpose in the face-to-face classroom, requesting participants for interviews, and providing a business card with contact information. I did the same with the online course in the chat function of the virtual classroom, providing online contact information similar to the business card I had created for face-to-face and standard US postal service contacts. Only one student responded to this request for interviews. Another attempt to garner subjects was made midway through the semester without success, then small handouts with the business card were again provided, along with snacks, during the final examination of the face-to-face class. Current SWCOPH students were also recruited at the Spring 2014 MPH Internship Conference. Student comments in the discussion section of the online course were used as observational data, since adding to the discussions was a requirement of the course and provided much useful information. While this data is not included in the interview data, it does allow for some voice from these students; therefore the lack of interviews from this group of students was not felt to be as large a limitation as it could have been. From these recruitment attempts a total of eight student interviews were obtained.

Alumni. Two attempts to procure subjects were made via email by permission of the Assistant Dean of Student and Alumni Affairs; one at the beginning of the Fall 2013 semester and one at the beginning of the Spring 2014 semester. No responses were obtained from these invitations. The importance of alumni responses was critical to the study, so I created an invitation to participate for alumni and received permission, again from the Assistant Dean, to have that department send these out to alumni on their list. I

did not have access to any personal addresses of alumni, but a staff member created the mailing lists and sent out 80 invitations. From this standard mailing, four subjects were obtained. One further attempt to garner more participants occurred at the Spring 2014 MPH Internship Conference. After the keynote speech, I gave a short introduction about the study, requesting participants. Any interested person picked up a flyer with my business card attached. This recruitment effort led to more contacts with subjects. In addition, the keynote speaker, an alumna herself, agreed to participate and made contact with several of her colleagues who are also SWCOPH graduates, who subsequently contacted me via email. These contacts resulted in email interviews with three additional participants and the keynote speaker. Total alumni participants were eight.

Reasons for the difficulty stemmed primarily from subjects and potential subjects stating that they just did not have time to help out. Even when the study questions were shortened and the researcher asked for only 30 minutes, there were still many who stated they simply did not have time to participate. At-the-office-door interviews with faculty showed that they did have time, but only when pressed with my presence. I could surmise that it was the subject matter that was a barrier for participation, but when I did the at-the-office-door interviews, faculty seemed quite open and honest; I did not get the sense that they were uncomfortable with the subject matter. Perhaps students and alumni were, but again, when the keynote speaker reached out, those that responded were eager to help. Funding the study myself, I did not have an incentive to offer people for their participation. That lack of some monetary or other reward could also have been a reason for the lack of participation. Rubin and Rubin (2005) state that "access is easiest to gain at a place where researchers work or have close friends" (p. 32). Perhaps it was this lack

of personal familiarity with me that made being busy a convenient excuse for non-participation. Giving time to friends is easier than giving time to a virtual stranger. It could also be that possible subjects were simply not interested in the topic or felt they had nothing to share on the topic. Whatever the reason, while the numbers of participants was small, the data is thoughtful, diverse, and insightful. Being able to "observe" the classrooms and view documents helped add dimension to the interview data, so data collection overall was fruitful.

The Public Health Critical Race (PHCR) Praxis Framework

The PHCR framework, as explained by Ford and Airhihenbuwa (2010b) is designed to "guide efforts to understand how racialization may influence disciplinary conventions… including modes of knowledge production … that may inadvertently reinforce inequities" (p. 1391-1392). Data collection was intended to address each of the four focuses and ten principles of the PHCR framework (Table 1) in order to organize the data in a way that analysis might then answer the research questions. This section briefly describes how the framework was used in data collection. The analysis section of this chapter will explicate how the framework was used in analysis. Race consciousness is the overarching foundation of this framework.

Focus 1: Contemporary Racial Relations. This focus addresses how racism operates within the time period under study. Data collection was undertaken from Fall 2013 through Spring 2014. The current climate of racial relations and racism in the US has been described as structural (Ford & Airhihenbuwa, 2010b) and systemic in nature (Bonilla-Silva, 2010). Rather than the overt racism of antebellum days, there is a subtle form of racism experienced by minorities on a daily basis; often termed microaggressions

(Sue, Capodilupo, Nadal, & Torino, 2008). The ideology of colorblindness is proposed by many in power to have addressed and eliminated negative outcomes of racism, however, such a view is not possible – we can't un-see skin color - nor does it function to decrease racism's negative effects on minority populations (Bonilla-Silva, 2010; Neville & Awad, 2014). There is also a vocal group very much against immigration, wanting to keep minority groups from entering the US (Fox, 2014), thereby maintaining a sense of power, privilege, and control over what happens here. The media attention brought about by the election of the US first black President, Barack Obama, in 2008 and more recent events like the killing of unarmed, young black men by white police officers in Ferguson, Missouri and New York City, have served to reveal hidden fears and biases of white individuals which exhibit this covert racism (Bouie, 2013; Coates, 2012). When brought out in the open, we can see racism's presence in the US. One must keep in mind how racism operates at the time of data collection to be able to accurately evaluate the data, thus this face of racism in the US was present in my mind as I analyzed this data.

Focus 2: Knowledge Production. This focus addresses how racialization affects the trajectory of a project and vice versa, how the project may reify racially constructed beliefs. This focus is particularly important for this study as it represents the very heart of how concepts related to culture and race/ethnicity are taught, discussed, represented, internalized, and practiced. This focus challenges disciplines to critically assess their own biases; in this study the curriculum, assigned readings and videos, and classroom environment were analyzed for such bias. Public health promotes the ideals of social justice and health equality (APHA website, n.d.), but does academia truly prepare future practitioners to work within these ideals? Under this focus it was important to consider

what types of topics were discussed and what topics were ignored; what a priori assumptions about working in the field were evident in faculty, students, and alumni discourse; and how knowledge regarding issues of culture and race/ethnicity were treated by each group.

Focus 3: Conceptualization and Measurement. This focus examines how a study defines and/or operationalizes "race- or racism-related constructs, the hypothesized relations between constructs, and the social contexts in which the constructs and relationships exist" (Ford & Airhihenbuwa, 2010b, p. 1393). By sifting the data through this focus, I was able to look at how participants defined topics discussed; the words used to describe minority groups and their health-related issues and by whom the words were spoken; as well as how students interacted with one another during discussions and presentations. It also helped me self-reflect on how I conceptualize these concepts and interacted with the data, demanding that I step back periodically to review the PHCR framework and CRT core tenets before diving into the data again. This iterative process is important in critical research (Ford & Airhihenbuwa, 2010b).

Focus 4: Action. Using the study results to "disrupt one or more causes of the inequities" (Ford & Airhihenbuwa, 2010b, p. 1393) is the aim of this focus. Action may include adding to the lexicon of power and privilege and how it is used to affect health outcomes of minorities; using narratives to allow marginalized voices to be heard; and direct action to bring attention to or challenge unjust systems. Indeed, Hylton (2012) states that research without a "participatory and transformative element" should not be called CRT research. While the writing of a dissertation itself does not constitute great action, it does add to the voices of those demanding answers to the thorny questions of

health inequalities and allows the "voice" of academia to be heard; in this case, how and in what ways a required cultural competency course in a MPH program addresses the issues of social justice and health disparities or how it can do a better job of such teaching. Sifting the data through this focus helped maintain integrity to the CRT tenets and plans to work on presenting these findings to the program under study to offer recommendations for improvements, as well as possible publication or conference presentation of the findings, are action-oriented aspects of this study.

The ten principles of PHCR as listed in Table 1 allowed for a deeper analysis of the data after viewing it first through the larger picture of the four focuses. The examples of the conventional public health approach versus the PHCR approach for each principle helped to view the data more critically and helped me, as a white woman, to see gaps where, although sounding good, the data actually did not move into the realm of critical praxis. A brief description of the ten principles follows. Using the four focuses and ten principles helped me to understand what data was important to the study; what data to focus on and what data could be essentially ignored as I analyzed data against this framework.

Principle 1: Race Consciousness. This concept undergirds all of PHCR research. As a white researcher, I needed to accept my own biases, learn to see past these and the messages I had based my ideas about race on and try to look at the data from a margin, not mainstream perspective as much as possible. Mainstream represents the status quo or white hegemony (the social, cultural, educational, ideological, and economic dominance of white racial framing), while margin represents a minority view (perspectives of those not belonging to the dominant group; Figure 2; Ford, 2014). By accepting my own biases

and trying to "de-centre" (Furlong & Wight, 2011) my own knowledge and place minority knowledges as "expert," I could explore the data with greater fidelity to critical research tenets.

Principle 2: Primacy of Racialization. This principle reveals how researchers often view problems within minority populations as problems of "race" rather than as problems due to the hierarchical structures that artificially place those of various racial categories in positions of higher or lower rank. Looking at how the data addressed such hierarchical processes in public health was my focus within this principle.

Principle 3: Race as Social Construct. This principle helped me look at the data in terms of how participants constructed their definitions and views about race. Did participants accept historical inaccuracies and descriptions of race at face value or did they point out the errors of such biological determinants of race and share new information that reveals how categories of race marginalize communities of color?

Principle 4: Ordinariness of Racism. The accepted view in current US society of racism is that it is rare (Bonilla-Silva, 2010), but this principle forced me to look at the data for signs that reveal not only this accepted position, but the more critical position of racism as frequently occurring and "ordinary" in the lives of minorities. Such racism is not "seen" by whites, because they do not experience such daily microagressions.

Principle 5: Structural Determinants. This principle represents the larger ways that racism is allowed to continue – the view that systemic, institutional, and political forces maintain white power and privilege. Viewing perspectives that addressed this principle or ignored it in the data revealed how pervasive the idea is; is it addressed as seen or not even acknowledged?

Principle 6: Social Construction of Knowledge. This principle helped me look at the data in terms of how the field of public health reports on minority populations; particularly through disciplinary channels – teaching, research, and practice. Looking for how the data revealed the status quo of "accepted" scientific research and knowledge versus how the data expressed minority voices, knowledge, and expertise was the aim of this principle.

Principle 7: Critical Approaches. This principle helped me view the data in terms of whether it represented an accepted standard practice or explanation in public health or whether some critical explanation was advanced; an alternative that represented a usually marginalized voice.

Principle 8: Intersectionality. This principle underscores the ways in which many populations are seen within health care – as a single entity, e.g. male/female, black/white, rather than as multi-layered, multi-faceted individuals. Interestingly, some of the students did mention the importance of paying attention to the ways individuals may be multiply oppressed and how these oppressions affects provision of health care. This principle helped me look for such critical interpretations of public health practice.

Principle 9: Disciplinary Self-Critique. This principle helped me look at the data in terms of language used and accepted without challenge; terminology used by faculty, students, and alumni that either maintained the status quo of health care (white hegemony) or challenged such terms; e.g. using capital versus deficit when discussing minority populations (Yosso, 2005). This principle also included looking at the data in terms of how newer strategies, such as community based participatory research (CBPR) is used, and accepted, by the discipline.

Principle 10: Voice. This principle helped me look at who was speaking and with what experience they were speaking from; e.g., minority voices among the participants; majority voices who had a lot of experience with communities of color, therefore had different viewpoints than majority voices devoid of such experience. This principle represents one of the reasons that I wanted diversity within my participants – as a white woman, I needed to hear, and listen to, voices of people of color to help me see my own biases as I collected data and analyzed it.

Summary of Data Collection

The data collection methods for this study were intended to reveal a whole picture of cultural competency education and its relationship to racial/ethnic health disparities and social justice issues in one MPH program. Evaluating data against the backdrop of the theoretical model revealed quite broad and varying perspectives and opinions among the different groups, and the perspectives within groups did hold some congruence as well as diversity. Analysis of the data collected did reveal some gaps in the education of public health professionals based on the PHCR theoretical frame. The next section details this analysis.

Data Analysis

Data analysis proceeded according to Bradley, Curry, and Devers' (2007) outline. As these authors point out, qualitative analysis is an ongoing process that begins with the first data collection, and proceeds during and throughout the collection and analysis. Their outline includes immersing oneself in the data as a whole to understand the data in its entirety. This step is followed by coding the data; assigning codes to frequent or important themes. The development of a code structure then proceeds inductively as in

grounded theory, allowing the data to speak for itself (Glaser & Strauss, 1967) and/or deductively from a framework developed a priori by the researcher; in this case the PHCR praxis model (Ford & Airhihenbuwa, 2010b). Critical studies are done deductively using narratives, primarily counter-narratives, of those of the non-dominant group (Came, 2014). The deductive method should not force the data, thus the framework for data analysis in this study was based on the literature and the theoretical framework. In this case, since the theoretical framework is PHCR praxis, the data was analyzed according to the themes presented in the framework; how well the data "fit" into the framework (four focuses and ten principles) and if it did not, how that data could expand our current knowledge of the framework and explain gaps in the teaching of cultural competency. The data was also placed into the categories of "mainstream" or "margin" as explained by Ford (2104), discussed in chapter two. While gathering data for such an analysis should be done to saturation, "the point at which the ongoing analysis of new data is not producing any new insights relevant to the emergent theory" (Kennedy & Lingard, 2006, p. 104), the limited number of willing participants may have precluded this saturation. The data that was collected, however, was interesting, enlightening, and poignant. Valuable information was collected and interview responses, as well as document analysis and observation, provided ample data for analysis. There is some concern, however, that some of the voices that were not heard during this study, could have illuminated the theoretical framework and conclusions reached more fully, particularly since minority voices were "heard" less often than majority voices and male voices heard less often than female voices; with no male voices heard from alumni data. Coding was done by going over the data, developing themes observed that related to the PHCR

framework; revisiting the data based on such themes, to revise and condense them; and continuing this process until major themes emerged. All data analysis was done manually, I used no software program for thematic evaluation.

The final results of an analysis are to generate a taxonomy that explains, in simple terms, the phenomenon under investigation; to develop themes based on this taxonomy; and to develop theory based on the taxonomy and themes (Bradley, Curry, & Devers, 2007). Current theory may be added to, more fully clarified, or revised based on the analysis of data (Miles & Huberman, 1994). This data analysis was viewed against the backdrop of critical theory and critical pedagogy to see how closely this case fit with current theory and, more specifically, with the PHCR praxis model (Figure 1). This "fit" helped to explain strengths of the MPH program as well as pointed out where weaknesses in the education exist and how these might be strengthened. The model also helped to explicate how cultural competency is taught by faculty and "caught" (internalized and practiced) by students. Evaluating data against a theoretical framework can then provide direction for recommendations to improve outcomes, inform policy, direct new research efforts, or in the case of PHCR, to illuminate, address, and achieve health equity (Ford & Airhihenbuwa 2010a). While such lofty actions were the goal and this study had limitations, the final results do add to this theoretical framework. This occurred particularly because the PHCR framework was designed to be used when developing programs for communities, rather than evaluating academic curriculum, but was found to bring to light many aspects of praxis that are influenced at the academic level. Such use of theory is another beneficial and appropriate pursuit.

Using PHCR as the theoretical framework allowed subjects' voices to be heard,

their stories to be told. It is this aspect of critical race theory research that imbues the data with such richness, beyond what quantitative analysis could have offered. The results of this analysis provided insightful recommendations from faculty, students, and alumni that may be generalizable to other cultural competency education efforts in MPH programs. While historically, generalizability is not considered the aim of critical research (Ulin, Robinson, & Tolley, 2005), I believe there is generalizability in this study due to the nature of using the PHCR framework to distinguish narratives from counter-narratives – either the data fit the framework (counter-narrative; race conscious) or opposed it (narrative; status quo). Fine (2006) describes theoretical generalizability and provocative generalizability. The theoretical frame of this study as described above fits her criteria for theoretical generalizability and the fact that these results may also be used as a springboard for other health care education program analysis to improve cultural competency education among other health care professionals, fits her criteria for provocative generalizability. Both of these concepts will be expanded upon in the conclusions and implications chapter.

In addition to the framework, the subjective personal reflections of the researcher are important in critical research as these biases and perceptions impact data collection and analysis (Ford & Airhihenbuwa, 2010b; Espino, 2012). Therefore, my personal reflections were sometimes included in the analysis. These reflections proved to be as interesting and expanding to me as the other data due to my ongoing learning through data collection, literature review, and discussions with others. New insights about the study itself and the topic in general were constantly and consistently being introduced into my thinking, which obviously affected the analysis. This important piece of any

research is often overlooked and left unmentioned by other studies both quantitative and qualitative, yet, with critical studies, such reflections are important (Espino, 2012; Milner, 2007).

Data analysis of each data group: observation, documents, and interviews, was done first as an overall review against the PHCR framework's four focuses. This analysis concluded in the development of narrative and counter-narrative themes. Second, the data was reviewed again against the PHCR framework's ten principles to look more closely at how the data could begin to answer the research questions in a more complete and critical way. Thirdly, the findings from these two analyses were used to answer the research questions. While each data set was analyzed and is presented in chapter four and five individually (faculty, students, and alumni), it is the overarching whole of the data that contributes to an understanding of cultural competence perspectives of these three populations at this institution.

Observations

Observations are used in case study research to increase understanding of the subject (Stake, 1995). Observations can add important nuances to the rest of the data under investigation since observations reveal what is happening, rather than how subjects' perceive what is happening (Ulin, Robinson, & Tolley, 2005). Observations of classroom activities, discussions, presentations (face-to-face class) and online discussions and final papers (online class) resulted in a large amount of data. This data set provided much insight into how faculty teach cultural competency, to what extent they directly address social justice and health inequality topics, and how students respond to such information, agreeing with, rejecting, and/or internalizing such teaching.

Due to the requirement in the online class that each student must post at least three days each week there is a discussion question - one substantive response to the question and at least two days of responses to other students' postings - a large amount of data was obtained from the online class. In many ways this data acted as a substitute for interviews in this class of students; not completely, but partially, as, in a sense, each student's voice was heard. The topics in the class did cover cultural competency, race, health inequities, and social justice, so students did comment on these topics during the semester.

Documents

Documents are used in qualitative research as primary and secondary data sources (Whitt, 1992). In this study, documents were primary sources consisting of class syllabi (which included required and supplementary readings and videos), discussion questions (online class), and exam questions (face-to-face course). Analyzing these documents for what faculty chose to include for readings, what they emphasized in each section, and what they chose to ask students to recall, helped to determine ways in which faculty taught cultural competence and to what extent they engaged students in critical thinking of this topic. These documents also revealed if, and to what extent, faculty engaged students to think about social justice and health inequities topics. Therefore, while documents may often be an underutilized data piece for qualitative studies according to Whitt (1992), this study made considerable use of documents in analyzing data to answer the research questions and in viewing how students responded to these documents as they were introduced to them during the semester.

Interviews

Interviews are a hallmark of qualitative research, especially in critical studies (Espino, 2012). It is gathering data from stories, particularly counter-narratives from minority individuals, that gives critical research its power to allow voices of those usually not heard to be heard (Espino, 2012; Griffin, Ward, & Philips, 2014). In this study, interviews from three different groups: faculty, current students, and alumni, allowed not only minority and majority voices to be heard, but hearing voices from each of these groups helped to illuminate the distinct perspectives on cultural competency, health inequalities, and social justice held by each group.

Some interviews were face-to-face, some were via email. Use of the internet to gather data is increasingly common and accepted within standard research protocols (Wilkerson, Iantaffi, Grey, Bockting, & Rosser, 2014). The interviews done via email were asynchronous (Mann & Stewart, 2000), often consisting of just one contact between myself and the interviewee.

The Public Health Critical Race (PHCR) Praxis Framework

The PHCR framework was developed to help public health practitioners analyze health programs based on social justice and health equality (Ford & Airhihenbuwa, 2010b). Although this framework is intended to be used when developing health programs, I could see its utility for analyzing classroom discourse as it relates to health disparities and social justice issues. It is in effectively teaching social justice and health equality concepts that future professionals can learn to dismantle the hierarchies in health care that now keep justice and equality from existing. Indeed, bell hooks states that, "The classroom remains the most radical space of possibility in the academy" (1994, p. 12). To

analyze the data against this framework helped explicate the ways teaching cultural competency does and does not create transformative, enlightened future practitioners. Data that opposed the four focuses of the framework was viewed as maintaining the status quo of white hegemony and hierarchical white normative health practices, while data that fit the four focuses was viewed as counter-narratives that help dismantle the current state of public health. Just by recognizing that there exists a "norm" that does not exist in reality, but that is culturally and socially shaped, transformative education can occur. Dr. Marylin Sanders Mobley stated, "What we cannot acknowledge, we cannot address. If we cannot address it we don't make the progress we need to make" (Mobley, 2013). By addressing these issues and engaging students in transformative pedagogical ways, these issues can be addressed in ways that allow change to occur.

It is under this theoretical umbrella, then, that data analysis was carried out. Using the four focuses to analyze how the data fit/didn't fit within the framework was a first step analysis. This step created narrative and counter-narrative themes that helped to answer the sub-questions of the research questions. The second step of the analysis consisted of reviewing the data against the ten principles of the PHCR framework as mentioned above. This analysis proved to be more critical and helped me see areas where cultural competency curriculum could be improved; how it could be made to answer tough questions and help students think more critically about the topics of health equality and social justice, thereby perhaps, creating more race-conscious and socially just health practitioners. This secondary analysis, along with the primary analysis, was then used to answer the major research questions and provide a conclusion to this study with implications for future research and practice. Within such analysis, however, every

researcher must acknowledge the validity and limitations of the study undertaken. The following sections address these issues.

Validity

Validity, or perhaps more appropriate in qualitative research trustworthiness, is an important aspect of any study. Integrity on the part of the researcher, data collection and analysis methods, and reporting of findings is essential to good research. Several techniques exist to increase the credibility of qualitative research, several of which were utilized for this study: triangulation (Streubert & Carpenter, 2011); interview strategies based on Heideggerian phenomenology that make member-checking unnecessary (McConnell-Henry, Chapman, & Francis, 2011); researcher bias; reporting of negative or discrepant findings; prolonged time in the field; and peer debriefing (Creswell, 2003).

The use of three populations: faculty, current students, and alumni, and three methods: observation, document analysis, and interviews, allowed for data triangulation and methodological triangulation of the data, respectively (Streubert & Carpenter, 2011). Such triangulation allowed for a more thorough investigation of the phenomenon, thus a more robust and comprehensive database for analysis. Unexpected findings as well as some observations regarding those not participating in interviews, but observed in class, are reported to increase transparency of the data and to better inform theory evaluation and development. I have already spent a prolonged time in the health care field as a dietitian, working with patient populations other than my own (white), but during the study I was more attuned to the emerging themes of faculty and student perspectives of cultural competency and racial/ethnic health disparities, as the study progressed. A planned timeframe of the full semester and a second semester to gather interview data

allowed me to provide more detail about the phenomenon under investigation. Due to the nature of data collection under PHCR, storytelling and the iterative process of data collection itself, provided greater and greater specificity of the underlying process. As the findings affected my own thinking, educational skills, and practice, this personalization of the analysis added a greater depth to the findings. Lastly, peer debriefing was used to prevent tunnel vision on my part. Having a non-white peer review the data and analysis who is unfamiliar with cultural competency as it relates to health disparities, but familiar with qualitative research and critical theory, ensured a greater degree of objectivity during analysis of emerging themes and comparison to critical theory.

Limitations

All studies have limitations. One limitation of this study is that it was a case study of one institution, thus may not be generalizable across all institutions. While generalizability is not a usual aspect in qualitative studies, many readers nonetheless look at this aspect of a study; and, this one did reveal some aspects of generalizability as mentioned above and further explained in chapter five. Looking at this issue from three different perspectives, however, particularly including those who graduated and are now working in the field, provided valuable evaluative information for all MPH programs. This particular methodology, using faculty, current students, *and* alumni from one institution, has not been seen in any studies to date that I could find. Closely related to this first limitation is a second limitation – since the same faculty member did not teach every student and alumnus this coursework, the variances found within and among the responses could have been due to individual instructor methods and their interpretation of curriculum development rather than on the topic as a whole. Since MPH competencies

have been created (ASPPH, 2014) as the standard by which MPH programs are accredited and have only been used since 2006 (L. Weist, personal communication, October 30, 2015), this limitation is well-founded. However, the topic of cultural competency in some form has been taught in health care programs since at least 1998 (Department of Health and Human Services, 2004), so analyzing perspectives on this topic with students and alumni, despite various instructors is still pertinent and has research soundness. Another connected limitation, the third, is the fact that there is just one required cultural competency course in this MPH program. Through an online search of many MPH programs, such a limited course requirement of cultural competency education is not unique and several courses are required within some of the concentrations in a MPH program. But only one is required of *all* concentrations. The data did reflect that faculty members state the importance of having the concept of cultural competence taught throughout the program regardless of the actual course, so such teaching may have happened throughout the program, but was not the focus of this study.

Fourthly, the limited number of interviewees very likely prevented a full range of voices to be represented in analysis and may not have led to data saturation. Despite several attempts at garnering participants, this limitation remains. The data that was collected, however, was rich and varied, providing a robust range of opinions and perspectives on the topic that was still quite informative and useful. It is hoped that observations from classroom work ultimately helped decrease, at least somewhat, this limitation. Overall, this data did reveal a comprehensiveness providing important insight into cultural competency education. The biggest disappointment was in not having a

larger number of minority and male voices, particularly in the alumni data. How these voices would have contributed to the analysis as a whole cannot be estimated, but is certainly a limitation, particularly within a critical study.

Fifth, choice of theoretical framework is always subjective. Every study may be viewed from several theoretical perspectives, thus the specific choice influences data collection. A researcher's own assumptions and biases are automatically evident in choice of theory. Such choice obviously colors data collection and analysis. The choice of critical theory for this study, however, is based on research from others in the health care field who also view this issue from a critical standpoint. Indeed, the IOM reports make clear that a critical analysis of these health disparities is justified.

Finally, length of time of the study may influence the results. It was felt that having only one to two semesters in the field may not have been enough. Certainly longer time spent in data collection would have increased subject participation and observing more than one semester of the course would have netted additional data. However, due to my own time constraints, longer time in the field was not practical and it is really unknown if a second class would have generated vastly different data from interviews and observation as that collected in this study. Certainly with what is happening in the US with race relations discussions and police brutality, immigration, etc. current classroom observations may be very different than those I encountered in the Fall of 2013, but that is the nature of data collection and history. This study's conclusions still fit our current time period and provide instructional commentary for curriculum development in MPH programs. My own expectations of what type of student transformations could occur in one semester added to this limitation, but was tempered by my committee members'

comments.

Having established the background for this study, addressed issues of positionality, detailed the data collection and analysis methodology, and discussed the validity and limitations, I now turn to the findings of this study.

CHAPTER 4: FINDINGS I

The purpose of this study was to investigate the perspectives on cultural competency education by faculty, current students, and alumni from a Master of Public Health (MPH) granting institution. To understand how cultural competency is taught by faculty and "caught" (internalized and practiced) by students, observation of a required cultural competency course for the MPH and interviews of faculty, students, and alumni were performed. This chapter reports on cultural competency through a critical theory lens to examine how these three populations, faculty, students, and alumni, view cultural competency's connection to health disparities and social justice. Feagin and Bennefield (2014) state that "Racialized health and health care inequalities are centrally generated by the direct and indirect discriminatory actions of powerful white decision makers and other key decision makers operating out of a white racial framing" (p. 12). Regarding social justice issues in health care, DasGupta, et al. (2006) refer to the Charter on Medical Professionalism which states, "physicians [and by extension, health care professionals] should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category" (p. 246). DasGupta, et al. (2006) go on to ask:

> If social justice is an integral part of teaching young physicians [and again, by extension, health care professionals] the tenets of professionalism, how do we as medical educators construct a pedagogy for social justice that is far reaching, consistent and central to our educational endeavors? (p. 247)

It is this critical lens that was used to study perspectives and pedagogical practices within

this MPH program. The specific framework used was the public health critical race praxis (PHCR; Ford & Airhihenbuwa, 2010b). PHCR as described by Ford and Airhihenbuwa is based on critical race theory (Delgado & Stafancic, 2012), but developed for the field of public health. PHCR has four focuses and ten principles that reflect a critical race foundation. This study asked questions about cultural competency and its relationship to health disparities and social justice from the perspectives of (a) faculty who teach, or have taught, cultural competency classes, (b) current students over the course of a semester in a required cultural competency course, and (c) alumni from this same program who are now practicing within populations different from their own. The study provided interesting findings on how these three populations see cultural competency's connection to issues of health inequalities and social injustices within the public health care field.

Just as McDowell (2004) states that "Most MFT [marriage and family therapy] programs are historically Euro-centered and embedded in White dominated institutions" (p. 305), so it is with the larger field of public health; this is the white hegemony of our current health care system. Using a critical framework allowed narratives to emerge that help to maintain the status quo of this white hegemony, while counter-narratives challenged the status quo and indicated perspectives that could help dismantle this status. While narratives and counter-narratives are the heart of critical studies (chapter four, Findings I), sifting the findings of this study through the further filter of the ten principles of PHCR (Table 1) provided a more in-depth and critical analysis (chapter five, Findings II) than reporting on the narratives and counter-narratives alone. Thus, chapter four will present the narrative and counter-narrative themes found in the data according to the four

focuses of PHCR, while chapter five presents the secondary findings based on the ten principles of PHCR and also combines the findings to answer the research questions.

As mentioned in chapter two, Ford (2014) explains that in critical research there is the "mainstream" and the "margin" (Figure 2). The mainstream is representative of the dominant hegemony and the margin represents those ideas and peoples marginalized, or dismissed, by this dominant ideology. Themes found were categorized into narrative (mainstream) or counter-narrative (margin) according to their "fit" within the four focuses of the PHCR framework. Each section in this chapter examines a participant group: faculty, current students, and alumni, presenting what the data revealed in terms of the perspectives of each subject group.

Faculty Perspectives

Documents, observations, and interviews were the data sets used to evaluate faculty perspectives. While faculty perspectives tended to fit within the PHCR framework, there were two themes that did emerge that represent narratives – perspectives that maintain the status quo. Four themes emerged that represent counter-narratives – perspectives that stand against the white hegemony of our current health care system.

Narratives

There were two themes that emerged from faculty data that indicate maintenance of the status quo of current health care practice. I've labeled these (a) that's not my job, referring to addressing possible racialized variables in research and (b) minorities must make adjustments to the white hegemony of health care.

That's not my Job. The two faculty members who work in biostatistics did

mention that it is important when developing a study to include information about the "normative" values we place on operationalizing variables, but one stated that "the study leads should take care of that." Even when asked if an epi/biostatistics professional feels they could or should influence selection of variables once they notice something of import, a white female faculty member stated, "No, I do not do that. That is not my position."

When reviewed against the PHCR framework, these sentiments maintain the status quo. Wing (1998) states that epidemiology, as part of science, is seen as value-free and truthful, yet he argues that there is an "alternative epidemiology" that is not reductive and that can address social injustices by expanding the variables chosen for a research study. Fullilove (1998) reinforces this idea, adding that researchers should question variable definitions and ask critical questions of data collection methods to avoid stereotypes and the status quo of research. Evaluated against these viewpoints, the theme of "that's not my job" fits as a narrative, rather than a counter-narrative.

Minorities Must Make Adjustments. Two faculty members (a male in Community, Environment and Policy; a female in Environmental Health) commented on the importance of minorities making adjustments to dominant cultural norms. The white male professor related that one of his PhD students is working on teaching minorities "how to maneuver in the white man's world." He stated that there is almost a need for two courses – one to teach the dominant culture to learn about minority cultures and practices and the other course to teach minorities about the dominant culture and practices. He stated that while white health care staff come and go, the people being treated in the community live there.

The white female faculty member mentioned how not having the exact same cultural and social capital (Bourdieu, 1984/1979) as the "accepted norm" can leave a person feeling "outside." She stated:

> I also believe this [being culturally sensitive] cuts two ways! You may grow up in a non-traditional household. It is your responsibility to become culturally competent relative to the majority. For instance, my very white middle-class family had no cultural competence relative to the majority of white America. They were never allowed to watch TV, movies or participate in sports. They did not know who Mickey Mouse is (or any of the TV programs that people routinely refer to); they knew about the concept of Christmas but did not know the date! Those in minority groups also need cultural competency.

While this sentiment might be understandable to majority individuals, it may actually be perceived as diminishing or negating the negative impact disparities have on minority populations; as if such comparisons actually equate to what minority individuals experience. These types of statements may reveal how majority individuals begin to understand the feelings of being "outside the mainstream" (Trepagnier, 2010), but unless a white individual moves past the "poor me, too" perspective, they might ignore or minimize the harshness and histories of injustices faced by minorities (Cabrera, 2014b). These types of sentiments continue to affect how studies are planned, variables are constructed, and results are interpreted. As Ford and Airhihenbuwa (2010b) assert, "our collective and individual biases, identities, power positions (relative to others) and worldviews shape our personal assumptions and these, in turn, can inadvertently

influence our research" (p. 1395).

Such sentiments as those voiced above, may also maintain white hegemony as the best way to do things by promoting the status quo. bell hooks (1994) mentions this premise and asks the question about why is it always minorities making the adjustments? She recalls from her childhood that blacks were bussed sometimes for hours to white schools, but whites did not have to be bussed and learn the ways of an African-American school – to integrate into *that* culture. She asks, "Why?" This question is legitimate, not often asked in research – what are the dynamics of the dominant versus minority players in any study? This relates back to Apple's whose knowledge is valued. Such counter-narratives emerge to question the status quo.

Counter-Narratives

There were four themes that emerged from the faculty data that indicate counter-narratives or the importance of questioning and standing against the status quo of white hegemony as the standard in health care. These themes demonstrated the concept of centering in the margins: (a) health equity as a social determinant of health – inequities in income, insurance status, access to health care, etc. impact morbidity and mortality of minority populations, (b) service learning – an experiential learning process designed to place students into under-resourced communities to increase interaction with and appreciation of diverse peoples, (c) thinking critically – power and privilege; how white's power and privilege in health care are accepted rather than questioned (this is the covert case), and (d) addressing racism and whiteness – how these concepts occur or are enacted in health care situations (this is the overt case).

Health Equity as a Social Determinant of Health. The syllabi of the face-to-

face and online courses each stated very clearly that health equity is a social determinant of health. The syllabi listed several required articles throughout the semester that delineated this concept. Examples from each syllabus follow. The online course syllabus stated:

> While curative healthcare is important, maintaining good health involves a wide variety of preventive measures, such as reducing levels of educational failure, reducing socioeconomic disadvantage and creating environments that make the adoption of healthy lifestyles possible for individuals and families.

Topics covered in class included the following headings: health disparities and social class; measuring poverty; race and ethnicity; Native American and indigenous health; and migration and border health.

The face-to-face course syllabus, while not as overt as the online course description above, did include learning about the social and behavioral aspects of health within populations, with a strong emphasis on noting the positive, or resilient, aspects of each population studied. For example, the research paper due required students to identify "*both positive* and negative social, cultural, and/or behavioral factors that contribute to the specific health pattern or outcome" [emphasis added] and under the class topic for service learning, one sub-topic was "Social Capital and *Resilience*"[emphasis added]. Topics covered in the face-to-face course included these headings: social, cultural, and behavioral determinants of health; childhood, foundation of the life course (which dealt with stress and poverty); political determinants of health; and health inequities and indigenous populations.

The final paper required from students for the online course was a "Health Disparities Report" – each team was responsible for choosing a population and a health disparity within that population and describe the issue, the factors impacting the issue, develop culturally appropriate intervention strategies, and an evaluation process of that intervention. All of this work was to be done with citations from the research. The face-to-face course also required a research paper that discussed "an at-risk or resilient population," with very similar requirements.

It was clear from the documents, required readings, online discussions and exam questions that neither course refrained from discussing the subject of cultural competency and its relationship to health inequalities and social justice. Instead the opposite was true. Many of the required readings spoke directly to these disparities and the need for culturally relevant and respectful interventions. Videos in both classes played an adjunct role in reinforcing the classroom and literature information. Some examples of required readings/video titles, and exam/discussion questions that reflect this subject matter are found in Table 4.

Observation of discussions within the face-to-face classroom and online chats also demonstrated that faculty teaching this course directly addressed the issue of health equity as a social determinant of health. Covering the basics of this concept within the parameters of the profession of public health was paramount in each course – mention of this competency was ongoing throughout the semester. Discussions of current events and the health equity issues involved in them also occurred during both courses.

One particular observation in the face-to-face class was enlightening: during a class about the political determinants of health, the professor for this course, Dr. Z, (a

Table 4

Examples of the counter-narrative: Health equity as a social determinant of health

Required reading titles	Community resilience approach to reducing ethnic and racial disparities in health Tackling inequality: Get them while they're young Global justice and the social determinants of health Socioeconomic determinants of health, children, inequalities and health. Poverty, equity, human rights and health
Topic/ Discussion /Exam questions	How do societies and political process produce inequities? Discuss the link between political determinants of health, stress, and health disparities View the video "Nicholas Christakis: The hidden influence of social networks" with what you have learned about the Social Determinants of Health in mind. How does Christakis' theory compare to WHO's [World Health Organization] approach to the social determinants of health? What is it missing? What does it add? How does it relate to other literature on social issues in health or similar fields? Feel free to discuss all or some parts of this question, or other thought provoking topics from the video.
Videos	A Place at the Table (hunger in the US, most felt by minorities in poverty) Health Inequalities - Social Determinants of Health Film Unnatural Causes: Is Inequality Making Us Sick?

pseudonym), spoke to the class about language and how we used to use war terms to describe interventions (e.g., the war on drugs) and now we use economic terms (e.g. cost of disease, epidemic downturn) and how using these "normative" terms marginalizes people of color who do not see the world that way, thus they may be excluded in many ways from health care discussions. In the online discussions, the professor, Dr. Y, (a

pseudonym) not only provided questions that required looking at each topic from a broad perspective, but at times interjected questions into the students' chats to interrogate the students' dominant stance. A couple of examples: when discussing race/ethnicity in health research, the discussion question was "When is it appropriate (or necessary) to address race or ethnicity in health research?" and one student had responded that at times collecting data on race/ethnicity helps reveal inequities in care and resources for minorities. The professor responded that these are credible assertions, then asked, "In addition to knowing where the disparities are, how doyou recommend this research is conducted to ensure it is the most valid and not unnecessarily racialized?" Such a question may have helped the student to think more deeply about the complex issues of health disparities and research and how and why researchers use the terms and variables they use. The second example, stemming from this same discussion, occurred when the issue was semantics in a different way: the difference between a risk factor and a risk marker (a risk factor is considered causal in increasing risk for a disease; a risk marker expresses where an element is correlated with higher risk for a disease, but is not likely causal). Dr. Y responded with the following question for this particular student:

> I think what you are getting at, [student name], is that many variables should always be looked at in the exploratory phase of data analysis – you need to know what your data distribution looks like based on multiple demographic factors. When you move into analysis and publication, however, do you think it is always important or relevant for race to be considered without context?

This question may have helped this student to think more critically about how we define

race in studies and did move the conversation along in terms of not only looking at context within studies, but how clearly variables are defined, who is defining them, and for what ultimate purpose, as students' responses did revolve around these issues in the ensuing online discussion.

Interviews revealed that many faculty members view health disparities as a social determinant of health as an essential component worth teaching for MPH students. One white female professor stated that she tries to teach students to be suspicious of all statistics that break down by race – there are too many confounders with this categorization. "Is it race or decreased social resources or increased social problems (environmental, poverty, etc.)," she stated that she asks students. Another white female professor stated passionately that the terminology of public health is limiting. She stated that public health practitioners say cultural competency is "just good practice," but then asked, "what does that really mean?" She went on to say that she has lived and worked in many different communities and that *respect* [her emphasis] is the key concept. She went on:

> There will always be differences, disparities go both ways; why don't we talk about what a group is doing well? We don't talk about successes, resource allocation, how we limit categories to define a community. We need to look at differences and patterns and ask "Why?" – revealing differences that public health can actually effect. We need to ask who decides what questions to ask on pre-tests and post-tests. When we start talking about *respect* [her emphasis] and simply treating people like human beings we'll make more progress.

This comment gets to the heart of what Apple and Buras (2006) talk about when they describe the phenomenon of worth in classrooms – whose knowledge has value. Apple and Buras discuss several cases where the "subaltern speak"; where minority populations voice their own history, their own perspectives, and their own struggles. When this happens it is truly a counter-narrative, allowing centering in the margins to occur.

Many of the faculty members also mentioned that they felt cultural competency concepts should be woven throughout the curriculum in the MPH program, not just taught as an independent course. Faculty members oft-cited that they exhibited for students how the topics of cultural competency, health disparities, and social justice play out in all aspects of public health in the courses they teach. One white male faculty member stated it this way, "Teaching cultural competency should not be a separate course, but embedded in the curriculum throughout."

Many of the faculty interviewees also stated that the Affordable Care Act (ACA) "is a step in the right direction" (a white female faculty member) of decreasing health disparities, by at least increasing access to health care for minorities who have traditionally been under-insured (Woodward, 2015). The ACA was also the focus of the service learning activity in the face-to-face class: students worked with "Enroll America" to provide information and education about the ACA to populations identified as being under-insured. To facilitate cultural competency learning, MPH programs often have students work within communities of under-resourced populations. This activity is the subject of the next theme.

Service Learning. The face-to-face course had a lecture session on service learning and its importance to public health, as well as a requirement to perform a service

learning project, as mentioned above. Dr. Z, shared her opinion that all MPH students should do a service learning project. She stated that this is a paradigm shift in public health, that working *with* a community is much more effective than working *for* a community (Campinha-Bacote, 2002). She felt that the old paradigm of working *for* a community reflects too much of a paternalistic view. Dr. Z also stated that service learning is "reciprocal learning" – that both the community and the student learn from the experience. The professor stated that academia gives students a "sanitized and generalized" notion of communities, but getting into the community, "being in the shoes of your population," can help students see the immediacy of the need from the perspective of the community, not from the perspective of those in power (this area does overlap somewhat with the next section on power and privilege and will be discussed further in that section). Students' experiences with this required service learning project will be reviewed in the current student section of this chapter.

Two faculty interviewees also mentioned the importance of service learning projects in MPH programs. One white male professor spoke about how social media has helped to "open avenues of communication with populations that were not available years ago" and that public health professionals need to use this technology to reach people with effective messages. He went on to explain that community based participatory research (CBPR) is critical for public health professionals; he felt that all students need to use CBPR or aspects of it to be truly effective. In his opinion, CBPR helps break down barriers that have existed for years between the "researched" and the "researcher". He reinforced that CBPR works *with* communities, not *for* communities. A white female faculty member stated that:

> Cultural competency is also important in terms of publishing findings that are culturally respectful – health research has a bad past; we need to put people first! Public health for community wellness can incorporate cultural competency – service learning projects; working in at-risk communities; we need to let them know we're going to be there for the long haul. You have to "show up"; you have to spend a lot of time in the community. It is very intertwined with so many other things, but as a white woman I've learned from the several communities I've worked with and I feel that, as a researcher, one must look at the values of the community and culture.

These views stand as counter-narratives to the status quo – the idea that communities of color have culture (Yosso, 2005) and in opposition to "we can help you, because we have the answers" that continues to place dominant ideology over minority populations' capital (Bergsma, 2004).

This data reveal that several faculty members felt that service learning or some form of being *in* a community, was an important part of learning cultural competency. This perspective may help move students from seeing the world through their own eyes, to begin seeing the world through the eyes of those they work with in health care settings. It is this awareness that Ford and Airhihenbuwa (2010b) are advocating with the PHCR praxis framework and what Ford (2014) expresses as centering in the margins. This shift in perspective may create critical thinking skills which are addressed in the next section.

Thinking Critically – Power and Privilege. Course documents and observations, as well as many faculty interviews, revealed the theme of power and

privilege and the importance of thinking critically about health and health care provision within the context of cultural competency. A white female faculty member stated that she asks "provocative questions" of students intentionally to move students toward self-reflection, to stimulate them to this endeavor. She stated that she tries to get them to think critically and intellectually about cultural competency issues within public health. Another white female faculty member, who discussed domestic violence in her classes, stated that there was a particular video she intentionally did *not* use because it depicts domestic violence in an African-American population and she felt that this video would reify students' stereotypes on the topic; she wanted them to think differently about the topic. She went on to say that although the video was very realistic, she wanted to avoid stereotyping any culture. An African-American female stated that Caucasians did not see themselves as having a culture – she said that she could not get this idea across to the students in her classes. If a group cannot see their own culture, how can they see their dominance over other cultures (Bonilla-Silva, 2010)? This professor felt that having whites see that they do have a culture was important, but difficult.

On the issue of power and privilege, many faculty members mentioned the systemic problems that exist in the US that should be addressed by public health professionals. One white male faculty member stated:

> Our premise of health disparities is wrong – when we look at it from an epidemiology/statistics standpoint, we're not looking at all the right things – education, income, geographical residence, decreased resources, etc. Epidemiology counts things, but not all the right things – it's easy to count certain things, but that doesn't tell the whole picture. Research is beginning

> to look at this now. Poverty is hard to fix – our concept of distributive justice is based on choices, but it's larger than that; too large, too big, and the dominant culture is threatened by this. It's really about structural issues. We need to talk about those aspects.

This quote echoes what Wing (1998) has argued about epidemiology – that it may not count all the right things. When asked why we haven't made more progress in the area of health disparities, another white male faculty member stated:

> It's a bit unfair to say that, as we have made good progress. But to make more progress we need to move away from race and ethnicity and look at poverty; the root cause is a resource issue – lack of access, rural communities, etc. Structural issues are impeding progress.

These quotes reflect the uneven distribution of resources in the US (Smedley, Stith, & Nelson, 2003) that are systemic and widespread (Feagin & Bennefield, 2014).

One Asian-American female faculty member wrote about these issues comprehensively. She spoke about the issue of poverty and how poverty is linked to historical and political factors. She went on to say there is a "need to challenge the belief that cultural competence may be achieved after completing a few courses." She asked, "How many individuals across diverse fields work together to reduce poverty, and to improve educational and employment opportunities for all people?" This faculty member also declared that:

> I believe more in *Cultural Humility* [her emphasis] than cultural competence because cultural humility suggests that working with other cultural groups requires self-reflection, growth, and mindfulness of power

> dynamics throughout the lifetime. One does not ever become fully "competent" after completing some amount of training.

Cultural humility is a concept coined by Tervalon and Murray-Garcia in 1998 because they felt that the term cultural competence was too limiting. These authors state that

> Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations. (p. 117)

While the concept of cultural humility was created in 1998, a literature search on the concept reveals that this term is still eclipsed by the term cultural competence. A literature search using the terms "cultural humility" and "health care" from 2006 to 2015 produced 14 results, while the same search using "cultural competence" and "health care" from 2006 to 2015 produced 1,102 results.

One of the videos in the face-to-face course was "Stress, the Silent Killer" which documented how having power over your environment (work, home life) helped decrease stress and conversely how feeling as if you have no, or very little, control or power over your environment/circumstances caused increased stress. Dr. Z discussed how this concept translates to health care for the poor – they have very few resources, very little control over their environment, a lot of stress in their daily lives (violence, racism, food insecurity) – and this can increase health problems. She discussed how this power/control equates to privilege in our society. Dr. Z stated that her goal is to get public health to change their way of providing health, to move past privilege and see those we work with

as individuals with capital and resilience. She again stressed the idea of reciprocal learning – that health care professionals should look to what they can learn from, not just imparting information to, their clients. She also stated that she prefers the term "health equity" to "health disparity" because disparity reflects the deficit model that public health has used for years and she felt it is inappropriate and far too biased and stereotyping of minority populations.

The online course also contained elements of this theme. In the "Social Determinants of Health" section of the classroom notes, Dr. Y mentioned the Ottawa Charter for Health Promotion which lists eight mandatory conditions for health. This list includes "social justice and equity." These class notes also include the World Health Organization's definition of health as "the conditions in which people are born, grow, live, work, age, *including the health system*" [emphasis added]. Dr. Y stated that "these circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels, which are themselves influenced by policy choices." This quote is a succinct analysis of her view that directly addresses power and privilege. There were also two weeks of lectures in the online course that further directly addressed the issues of power and privilege ("Health Disparities: Social Class and Health" and "Political Economy and Health") and these notes and videos were used to encourage students to think critically about health inequality issues. Some examples to illustrate this directness included the historical descriptions of Marx, Weber, and Bordieu's explanations of social class, power, and privilege – introducing to the students these foundational authors and their contributions to the ideas of class, stratification, prestige, power, and capital. This section also included a non-required, but additional resource

article titled “An Examination of the Pathways in which Social Class Impacts Health Outcomes.” A video from the political economy lecture notes was titled “Power and Inequality.” In this video Marshall Ganz, from the Harvard Kennedy School, discussed how one minority group worked to overcome inequalities by using the resources they did have collectively to gain political power. This video was a striking and explicit explanation of power and privilege and recommended that communities must leverage what little they have to fight against the power hierarchy that they live within. While this theme addressed power and privilege, there was data that conveyed a more direct message about racism and whiteness. These results are listed in the next section.

Addressing Racism and Whiteness. This theme was exhibited in interviews, documents, and observations. Some examples of statements that reflected faculty members’ sensitivity to racial issues follow. One white female faculty member stated that she asked for and expected respectful attitudes from Caucasian students and also requested teaching assistants who represent minority groups here in the US to “further break down the barriers surrounding discussions of cultural competency.” This same professor stated that she also tries to set up her student discussion groups to be as diverse as possible “so that students are intentionally exposed to various cultures.” She stated that she feels “students need to know and realize that their white privilege does benefit them,” so she intentionally tried to create diversity within her classrooms.

Some faculty members directly addressed the issue of racism and whiteness. One white male professor was quite blunt in his assessment of the US health care system. He stated:

> Cultural competency is very important and should be emphasized in

> courses. Public health and health care exists in a "White Man's World"; it is framed within a white man's, Protestant lens – this is the dominant culture; so this works well for white patients. For non-dominant groups, beliefs and attitudes don't match up and they become marginalized, they can be insulted and become frustrated with the system. Practitioners can improve outcomes and interactions if they recognize this difference – this system. This can be threatening to the dominant culture – "Why do I have to change?" This is an understandable response; sometimes there is a backlash from whites.

This statement lines up with what Feagin and Bennefield (2014) suggest is "systemic racism" within the US health care system.

An African-American female stated that she discussed larger racial/ethnic issues in her classes. She emphasized the importance of disaggregating populations because, she stated, "race does not equal culture." She went on to state that she would talk about how public health uses "categories to lump people altogether into these categories," but they are "actually pretty meaningless." She related that one of her classes "did not know what Hispanic meant," which she claimed reinforced her assertion that these categories are arbitrary and "meaningless." These statements point to the social construction of knowledge within research.

When asked about how cultural competency in public health professionals is related to social justice and health disparity issues, one white male professor stated:

> Public health effects are inadequate because we're talking about a societal shift – this is very difficult. When we look at the Affordable

> Care Act and social justice and health disparities we are confronting some difficult issues head-on. I feel that the dominant culture doesn't want to openly discuss this, so progress must be made incrementally.

This same professor went on to say that while this "incremental progress" is not the way he would like it to be, it is the reality of the system we live in. He felt that SWCOPH tries to address these issues by having diversity in its student population. He added some additional comments about the Affordable Care Act (ACA):

> An example of what I'm talking about is the ACA – it's obvious – the rhetoric about this has shown the resistance to changing the status quo, the dominant ideology; not everyone shares this same set of values - the value of a healthy community/state/nation. We're willing to tolerate disparities in the US; we have this mentality; if a group is disadvantaged they don't affect policies which impact social justice issues directly – *policy* needs to change. [his emphasis]

This professor's statements revealed how race and the dominant white hegemony of our current health care system play a role in health equity and social justice issues from his perspective. Interestingly, one white female professor stated that:

> I think people have the training in cultural competency, health disparities, and social justice. If you start the conversation with a medical professional in this context, he/she will discuss it with you. I think it can be as frank as the patient/subject is open to. Having said this I do not believe most people will talk about anything that challenges their comfort level . . . therefore little progress has been made.

This statement echoes those of other professors above, as well as some studies that indicate frank discussion of race within the classroom can occur resulting in growth on the part of white students (Lea & Helfand, 2006).

This theme was also found in classroom documents and observations. In a face-to-face class, Dr. Z brought up the dichotomy between helping women financially and how that affects the dynamics of men-women in some countries. She emphasized how health professionals need to be keenly aware of how what we do affects the population very broadly. She stated, "we're pretty passive about inequality in our country." She discussed some of the ways minorities have been "used" by researchers to further their own careers while simultaneously abandoning the very communities that helped them move forward in their careers; how so often, researchers come into a community, perform research, offer programs, collect data, then once the researchers are done, they leave the community. There is no plan for sustainability within the community of a project that did help the people. Dr. Z also made the point that "this stuff [speaking of what happened during the 1963 Civil Rights era] is within our recent history. Your parents and/or grandparents remember this. Racism is still here, but is more subtle and insidious." She discussed how the science that we rely on in the field is there, but "when you read it where does your mind go? To personal responsibility – they're [meaning minority groups] not trying hard enough; it's some other problem; etc." She encouraged students to think more critically about the science and their assumptions about race/ethnicity and health; think about the bigger picture, the contexts within which minorities experience health issues. Two of the required readings in her class dealt directly with racism in health care. One was titled "Historical trauma among indigenous Peoples of the

Americans: concepts, research and clinical considerations." The other was titled "It's the skin you're in: African-American women talk about their experiences of racism. An exploratory study to develop measures of racism for birth outcome studies." These articles recorded, very directly, the effects of racism on Native Americans and African-Americans, respectively.

The online course also dealt directly with issues of racism and whiteness. While these are extensive pieces taken directly from the class notes, I felt they were important enough to quote in their entirety as they concur with the literature review on this topic. From the class notes on "Health Disparities; Social Class and Health" section: "It is widely accepted that the social determinants of health are responsible for health inequity (disparities in health that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity)." This opening to the section mentions health inequalities and social justice issues, introducing students to this topic quite directly. The section went on:

> Writing in a recent issue of Public Health Report, Bill Foege asserts that the real causes of many deaths are social determinants such as illiteracy, fatalism, gender bias, *racial bias*, unemployment, and poverty. Poverty, he observes, is the single biggest contributing factor to adverse health outcomes, and health outcomes worsen as poverty becomes more severe. . . While the overall health of the American population has improved over the past few decades available evidence shows that not all Americans have shared equally in this health gain. Disparities in health have been documented repeatedly across a broad range of health conditions and for a wide

range of ethnic and racial groups. [emphasis added]

The class notes then went on to list several examples of such disparities between whites and minorities in health-related conditions. The notes then commented on how access and utilization of health care services reveals majority-minority disparities, again with examples. These class notes then delineated other factors that affect these disparities:

> Although health disparities are very often focused on racial and ethnic disparities in the literature, it is important to remember that health disparities are also a result of many other types of inequity (such as poverty or gender), which very often interact with each other. Jeroan Allison notes that "to eliminate health disparities, we must confront residential segregation and the attendant inequities in education, neighborhood safety, housing adequacy, and income potential." Effective interventions and programs require an understanding of these various and interacting mechanisms that create health disparities, which is why health disparities research is so important.

This section began to address some of the intersectionality issues common among minority populations that affect health outcomes and that are part of critical research (Crenshaw, 1991).

From the class notes on the “Race and Ethnicity” section of the online course, Dr. Y examined literature that touches on the ambiguous nature of the term “race” and yet, how these terms are still used in research. She encouraged students to think critically about these variables:

> Race is no longer considered a true biological distinction among researchers. There is little variation in genetic composition between 'races',

> and the physical characteristics distinguishing races result from a small number of genes that do not relate closely to behavior or disease. In fact, there is more genetic variation within population groups than between them, meaning that two individuals with the same ethnicity may have more disparate genotypes than two individuals of different ethnicities. Nevertheless, ethnicity continues to be a widely utilized marker in demographic and health research for a variety of reasons. . . . It is critical to be cognizant of how societal notions of race and ethnicity are influencing research, and in turn how research may influence societal norms and risk perceptions among minority groups.

This instruction to be critical of how the categories of race and ethnicity are developed and utilized in research points to the social construction of knowledge and race as social construct found in the PHCR framework; focuses 1, 2, and 3 (Ford & Airhihenbuwa, 2010b). In these same class notes, Dr. Y went on to say:

> In addition, it is helpful to remember that recognizing these issues is not to suggest that researchers who study this topic are racist, but rather they are products of a society in which racism is systemic, despite the incredible progress that has been made since the days of racial segregation and eugenics. And sometimes, many would agree that these categories are valuable parts in health research, as long as the researcher considers the many dimensions of the issue.

This final section above, taken from the class notes, set the stage for the discussion questions Dr. Y asked the class for that week. Her discussion questions asked students to

consider how to develop racial categories, if and when such categories might be appropriate and not "racialized," and how to differentiate between "appropriate" use of such categories and "racialized" use of these categories. Such questions may have helped students think critically about research and how it is constructed in the public health field, rather than accept how these categories are used at face value.

The required and supplemental readings in the online course also contained several articles that directly addressed this theme. They included articles titled, "Is research into ethnicity and health racist, unsound or important science?"; "Race, socioeconomic status, and health:The added effects of racism and discrimination"; "Abandoning 'race' as a variable in public health research – an idea whose time has come"; "Eliminating racial & ethnic health disparities"; "Interventions to reduce racial and ethnic disparities in health care". These articles discussed race and racism directly.

Faculty Perspectives Discussion

Based on the above findings from the data, the majority of data collected from faculty fits the PHCR framework and its four focuses. Faculty members within SWCOPH were sensitive to issues of cultural competency and how they intersect with issues of health disparities and social justice. Faculty members discussed race as a social construct (focus 1 & 3), the structural determinants of racism and health inequities (focus 1), the importance of thinking critically about whose knowledge has value and how research may be biased (focus 2 & 4), the problems with using race as a variable in research (focus 3), and the importance of listening to the community – their voice – when developing community programs (focus 4). While there were some data that reflected narratives (the white hegemony of health care), even that data bordered on being in a transitional phase

between seeing whiteness as the norm and working within this dominant framework, rather than taking it for granted, ignoring it, and not addressing it. For example, data from the "minorities must make adjustments" theme made reference to helping practitioners and communities deal with the status quo; learning ways to remove barriers and improve health care for community members. These views began to approach the "centering in the margins" concept of Ford (2014).

When faculty members related a personal reflection on cultural competency they mentioned respect, humility, working *with* not *for* communities, and whiteness as evidenced by quotes above. One faculty member, as quoted above, stated how difficult it was to get white students to realize that they do have a culture and another professor stated that "we have not made more progress in cultural competency because people don't understand the concept, and do not know how to improve their cultural awareness and apply it to their work." These findings had more congruence with the PHCR framework four focuses, than opposition to the framework, so it appears that faculty members at SWCOPH address the issues of racial/ethnic health disparities in their professional academic work and are sensitive to the issues of race consciousness.

Current Students' Perspectives

Observations (discussions and presentations from the face-to-face class and required discussions during the semester in the online class) and interviews were the data sources used to examine current students' perspectives. In general, current students were aware of the need for cultural competence and its connection to social justice and health disparities, but the data revealed that those students who had more experience with communities of color, or populations which experience health inequalities, had a greater

understanding of critical thinking and espoused more counter-narratives than less experienced students. Two narratives which reflect maintenance of the status quo or a slowly increasing awareness of the existence of mainstream versus margin (Figure 2; Ford, 2014) were found and five counter-narratives were revealed. Due do the enormous amount of data in this population, quotes used were chosen for their representative nature of the themes as a whole.

In addition to the narratives and counter-narratives, a separate section that presents current students' perspectives on how they felt about the amount of cultural competency education they got in their MPH program will be documented. This section is placed separately because while some of these responses did fit into a narrative or counter-narrative category, the student responses, looked at separately, represent interesting data that informs the overall final analysis.

Narratives

Two narratives were exposed in the current students' data. I've labeled these (a)white as the norm – comments that reflect acceptance, without critical reflection, of the dominant white ideology in health care and (b) increasing awareness - which reveals some movement from narrative toward recognition of the binary of mainstream and margin.

White as the Norm. I start this theme with a quote from an Asian-American male student in the online course because his statement was not challenged by other students in the class. When discussing personal responsibility he said,

> Even individuals who receive government nutrition assistance programs may not choose to consume healthy foods and add to the current obese

> population. I wonder if there is a more effective system then nutrition education that may slightly force individuals to choose the better choices, however that may be considered unethical!

Although he ended this statement with an understanding that to "force" people to do a certain thing "may be considered unethical," his comment is indicative of the idea of a patriarchal hierarchy in our current health care system, which is based on white hegemonic principles; we know what's best for you, therefore you should listen to us (Bergsma, 2006).

A notable observation in the face-to-face class was in response to a discussion about getting people enrolled in the Affordable Care Act (ACA). One white male student responded that "we" thought we had correct knowledge when we did such things not so long ago (denied people insurance); many people didn't know about insurance, they were "backward." Another student interjected that this statement was very judgmental. The first student corrected himself immediately, even cutting the responder off, stating that he didn't mean to say people were "backward." This student's perspective and the collective use of the word "we" reveals an attitude of normalcy – this is just the way things are; maintaining the status quo. Although he was quick to correct himself when another student pointed this out, the belief system was evident (Trepagnier, 2010).

When talking about public health programs some students used language that maintains the current status quo. This quotation is an example from an Iranian student in the online class:

> The community must be fully understood, in order to have them trust modernized methods like ORT [oral rehydration therapy]. Models have

> been established to appreciate cultures when promoting a health behavior; these models allow health care providers to understand the local perception of diarrheal diseases, develop recommendations that the community would accept, and representing local traditions while utilizing community resources.

While this example mentions being culturally sensitive when developing health programs, it still contains terminology – "modernized methods" and "that the community would accept" – that indicate hierarchical, biased thinking about health care providers and communities they work with. In other words, contemporary medicine is thought of as "modern," while other forms of medicine (e.g. acupuncture) are seen as "traditional" or "not current and efficacious;" and the idea that a community should "accept" such methods or treatments rather than question them places "modern" medicine in a position above traditional medicine or cultural practices (Feagin & Bennefield, 2014).

This theme of "white as the norm" was reiterated several times in both classes, but the majority of students saw this concept as problematic in health care. Statements that address this concept as an issue that should be critically evaluated and challenged in health care will be listed as counter-narratives under the "systemic/institutional problems" and "racism/white as the norm" sections.

An example of transitory thinking from mainstream to margin came from an observation in the face-to-face class. One group was discussing their service learning project. They talked about the "trouble of inherent assumptions" – that it was important *not* to pre-determine a person's/group's needs/desires. They pointed out that "we," as health care professionals, get these "grand ideas in the classroom," but then really need to get into the community to see what *their* needs are, stop making assumptions. These

"inherent assumptions" are often the result of the white hegemony that dominates our current health care system.

The idea that the current scientific method used in research is objective and race-neutral was mentioned by a few students. From an online discussion about racism and research, one white male student said:

> When research is also associated with an overall racial bias, the focus becomes tainted. . . that is where there is the need for our scientists and researchers to step in to identify the unknown casual mechanisms as they related to the association. If a link is associated between a disease or disparity and race, then the reason for that link can be focused on.

This student falls back on the idea that the scientific method is objective and can help address research that is unduly racialized. Yet he then goes on to say, in addressing another student's statement about how research done by white scientists may help to maintain "an imperialistic system of privilege" by reinforcing, through the use of science, stereotypes of minority groups, that this is a "very bold statement." Then, this white male student completes his response with:

> There are many researchers out there that want to benefit civilization, regardless of their race and the race of the people that they are trying to help. Classifying race research as a way to keep Caucasians in power is in itself a very racially biased statement and only reinforces that negative behavior.

This statement is reminiscent of the reverse racism stance white's often take when challenged as described by Cabrera (2014b) in his studies of white college-going males.

Increasing Awareness. In an observation of the face-to-face class, the professor, Dr. Z, was discussing that chronic discrimination leads to poor health outcomes and that many communities of color "normalize stress" because it is so pervasive. A white female student stated that some people have a "perceived discrimination when they really aren't discriminated against." She related this sentiment to the feeling that "I'm not as smart as everyone else, yet a person is in a cohort with those people, so she/he must be as smart as everyone else there, to be there." She stated that discrimination may not actually exist, but a person perceives it does. Many students made comments against her point, basically stating that this student didn't understand true discrimination. They stated that her example was too simplistic and discrimination that leads to health inequalities is much more complex. To my knowledge, this student did not say anything else in class aloud the rest of the semester. This interaction occurred in week four, so it is unclear if this student understood the criticism she received and increased her awareness of how discrimination and racism affect people of color, and is not as simplistic as the example she used, or if this silencing of her comment caused her to withdraw without gaining insight into this concept.

As students in the online class reviewed required, as well as self-selected, articles and analyzed them for various professor-selected queries, the students' awareness of and changes in thinking and perspective on cultural competence, health disparities, and social justice concepts were evident in their online posts. One white female student, when analyzing whether an article about Hispanic teen pregnancy rates was racialized, stated "it is important not to generalize that all individuals of a certain ethnicity adhere to beliefs that are associated with their culture. It is that very practice that leads to

stereotypes and racist underpinnings in any research." She had come to this conclusion through a thorough discussion of the article in her post, critically analyzing if it was "racialized research," the question asked by the professor. This student went on to say:

> The argument that Hispanic culture influences teen pregnancy partly hinged on the notion that it shapes desires among teens to value motherhood/ marriage over higher education. While I think it is safe to say that the Hispanic culture certainly values family, I was unsettled by the claim that this was superior to higher education. Again, proving desire can only be done by interviewing the teenagers themselves which was absent in the study. Furthermore, my own personal reaction was that Hispanic culture was presented in opposition to U.S. culture (stagnant, conservative, and not progressive). However, the population in question was Mexican-American girls. There was no acknowledgement of the hybrid cultural space that these teenage girls occupy.

This last statement is particularly indicative of an increased understanding of critical race underpinnings as this student recognized the intersectionality of the article's subjects. In responding to this post, another white female responded:

> Even aside from the race debate, is it appropriate and accurate to report that cultural beliefs are a risk factor for certain ethnic groups? It is so hard to draw the line between what could be useful information, and what could ultimately be more harmful and contributive to prejudice than helpful for a given population.

Another white female added to this comment by stating:

> It is important to be mindful of racialized research when drawing conclusions and this assignment made me sensitive to the apparently thin line that exists between drawing conclusions that lend helpful insight into disease, and conclusions that do little to better treatment of disease but rather suggest superiority of one race over another.

This increased awareness, and critical analysis of, such perspectives shows movement from narrative to counter-narrative as students applied what they were learning to articles they were reading and to their own belief systems and understandings.

Another interesting look at this increasing awareness came from a white male student when he referred to how researchers may "get off track" as they are performing research on minority populations. He defended such researchers, but then realized that even he could see where his biases come out. He stated:

> It is not as though the authors or researchers have a racist framework in mind but somehow, whether because of the guidance of the grant they are working under or in pursuit of or just being unmindful of phrasing, a body of work can quickly become ensconced in racism (or any other ism for that matter)…I am no way saying this was intentional but am trying to note how easy it is to build frameworks where we cite the causal factor as the identity of an individual. I am putting up my hand as a guilty party and having done it as recently as this week when talking in my group about section 2.

This viewpoint reveals an increased awareness of how studies can be unnecessarily racialized and perpetuate stereotyping or health disparities. His admission of guilt shows

that he is becoming more aware of his own biases, transitioning from mainstream to margin thinking.

Some students believed that the safeguards for human research put in place in recent years protect subjects from unnecessary racialization. One Native American female stated:

> While I agree that there have been many atrocities once committed against populations in the name of "research and science" I believe that we have learned a lot from our past mistakes and now have many safe-guards in place to prevent faulty or cruel research practices. There are now many ethical boards and standards that researchers must answer to, as well as IRBs (Institutional Review Boards). The fact is, if a researcher is conducting a study that will be more harmful than useful, it would probably [not] be funded by any major backer. It would also-hopefully not be pub-lished in a major journal or spread as misinformation.

This perspective shows that the student believes that safeguards have been put in place that eliminate racialized research, yet Leiter and Herman (2015) report on studies done in the 1990's, even with IRB approval, in which African-American children were unethically experimented on. This same student went on to ask, "What if we [public health professionals] can perform ethnicity based studies of populations to end health disparities, therefore using such studies for good rather than harm?" She went on to list some examples of such studies, then stated:

> When researchers account for outside factors such as the environment and SES [socioeconomic status] and there are still few answers to their

> questions, then simply-there is still work to be done and we should not be afraid to do so because of the mistakes of past researchers.

Interestingly, she does not say directly that when "there are still few answers" that this could be due to racism or discrimination. She implies that, but never says it directly. Another white male student went on to defend the intention of health care practitioners. He stated:

> There are many such instances and disease states that could benefit from having background knowledge of susceptibility and common responses based on genetic factors. The recognition of these differences between races, I feel, does not dispose a provider to racist or biased acts but rather focuses their efforts to overcome likely issues. The Hippocratic Oath all physicians take is, after all, 'to do no harm' (Hippocratic Oath Definition, Dictionary. com). It is therefore appropriate and responsible for conscientious physicians to consider race when developing appropriate drug and treatment strategies.

This statement reflects what sounds like an appropriate use of race in medicine, which is the current hegemonic stance, but ignores the current state of affairs as evidenced by the Institute of Medicine reports mentioned in the introduction previously (Smedley, Stith, & Nelson 2003; Smedley, Butler, & Bristow, 2004).

In response to a fellow student's claim that medical education should include working with marginalized communities, a white male student, who is a physician, stated that, "It could perhaps be incorporated into a one-month clerkship rotation into care of the medically underserved or non-mainstream medical practice." This student's use of the term "non-mainstream medical practice" reveals that the current white hegemony of

"medical practice" is the norm or "mainstream" which shows just how ingrained this "norm" apparently is for this student as he used that particular phrase. His statement about such a clerkship being a "one-month rotation" also gives the impression that cultural competency can be learned in a relatively short timeframe, something that the literature review and other participants in this study disclaim.

Some students did reveal increasing awareness about cultural differences among races and ethnicities in ways that reflected growth. One white female said, "I really feel fortunate to have learned more about this topic of cultural somatization in this course because it really opens my eyes to the vast array of cultural diversity that we will eventually be facing down the road." The exposure to "popular illnesses" in cultures as brought to the online discussion by individual students was quite varied and created a lively discussion among the students as they learned from one another, oft-stating that these were diseases and cultural ideas they had never heard about.

A white male responding to an online discussion about cultural humility related an experience he had when working in India that helped him understand this concept better. He shared his experience with educating communities about HIV/AIDS and the use of condoms and how this teaching was met with "significant resistance and even outright anger." He stated:

> I was forced to really re-evaluate how we would still achieve our goal while operating under the [cultural] restrictions. Ultimately we focused on discussion of sharing body fluids and left our audience to draw their own conclusions with respect to what activities that constituted.

Another student, a white female, added to this discussion saying:

> I hadn't really heard much about ethnomedicine before this week's class . . . These differences in cultural anthropology are very interesting and show the greater need that we as public health professionals will have to target and combat different illnesses throughout different cultures.

Two other students' statements briefly show, again, how much the course helped increase awareness: a white female stated:

> I think that this is an interesting subject … and I honestly didn't know much about it until I read your post and started reading up on it. The inequality among the Maori is clearly evident by the prevailing health disparities as well as the lack of cultural representation within the health system.

A Mexican male stated:

> Thank you for introducing a topic I had known nothing about previously. All of the discussions about Indigenous groups throughout the world all seem to have striking similarities in the horrific consequences of colonization, assimilation, and destruction of culture and traditional economies.

While this last statement does show this student making connections to concepts related to social justice issues (a counter-narrative stance), the fact that he was making the connection itself shows movement toward an increasing awareness of how many strands of cultural competence impact issues of health disparities and social justice, thus I place this quote in the narrative section.

All of these statements, taken together, illustrate how students learned through readings, other students' discussion postings, and their own experiences that cultural

competence is a multi-layered, complex concept that, in practice, is difficult. They all agreed, however, that it was important. Counter-narratives help to explore such increased awareness and more fully developed views that show perspectives from the margin rather than the mainstream. These perspectives are presented in the next section.

Counter-Narratives

Five counter-narratives were found in the current student data. I've labeled these: (a) service learning – an experiential learning process designed to place students into under-resourced communities to increase interaction with and appreciation of diverse peoples and their health issues; (b) reciprocal learning – learning within a service learning type of environment that goes both ways, not only does the community learn from the student, but the student learns from the community; (c) intersectionality - the way that various self-identities impact an individual (e.g., female *and* African-American) separately as well as simultaneously; (d) systemic/institutional issues – the acknowledgement of policies, modes of knowledge, environments, or organizations as inherently racist or racialized; and (e) racism/white as the norm – how racism is exhibited in health care and/or how white racial frames are set as the standard by which something is measured. The majority of the data fit into a counter-narrative perspective. Many of the students taking this course had previous experience working with cultures in other countries, were from minority cultures within the US, or were from countries other than the US, which likely contributed to more data that supported a counter-narrative view - these students came into the class with their dominant hegemony already challenged or with a different ideology to begin with.

Service Learning. Service learning occurs when a student works within a

community as part of their academic experience. The purpose of service learning for the student is usually not only to gain experience, but also to be exposed to communities of people that differ in some significant way from the student. These learning experiences also often partner an academic institution with a community that experiences a lack of resources compared to surrounding communities, thus often service learning programs occur within communities of color. This concept was mentioned often by students as a way to improve cultural competence.

One white male stated:

> To be honest, I don't know how you can teach this [cultural competency, CC] in a class. In fact, I think the most effective ways of teaching CC are outside the classroom. SWCOPH does a nice job of this through its service learning experiences.

This student was mentioning the one week intensive service learning opportunities that occur for students in border communities, rural areas, with Tribal peoples, or with immigrant families. This student went on to state that the emphasis on "evidence-based practices," which is a concept held in high regard in all of healthcare currently (personal observation), "stifles creativity of intervention design, especially when it comes to designing culturally relevant ones." He added that community based participatory research (CBPR), which comes from an emic, rather than an etic view, is a "promising research practice" that can help create more culturally sensitive studies and has the "potential to reduce health disparities." CBPR is a novel approach mentioned by many faculty members above that does look at subjects in studies from an emic (insider's) view, rather than the traditional etic (outsider's) view (Teufel-Shone, Siyuja,

Watahomigie, & Irwin, 2006).

Some short quotes that display this idea of the importance of considering the community or individual, and their needs, before developing a health care program follow. An Iranian female opined, "Many well-thought out and funded public health programs will go to waste if they do not appropriately address beliefs and perceptions in the target population." A white female reported, "It is impossible to connect with communities and make meaningful change if we are unable to display humility about their culture." A Mexican female stated, "Some studies indicate that community health frameworks based on Indigenous epistemologies may potentially transform the hegemonic power relationships that exist in the IHS [Indian Health Service]." Such impressions are things one can learn from a service learning experience. Another white female stated:

> While ethnophysiology can bring an extremely important awareness and understanding of cultural differences to the table and create more effective public health and medical interventions, …it is important to remember that not all members of a given population will fall exactly into the spectrum of beliefs of their perceived culture. It is important to remember not to stigmatize or stereotype based on ethnicity.

Each of these short quotes reveals that the students have a basic understanding of the importance of working *with*, not just *for* an individual or community. They see the value in taking time to understand the target population and develop health programming that considers cultural understandings of health and illness, while not stereotyping the population as a whole, nor the individuals from the population. Such a view is actually

one of the aims of service learning experiences.

Some more lengthy opinions expressed by the students that continue to show their understanding of the concepts above that provide a more layered perspective follow. A Native American female stated, "Collaboration between community and the medical system may provide successful outcomes that develop into improved systems. These systems may better address social determinants of health and provide support needed over a lifetime." She went on to describe a barbershop-based program to reduce high blood pressure among African-Americans that was effective. She used this as an example of how developing health care interventions from the communities' perspective can improve health care for community members and improve health care providers' cultural competence at the same time. Similarly, a white male described a study done with the Navajo Nation to improve healthier food options and to decrease diabetes in the population. He stated:

> The authors talk about the tradition of gardening with the Navajo Nation prior to US expansion and offers the idea that gardening and education in a multidisciplinary approach. The article discusses a program, Gardens for Health project, that can be implemented with the Navajo Nation to do the following: test for diabetes, treat the diabetes if found, provide counselling and education, and utilize the knowledge of the farmers and agricultural experts in the area to teach the Navajo Nation about this educational and practical approach.

These examples point out programs already in existence that demonstrate the type of culturally competent and respectful health programming that can occur if professionals

choose to use an emic approach. Such creative ideas show how important working *with* a community and their strengths is; another aspect service learning attempts to teach. Building further on this theme, a white male stated:

> I would suggest that the most essential connections that need to be formed are between groups and not within them. …interacting with people outside our group can open our eyes to different perceptions and different realities. It would appear that effort is required at the individual level to ensure that we do not become too rigid and set in one comfortable way of thinking and living.

This perspective shows that the student is thinking about how groups interact and how that can change the way health care providers think about ethnic groups other than their own; how such practice can challenge one's own perspective of the world; another aspect of service learning. This emphasis on experience and openness was seen as important to these students.

Many of the students had experience with minority cultures prior to enrollment in the MPH program. These students' statements often showed, personally, how working *with* people, instead of *for* people, helped diminish the gap between mainstream and margin. When discussing teen suicide in LGBT youth, one such experienced white female stated:

> Adolescence is a time of determining identity and much of identity is surrounded by socially specified gender based roles. When youth vary from these binaries they are marginalized by dominant groups. This marginalization may be seen as bullying, physical aggression, harassment, and abuse.

This student went on to describe how marginalization occurs, but said "we tend not to marginalize our friends." She describes how "safe spaces" for marginalized youth occur when people stop labeling and stereotyping each other. Her insightful comment continued:

> However, knowing that they [clients] create amazing ceramics, write touching poetry, run the mile in under six minutes, or build chairs out of recycled pallets makes a person less of a label and more human. It is the difference between a doctor treating a nameless patient compared to Molly, the new teen mother who is nervous about raising a child with her partner, Amanda and has questions about post-partum depression and thoughts of harming herself as she tries to juggle high school classes, a job and mother-hood. Interventions need to include ways to connect with people on a deeper level than to label them by some characteristic that does not define their identity.

This student appears to have a more complex view of the issues this study is exploring. She tended to articulate them in down-to-earth ways. This particular portion of her online input is well stated. She reveals a way that health care professionals can learn more about the populations they work with that increases cultural competence and decreases stereotyping or marginalizing. She used many of the principles in the PHCR framework in this and other contributions to the class discourse.

From all of these student contributions, it appears the students saw working with populations other their own as a good way to learn and increase cultural competency, *if* a person is careful to listen to and respect the population they are working with and refrain

from stereotyping the population. This perspective coincides with the purpose of service learning. Their quotations also reflect that this learning goes both ways, the subject of the next section.

Reciprocal Learning. While reciprocal learning is very similar to service learning, it differs by promoting an even more egalitarian process of education – the education and growth, while occurring in both directions, is more equal than in traditional service learning programs; the health care provider, while educating the person or community, is actively and intentionally learning from the individual or community, while both groups are growing in their knowledge and experience of one another (Wallerstein, Yen, and Syme, 2011).

From an observation of the service learning project presentations in the face-to-face class, one of the groups realized they had preconceived ideas of people before the project began and used the term "marginalized population" often, but at the end of their project they stated that Criss' concept of "shifting of consciousness" [reference to a course reading] was helpful to them as they moved from "academics to the real world" and that reciprocal learning was important. This group stated that "the impact you had on the community and the impact the community had on you" was an important aspect of this project as well as learning to "adapt your language to the community you're in is important. You need to explain some terminology." In an interview, a white male stated that he sees CBPR and the use of Promentoras (people from within the community trained for the health care program they are working with), for example, as they become more of a mainstay in the field, leading to more in-depth practices that are culturally competent. He went on, "Experts recognize the importance of exposure to cultures

different from one's own, but don't really stress the importance of imbedding oneself in the culture; they seem to be backing off of exposure to cultures." He sees this "imbedding" as critical for a health care professional to learn enough to truly engage in culturally competent ways with a community.

The online discussions included many quotes relating to this idea of reciprocal learning. One Asian-American female was describing her increased understanding of food and gender in Islamic cultures. She quoted one of the required articles as to the relationship between food preparation and patriarchy as not just one of a social hierarchy, but that this relationship to food and its preparation extends well beyond that. She stated:

> Rather, the relationship focuses on religion and community and the enactment and creation of an identity within the context of the community. Interestingly, in this context, the gendered aspects of food and food preparation did not perpetuate inequality, but individual empowerment… [that] may not be necessarily to promote gender equality as we traditionally understand it, but to emphasize empowerment within individual social contexts to promote health in regards to nutrition.

Her statement reflects an increased understanding of the community that affected her ideas of a health care subject and how she could address this issue differently than she would have without such knowledge increase. She increased her own learning from the way the community deals with a subject. While technically not reciprocal learning since she was not working within the community, this heightened understanding represents the type of increased knowledge that can occur prior to working with a community. Such knowledge increase can then enhance the learning when a health care professional is

actually working within the community, to enhance reciprocal learning.

In an online course discussion, a white male expressed his agreement with using community members' in designing research studies and mentioned this action in a way that shows the importance of reciprocal learning. He listed "five key points to minimize the effect of discrimination and stigmatization in these studies" that came from a required reading, then went on to add:

> I would suggest that it would be good to begin collaboration with the community by requesting the delegation of a group of representatives. This could give a voice to a variety of perspectives within the community. I would then suggest that those interested in this research topic collaborate with the representatives in the formation and modification of their research methods and study design, with a final stamp of approval being the end result of the collaboration.

This statement reveals how this student sees not only the importance of collaboration, but that the collaboration with community members be incorporated into a study design – an example of learning on the part of the health care professionals, then went on to state that the "final stamp of approval" would come from the community – the ultimate way of truly learning from the community; without that stamp, the study iterations would continue until the community was satisfied. This quote also mentioned making sure the "voice" of the community is included in programmatic or study design, an important critical theory concept.

In response to an online discussion question about ethnophysiology, the "way in which cultures conceptualize how their bodies work" (from class notes), several students'

comments touched on this idea of reciprocal learning. Some examples follow. An Iranian female stated, "public health program educators should attempt to take their ideas and use them in conjunction with traditional techniques that already exist," indicating that health providers must learn about the traditional techniques of a community. A white female stated, "Without clinicians understanding cultures other than their own, treatment, prevention methods, and research will be significantly impeded," expressing again the need for health care providers to learn and understand cultures. A white male stated:

> It is critically important to meet clients and participants where they are and in order to do that, health professionals must be able to garner an understanding of the cause, workings, and potential treatments as perceived by those within the population they are occurring…. Ethnophysiology is not only important to build understanding of the disease or illness for those providing support but it also helps build the bridge from the biomedical back to the people.

This quote represents a very good illustration of reciprocal learning as the student talks about a "bridge" to connect the two populations – providers and people. A Native American female added to the discussion by saying:

> The researchers of this study [a study she was addressing] also found that only around half of the identified plants that Cameroonian's have used for antimalarial purposes had been scientifically validated and some of them had even helped in the creation of new pharmaceuticals. Future research that can help validate more plants may also help in the creation of new medicine.

This example reveals a different, but also important, aspect of reciprocal learning – health care providers can learn about new ways to treat not only a community they are working with , but extend such processes and discoveries to other people groups as well.

Several students discussed the importance of relationship building as one way to improve and increase reciprocal learning. The following quotes are similar to the student above who talked about knowing people as human beings with lives, rather than as stereotypes. One white female stated:

> It is the interplay of understanding that leads to relationships that can pave the way for health care professionals to educate larger groups of individuals about health practices that can create ripples of positive healthy choices. This type of cultural competence allows for a broader range of 21st Century health education to be achieved, but it may take a little bit of folk health education on the part of current day health care providers.

Her addition of the "take a little bit of folk health education on the part of current day health care providers" is a humorous way of stating the importance of, and humility involved in, reciprocal learning. A Mexican female stated, when talking about a common Hispanic culture's stomach aliment, "it is important for these populations to feel that the practitioners actually understand these concepts in order for them to trust them and approach them for treatment." This idea of trust was stated by several students along with the importance of relationship. They iterated the importance on the part of the health care professionals of learning about the culture and accepting the culture's ideas about illness to engender trust on the part of the community toward the health care practitioner.

Intersectionality. While quotes that represent this theme were fewer in number than those for other themes, I felt that this theme was important, because it is an aspect of critical race theory and one that is often overlooked in studies. These quotations from interviews and the online discussion represent complex, critical thinking.

From interviews a white male stated, "working in cultures other than your own is too broad a phrase – each individual is made up of several 'cultures' – gender, religion, community, race, ethnicity, etc." This quote shows a very direct mention of the idea of intersectionality. A white female stated:

> Cultural competency is very subjective, and difficult to define. Culture itself is often a term that should be allowed outside the box of region and/ or race. We each fall into cultures we don't even realize; the culture of athletics, the culture of professionals, the culture of heterosexuality, the culture of the middle class, etc. I think the task of offering a culturally competent environment will forever be ongoing in any subject and/or field.

These quotes show the depth of understanding of this concept – how very complex culture, race, and ethnicity can be (Delgado & Stefancic, 2012)

A few quotes from the online course students revealed their more complex understanding of culture. A Native American female stated, "health care planning and delivery is influenced by the conceptions of different societies and cultures and as we have learned throughout the course, these conceptions are shaped by social class, poverty, race and ethnicity, and gender, sexuality and health." Several students listed many of these factors as influencing health and health outcomes as being important aspects to consider when working with cultures other than one's own. Knowing that the

intersections of many factors of an individual's life affect illness and wellness is a big step toward cultural competence on the part of a health care professional, for it is in these nuances of a person's life that understanding the whole person can begin to occur (Crenshaw, 1991). Too often in health care, practitioners treat the presenting problem without consideration of the many identities of an individual and how these various identities might impact treatment or outcomes. By acknowledging and working within a person's full range of identities, a health care practitioner can provide more appropriate, culturally sensitive care.

Systemic/Institutional Issues. Quotations that reveal students' understanding and concepts of systemic or institutional aspects of health care and health care delivery that may decrease cultural competence and may lead to health inequities or social injustice are presented in this section.

In an observation from the face-to-face class as they were discussing health disparities one white female student stated plainly, "How privileged are we to be sitting in this classroom?" She went on to talk about privilege. The acknowledgement of privilege is relatively uncommon among whites (Holland, 2015), yet does impact health outcomes. This is a systemic issue. In an interview, a white male stated:

> Unemployment rates, poverty rates, incidence of chronic disease such as diabetes, all appear to be connected to a lack of CC [cultural competency] on the part of individuals and institutions intending to serve persons who suffer from health care disparities and social injustice.

This plainly stated linkage to an institutional component of cultural competency, health disparities, and social injustice is clear. Another white female student interviewee also

stated plainly, "I definitely think cultural competence is necessary in order to move forward in closing gaps in health outcomes among at-risk populations. Racism, judgment and classism perpetuate injustices socially and in health outcomes." A Mexican female interviewee stated, in reference to her own culture and the lack of real progress on the part of Mexicans in the US, "It's really the power structure…why can't we get past this? We work just as hard. What is it? And then you start to examine the structure of power, the power dynamics." This same student went on to add that in academia, it is what gets prioritized – if research that reveals systemic or institutional problems with health inequalities is prioritized, then it will get funded; if not, such research will not get funded. She saw a direct connection of priority and money to health inequality research.

The discussion questions from the online class during week two encouraged students to write about the social determinants of health. There were many students who clearly saw systemic and institutional problems contributing to poorer health outcomes for communities of color. One white female wrote in a discussion about the disparity of health outcomes between whites and minorities:

> The physical and social environments are fundamental to the health outcomes of individuals and communities. The recurring process of poverty, chronic stress, and material deprivation, increase the likelihood of harmful behaviors and choices. . . . The availability of resources and design of a community is important in building a healthy environment.

This student went on to talk about systemic and institutional factors that affect physical activity, then called for policies to change these factors and improve equality in environments that promote lifestyle health behaviors. A classmate, a white female

student, also described the systemic and institutional factors that impact respiratory diseases differentially between whites and communities of color, in a way that was similar to the above quote. Another student, a Native American female, discussed low birth weight outcomes disparities and the social determinants that can create such disparities for women of color. These quotes and perspectives all revealed students' understandings of systemic or institutional reasons for the disparities.

The following quotes reveal that some students used examples that brought together critical thinking and health outcomes, making linkages in ways that reflect the PHCR framework (Ford & Airhihenbuwa, 2010b). A Mexican female was very direct about her analysis of the systemic and institutional factors that impact health. In an online posting challenging one of the required viewings, she stated:

> Health is shaped by the interplay of social conditions and larger social, political, and environmental contexts on health statuses. Social justice serves as an underpinning in the discourses of social determinants of health (SDH)…there is more to the health status of the individual than their proximal social interactions. …If health status was dictated simply by our individual social networks, then there would be no reason to seek to change public policies. Change would only need to occur on an individual scale. Moreover, Christakis's [required viewing] theory echoes the tenants of neoliberalism by citing health as being a matter of individual choice. This reductionist analysis does not critically interrogate the institutional mechanisms affecting the health of the individual. Health and SDH are more complex.

This student had a great deal of experience not only with communities of color, but with the writings of critical researchers, thus her discussion postings were often critical and challenging. She has a background in education as another of her quotes reveals below.

Some students saw the uneven playing field that exists between privileged whites and minority individuals and how that affects lifestyle behavior choices as problematic. One white female stated it in this way:

> I can see where Keeney's [required article] "personal decisions" point of view is being skewed. It is true that we ultimately do have a choice to be healthy, but only when we have the opportunities presented to us. … Keeney's theory could be true if despite all of these advantages, a person still chose to live an unhealthy lifestyle. But this is clearly not the norm. Keeney ignores the large segment of the population that is not faced with these opportunities…It is the social determinants themselves that restrict a person's ability to gain opportunities to live healthily. …Essentially, if every person were faced with the same choices, economic successes, and opportunities, Keeney's analysis would be correct because it would simply be a personal choice.

This student is getting to the heart of the idea that the systemic issues currently found in the US can negatively impact people's choice to live a healthy lifestyle. It is more than just a person's decision that impacts their options for healthy lives, it can be their environment, their opportunities, or even their race. This same white female, who comes from an educational background, was more direct when discussing this issue in a later online post, even bringing in critical race theory in her commentary:

> I'm not sure I can explain fully how, as a person with a background in education rather than public health, I fundamentally view many of the issues around SDH [social determinants of health] as issues with education as much as issues of health. In my EDL 625 class, Leadership for Diverse Communities we discuss the ways in which the middle and upper class have shaped policies for people of color in Tara Yosso's (2005) exposition of Critical Race Theory. Yosso posits that dominant cultures are not the only cultures with social capital and she discussed the need for advocacy and education to create more equitable situations for individuals of color.

Her exposure to writings that describe systemic and institutional disparities in the educational field are linked, in her opinion, to the health care field as well. Although she went beyond the course's description of health disparities by bringing in critical race theory, this quote fits tightly with my own thinking about these two fields of study. This student went on to say, later in the semester, that:

> I read the postings and it is as if all of you are speaking a different language than others with which I work in the field of education. We need to find a way to find common discourses that translate into any field of study so that health is brought to the forefront of interdisciplinary teams to solve real life problems today and in the future.

This addition to the student's perspective mirrors my own and complements the direction of this study. It also complements the quote from a faculty member about disciplines working together to decrease health inequalities and bring about more social justice in health. I was not expecting this finding from students, yet since this student's background

is education, it does make sense that her perspective reflects my own as I consider this study's objectives.

Still other students went beyond health care in the US to see a larger contributor to health inequality by bringing in the concepts of global capitalism and Marxism. A Mexican male stated:

> I think what is interesting is that Marmot and the CSDH [World Health Organization's Commission on Social Determinants of Health] kind of gingerly finance the role of global capitalism in global health and as a driver of SDH. While clearly pointing the finger at economic inequality, they kind of demure from calling it out by name and suggesting any more radical of a political project. Venkatapuram [required reading] in particular talks about the drivers of SDH and gets closest to pointing the finger directly at capitalism in talking about the upstream drivers "specifically the inequitable distribution of power, income, and resources" (p. 122). Unfortunately, even he kind of keeps veering away when he talks about economic, social, and political processes "driven" by cultural values (p. 124). And we know the reverse is true. These social and cultural values are driven by a particular mode of production.

While the above quote is interestingly blunt, another student, a Mexican female, connected that blunt quote to Marxist thinking. She stated:

> I also think a Marxist analysis is very appropriate for SDH. Wilkinson & Marmot [required reading] discuss intergenerational poverty and its health implications, which is a phenomenon easily explained through the

> theoretical framework provided by Marx. The heavy reliance of agency of the individual is where Christakis's theory [required reading] fails for me. A Marxist analysis would argue that there are institutional mechanisms in place in society that hinders complete agency disallowing us from being able to have complete choice of our social networks/contexts.

This same student added to her opinion in a later online post, directed toward another student, about having choice in lifestyle behavior change to improve health. She stated:

> You make some great points in your comment. You seem to be framing this issue as being an issue of pure choice. Unfortunately, not everyone is in a position where they get to choose their context. It is within these contexts that construct the majority of individual's social networks. … Just as health mirrors populations' distributions of deprivation and privilege our social networks also mirror this deprivation and privilege.

All of the above statements reveal that students are cognizant of many critical concepts and how they relate to the topic of health disparities and social justice. The students who have more experience with communities of color, or who come from minority populations (in the US), did make more of these direct statements than students with less or no experience with populations other than their own, but because many of the students in both classes did have experience with cultures other than their own through Peace Corps, travel, service-learning experiences, etc. the comments were complex and multi-layered.

Another aspect that students discussed that relates to the systemic and institutional basis of cultural competence, health inequalities, and social justice is in the realm of

science and scientific inquiry as it relates to categories of race and the genetic similarity of humans. Although these comments could be placed under the racism theme, they are included here because they were comments on science and scientific research, an institution and also a system of beliefs. A Mexican male responded to another student's post about sickle cell anemia being primarily a black disease with these comments:

> As public health practitioners, medical doctors, and researchers how do we engage with these categories [of race] being cognizant of the history and careful to not reproduce racist discourses and unintentionally engage in discrimination? Social justice and equity are explicit goals of public health. But I believe they should also be explicit goals of health care and research. And that is why I will argue these old categories must be rejected and new language and definitions must be developed.

This same student went on to talk about a book, "The troubled dream of genetic medicine: ethnicity and innovation in Tay-Sachs, cystic fibrosis, and sickle cell disease" which delves into the history of how these three diseases became racialized and the harms that racialization has done with regards to research, care, and access for each of these diseases (Wailoo & Pemberton, 2006). He points out that, "Sickle cell anemia was among those diseases pointed to demonstrate the inferiority of those of African and Mediterranean dissent [sp] and argue for miscegenation and anti-immigration laws." This student was getting to the heart of the idea of the social construction of race and how it gets used by majority researchers in ways that are not always pure and impartial. Several students added to the idea of race as a social construct and how it gets used in science. One white female stated:

> Few articles pose the questions and share the realities of there being greater genetic differences among similar populations than those of different racial groups. Race is not a "scientific reality" but a "social construct" (Bowser, 2000). Geneticists have shown that the variation among racial groups is only a 10 percent difference, as most of the association is attributed to the genes of skin color (Bowser, 2000). However, scientists among the research community have been divided on the relationship of genes and race when determining the probability, prevalence and human disease outcomes.

This student's assertion that scientific research rarely exposes the fact of how faulty race and genetics can be, helps make the case against impartial, race-neutral science. An Indian male added to these postings with a specific example of how science has used racial categories in osteoporosis research. He stated:

> Megyesi, Hunt and Brody (2011), examined the issue of racial classification in osteoporosis by looking at 55 articles that included bone density and race/ethnicity as key variables. They discovered that race and ethnicity were often highly variable and discussion of how race/ ethnicity was determined was often "vague and idiosyncratic." Racial/ ethnic groups were defined by a wide variety of attributes including skin color, place of birth, political unit, language and continental region. Because of this, the authors note the same label was often used to describe people from various geographic regions.

This observation reveals that the student understood how problematic categorizing race

and ethnicity can be. A Mexican male added to this discussion in terms of how such "science" gets interpreted and used by the rest of the scientific world and the general public. He stated:

> My understanding of Bhopal's [required reading] argument is that epidemiological research which disaggregates data based on race/ ethnicity is not in fact showing any casual mechanism related to race or ethnicity. However, there is an implicit message of correlation and causation in how this data is reported. Bhopal says this gets read as racial and ethnic minorities being less healthy and a burden to society. The causes of the poorer health are then ascribed to the racial and ethnic origins of individuals.

This quotation shows a cogent argument for the way that research can be used to imply negative factors - or positive factors, but that is rarely the case as evidenced by Yosso's research on looking at capital in minority populations (Yosso, 2005) – as being associated with simply being a certain minority rather than looking at the broader contexts within which minority populations tend to live and work. A Mexican female further added to this discussion using an interesting concept in science. She stated:

> Rather than a simplistic explanation of race and disease there needs to be an interrogation of the larger institutional issues at play that may contribute to adverse health outcomes--like how living conditions can prove to be pathogenic for minority populations. We need to work towards dismantling black box epidemiology in order to get to the crux of what is the root causes of diseases.

This student goes on to discuss the way that minorities are often seen through a deficit model lens. This deficit model thinking was mentioned above by Dr. Z in the face-to-face class and by other current students as already mentioned. This Mexican female added that when positives are found they are viewed in the literature with suspicion. She stated:

> The example I thought of while reading this article was the Hispanic health paradox that discusses the low mortality rate among Latinos in the United States relative to non-Latino whites. Generally, the Hispanic health paradox is referred to as being a "mystery" or "inexplicable" which I find interesting because it is a positive health outcome. It seems as though negative health outcomes for ethnic minority populations don't receive this type of analysis—meaning there seems to be an explanation for negative health outcomes more often than not.

This observation is quite germane to the topic of this study – how marginalized communities are viewed by the mainstream (Ford, 2014) – with deficits rather than capital (Yosso, 2005). In response to this post, another white male student stated, "I believe, and this may be idealistic on my part, that this is not the intention of the majority of those conducting this brand of research." This same Mexican female replied back:

> While it may not be the intention of the researcher, it is unfortunately the consequence. These studies contribute to the larger cultural discourse on race, ethnicity, and health. This consequence can be far reaching. I think the most important aspect of this consequence to consider is that the scientific knowledge that is generated is a product of the cultural context meaning scientific knowledge is more telling of the historical moment

than the actual scientific discovery.

This response, as well as the many others listed above, shows that this student is quite cognizant of the systemic and institutional issues imbedded in health research and health practice. It was interesting that a white person responded defensively (mainstream thinking) to the Mexican female student's post, but this Mexican female student allowed her voice to be heard, as a minority (centering in the margins). All of the preceding comments reveal great depth of thinking about these issues on the part of the students in this course.

Students had an assignment in the face-to-face class to complete a service learning project. While this data could fit into the service learning theme, it is what these students said *about* the experience that places this portion in the systemic/institutional issues theme. That semester the students worked with Enroll America, an organization dedicated to educating people about their options under the ACA; not enroll people, but let them know what is available to them. Students formed groups and decided the location of their service learning site. Each group was instructed by Enroll America, then provided education for the public in various locations; primarily places where low income and minority people congregated as they are the populations most likely to benefit from the ACA, as they tend to be un- or under-insured (Morgan, Kuramoto, Emmet, Stange, & Nobunaga, 2014). Project presentations to the class revealed that all seven groups discussed how their biases and stereotypes were challenged, how this experience helped them begin to "see" through the eyes of their selected population and show them they needed to be more open in their perceptions, less biased beforehand – these are systemic issues. These observed presentations added another layer to the data as

students revealed what they learned.

One group who presented Enroll America at a mosque was extremely culturally sensitive in their approach because one of the students in the group was Muslim. This student made sure to follow accepted protocol by asking the wife of the imam if this project would be acceptable, then asking the husband. They also planned to set up separate tables for men and women, but were allowed to only set up one table. Discussions among class members during the presentations, which occurred in the second half of the semester, did indicate that the service learning project helped students view their role as health professionals more critically: they learned to listen to the "voice" of "others" and gained a respect for acting in ways that were more culturally sensitive. During presentations many students expressed the realization of socially constructed knowledge and how their perspectives were challenged, as well as how much race and the structural determinism of systems and institutions play in health inequalities. Another common theme of the presentations was that because the students were primarily white, or could be viewed as white by others, they struggled initially to get people to come over to their booth to discuss the ACA options. They talked about "reciprocal learning" and remaining neutral and inclusive in their interactions with the communities they visited.

These service learning projects, although performed in various sites and with various marginalized communities (Native American, Muslims, low SES, Hispanics, children), had influences on the students that matched the PHCR model above (Figure 1). Such experiences may help to create more antiracist praxis (Ford & Airhihenbuwa, 2010b), or as Cabrera (2012) states, working toward a racial justice alliance praxis. These experiences helped students begin to "see" the systems that maintain the status quo of the

current health care system and how they can begin to break that down to improve the health of minority peoples. These courses also allowed minority students to have a voice in the course discussions.

Racism/White as the Norm. Students appeared to see how racism directly affects cultural competence, health inequality, and social justice issues in health care. As mentioned in the narrative section under the "white as the norm" theme, the majority of students saw this concept as problematic in health care. Statements that address this concept as an issue that should be critically evaluated and challenged in health care are presented here. This section starts with a discussion from the face-to-face class after a video about happiness, covers some comments from interviews, and then ends with remarks from the online course student discussions.

When discussing health disparities, one white male student pointed out that "some of this portrayal of happy [from an in-class video] allows the continuance of the status quo – allows wealthy nations to justify their wealth." Another student, an Indian female, stated that "social hierarchy can happen no matter what." A Native American female student stated "some cultures see themselves as part of a community, not so much as individuals, they have a feeling of 'I don't come first, the community does.'" This discussion went on as students shared various opinions about happiness and what that means, revealing that many students could see how the definition of happiness that is often used as a standard stems from the white hegemony that much of our health information stems from. Some students did use the term racism to describe why a "white" definition of happiness, as well as other health-related terms, is so often used in research.

Other students voiced the idea of hierarchical systems with white being the

standard as well. From the interviews, three students made statements that reflect this theme. One white female stated:

> So often with international aid and development it's like, 'oh, let's build a school for this impoverished community,' but no one considers that in that [community] students are more needed by their families in the fields or that qualified teachers are not going to want to move to a community out in the bush especially when they may be from a different ethnic group.

This observation shows insight this student has about how coming from an etic, in this case white perspective, may not serve a community well, yet how often (her "so often") this actually does happen in public health programming (London, 2002). An Iranian-American male stated, "I believe that disparities and social injustices are caused by a lack of cultural competence and understanding. When an entity or person does not understand another culture is becomes easier to oppress them." The fact that this student actually used the phrase "oppress them" is interesting. That is a very strong word to use, yet this was his opinion. He seems to be alluding to how colonization has negatively affected so many cultures (Sherwood, 2013) as this subject was part of the discussion as well. A Mexican female interviewee had quite a bit to say about this concept. She mentioned how she felt that her voice, as a minority, was not always heard in a classroom setting. Her comments:

> I like that in this class, this is the first time I really see it a little more blunt, but I think it could be more and less up to the students. I feel like we have responsibility in that and maybe, well I feel that way. But maybe sometimes we are just trying to get through the classes, you know? I know

> from the one environmental health class, for example, I would be like, 'this is what it is, this is what I think' and no one would reply to me. And it would be like, "Ah man", and so I would try to be more censored and I would get replies. I was comparing that and I was like, "that's not cool. I'm going to write what I want, and I'm going to reply to people."

Her observation that she sometimes had to "censor" herself shows acquiescence to the status quo, but she realized that such censure did not serve to further classmates' knowledge of how individuals in minority communities may feel. So she chose to state her opinion no matter what other students might comment. She was willing to allow her voice to be heard to challenge the status quo, but did so only after initially silencing herself and her voice. She added to this idea later in the interview by stating:

> That's why it is what it is, because a lot of people in public health are white men and they don't experience oppression or experience discrimination. It's really what it is underneath, but you can't really say that because you'll be dismissed with "That's not a race issue, that's for social science.'' Even though we are social scientists!

This observation was blunt and spoke directly to the idea of how viewing health care issues from a mainstream perspective marginalizes minority voices (Ford, 2014).

Week two's discussions in the online class related to the social determinants of health, so engendered a lot of student comments around this theme of racism and using whiteness as the standard when evaluating health care issues. A Mexican male stated:

> [Name of another student], your comments in particular grabbed my attention for focusing on the physiological and psychological effects

> of racism across other socio-economic categories. I wanted to add to your discussion of the role of racism in negative health outcomes for African-American women and share a resource you may find helpful. Since the interrelationships of biology, genetics, and social determinants is so complex and the discussions often dominated by reactionary ideologues trying to construct biological and genetic justifications for racism, as public health workers we must always critically engage with the science.

This student went on to list a resource that, he stated, would contribute to another student's increased understanding of how racism and discrimination negatively impacts health for minority populations. The Mexican male student provided this resource, despite the fact that there were already several articles dealing with the issue. To me, this interaction reveals the importance of whites being able to learn about what it is like to live in the margin from those who live it every day, a PHCR goal according to Ford (2014).

Some brief comments that highlight students' perspectives of this concept follow. There were so many comments related to this concept in the data, that condensing them to expose many students' voices made more sense to showcase the variety of responses. A white female stated, "I think we need to encourage public and private organizations to step in and ensure that minority populations are receiving the same types of opportunities and health care advantages that whites are experiencing." Another white female, talked about the PBS special "Unnatural Causes," a documentary that outlines how racism directly impacts negative health outcomes. She stated, "'Unnatural Causes' concludes

that internalized, personally mediated, and institutional racism may play a large role in the overall health of these populations." When the group was discussing one of the required readings, a Latina stated:

> Although the term "black box" epidemiology has been defended in terms of "risk-value" epidemiology which may provide useful interventions in the absence of known causal mechanisms of disease, when research is also associated with an overall racial bias, I think the focus becomes tainted. The "black box" can also be synonymous with trying to 'put blacks in a box' of constant disparity.

This direct comparison of "black box" epidemiology to racist actions was quite blunt. Another student, a Mexican female, added "Regardless of health outcomes, it must be recognized that education designed to dissuade cultural standpoints explicitly or implicitly presupposes a hierarchy of beliefs." These students recognized the stratification that occurs within health care when white hegemony is left unexamined and how that hierarchy places whites at the apex.

In a discussion about racial categories and their utility in health care or their misuse, students again had many comments. While some of the students did relate the common opinion in public health that racial categories help to uncover areas of under-resourced or under-treated minorities (Levy & Sidel, 2006), most students took the tack that these categories are social constructs that, due to the genetic similarities among groups, only serve to racially profile or harm minority populations. A Mexican male stated:

> But how do we categorize and understand genetic predisposition? Do

> we do it in ways which recall the racist past or reproduce racist discourses? We have to struggle and find new language. Healthcare on the genetic level offers us a chance to confront and reject the racist past and find a new way of recognizing and naming diversity and difference.

Several students had mentioned how our current language in health care and health care research limits our ability to talk about race issues and the above student also mentioned language as being problematic. In a posting later in the semester than the above posting, this same student stated:

> I think this is one way in which public health can lead health care and research. This old language is still being reproduced in research and manifesting itself in our understandings of how to treat an individual with all of these social markers of race and gender etc. One I think he [referring to an author] misses is how a perception of race can influence what a patient is treated or screened for. If the idea of racial etiology (or even just the old language) persist in research, that carries through into how a racialized person is understood by a provider.

A white male student echoed this sentiment when he stated:

> It would be incorrect to say that racism does not permeate the healthcare system, and while there may be clinically relevant reasons for knowing a patient's genetic makeup, some physicians have biases and implicit attitudes towards race that have the potential to influence how they treat patients.

An Indian male student added to this discussion by stating a specific example of physicians treating hip fractures in female patients. He stated, "And even after adjusting

for socioeconomic status, African-American women who already had fractures due to osteoporosis were still less likely to receive screening or treatment for osteoporosis than white women." Since these fractures were ultimately attributed to the fact that the women had osteoporosis and no other cause, this finding shows a clear case of racial bias against African-American women. A white female summed these ideas up by stating:

> The ideas behind Black Box Epidemiology follow Link and Phelan's (2001) concepts of stigma which are defined as "when elements of labeling, stereotyping, separating, status loss, and discrimination co-occur in a power situation" (p. 382). Bhopal (1997) purports that race is used as a labeling difference for diseases when there is little evidence of physical or genetic differences. It is through this labeling difference that individuals of color are separated and discriminated against through the use of standardizing whites as the status quo.

This quote points directly to racism and using white hegemony as the standard in health care.

During the week of discussion about the health of Lesbian, Gay, Bisexual, and Trans-sexual (LGBT) populations, many of the same issues that relate to racism came up about inequalities and injustices faced by individuals within the LGBT community. A comment by a Mexican female stated:

> Distrust in the institution of health linked to a history of medical and psychologic interventions that oppress lesbians, gay men, and bisexual persons coupled with social conditions characterized by rejection, discrimination, prejudice, and stigma distinguish public health of LGBT

> populations. …Discrimination, homophobia, irrational fear and hatred of lesbians, or the privileging of heterosexualism as normative has been attributed as factors for the understudying of IPV [interpersonal violence] in lesbian relationships.

This description could be used about many of the minorities mentioned by students during this course; the discrimination, the distrust of the medical profession, the use of white hegemony as the norm, etc. have all been described in this data set about various minority, non-white, populations.

During week nine in the online class discussions, the problematic use of "Western medicine" as the norm was commented on by several students. One Asian-American female stated, "While the biomedical model of health is the predominant model used to view health and disease in Western medicine, such model is not necessarily the way in which all communities conceptualize health." Another student, a white male added, "While public health, health, and support professionals want what is 'best' for those it served, it is important to recognize that the professional consideration of 'best' may not always align with the ideas of those within the community." A Nigerian female added, "Many public health interventions have been unsuccessful because they attempted to supplant the local health practices with ethnocentric ideals of health." An Asian-American male stated:

> I agree that ethnocentrism in public health will only prolong the mis-understandings between foreign nations, and the efforts to battle inter-national diseases will only be hindered…. Healthcare programs do not always need to focus on the results of scientific research into innovation

> systems, but rather on how local communities, in a network of supportive partnerships, draw knowledge for others, combine it with their own knowledge and then innovate in their local practices.

This student's comments push for empowering communities of color by utilizing their own practices in combination with "supportive partnerships" rather than hierarchical practices that dismiss or ignore the cultural wealth (Yosso, 2005) a community has regarding health care. A Mexican female commented on some of what the students had been learning in this course when she stated:

> In our society, the biomedical model has been framed as the scientific truth of human physiology. However, the concept of ethnophysiology illuminates the fact that this is a scientific *and* cultural formulation of health and the human body. …This means that we must not only have an understanding of the biology of illness, but also how culturally-rooted belief systems conceptualize the functioning of the human body. [her emphasis]

This summation reflected the discussion the students had surrounding this topic of the biomedical model – the current standard in health care in the US and how problematic it is in regards to communities of color.

Closely related to this subject was the idea of increasing cultural competence of health care professionals by increasing the number of practicing minority health care professionals. A Latina addressed this issue by saying:

> … given all the evidence of broadly rooted bias, it would be absurd for an institution to presuppose that it and its health professionals are free of

> racial and ethnic bias. Therefore, it is imperative that people of color be actively involved at all levels of health care. More recruitment is needed to gain underrepresented ethnicities in the medical profession, especially to bring different perspectives to research, since it is their health at stake.

This student makes a direct argument for increasing minority health care practitioners. Adding an additional layer to this comment, a Mexican male student said:

> Education of providers seems to only get us so far in achieving better health outcomes. . .health care has a distinct and complicated culture in its own right. Interacting with and navigating that culture is frightening and intimidating in the best circumstances. There is also the challenge of how to diversify the medical provider profession. Sky-rocketing tuition and increasing exclusivity of higher education is not helping to diversify the provider base.

Not only did this student address the cultural divide going both ways in health care and advocates for more health care professionals of color, he even mentions a systemic barrier to this happening – the socioeconomic divide when it comes to educating health professionals. This student's comment addresses several of the aspects of the PHCR framework (Ford & Airhihenbuwa, 2010b). Other students continued this thread discussing the importance of expanding the diversity of health care practitioners to reflect the populations the health care profession serves, as well as continuing to help educate health care providers on the importance of cultural competence.

Amount of Cultural Competence Education in the MPH Program

This section lists interview responses from current students when asked the

question, “Do you think there is enough/too much/too little training on cultural competency in the MPH program?” The students’ direct quotations are presented here because they are candid and provide some context to their responses. As mentioned, these quotes are included in a separate section because they provide an additional layer of understanding students’ perspectives on the issue of cultural competency education.

The following students felt that there was too little cultural competency education in the MPH program (four of the eight): BB (white male) responded, “Most people will say that it is sufficient, but that’s based on the social determinants model which doesn’t truly address the social justice issue, so I don’t think there is sufficient training on cultural competency in the MPH program.” AR (Iranian-American male) said, “I believe that cultural competency is rooted in many aspects of MPH classes, yet more emphasis on it would be critical for practitioners.” DP (Mexican female) responded, “I think it is too little. I mean, it’s great that you have one class that is mandatory, but in public health that should be expected. I think the service learning courses do a great job.” EL (white female) stated:

> I’ve actually been somewhat shocked that cultural competency hasn’t come up in any of my classes yet … I just came back from 2 ½ years in the Peace Corps in West Africa . . . , so I’m probably somewhat biased. So yes, there is far too little training in the MPH program.

These sentiments show that half of the interviewees felt there is too little cultural competency training and expressed the importance of this education for public health students.

The following set of interviewees (three of the eight) stated that they felt the

amount of training was about right, but added the caveat that service learning projects were an important part of this education. CC (white female) stated:

> Since cultural competency can only be really learned and adopted in practice, not abstract academic theory, I believe the program does its best to approach this topic and teach students at least what to look for and ask once they graduate and have the opportunity to really learn cultural competency in the workplace.

SM (white male) stated:

> I'm not sure whether there is too little training on cultural competency in the MPH program. To be honest, I don't know how you can teach this in a class. In fact, I think the most effective ways of teaching cultural competency are outside the classroom. SWCOPH does a nice job of this through its service learning experiences.

KW (white female) responded:

> This is a difficult question to answer because I don't particularly think there needs to be specific courses or training on cultural competency. Instead, this should be something people bring from outside the program. And most students and faculty do come into SWCOPH with cultural competence based on the many experiences they had before entering the program.… I have had a very good experience with professors and their cultural competence.

It is interesting that these sentiments match those of faculty members about the importance of service learning activities and experiences, not just academic classroom

preparation. The final student interviewee, WD, a white male, also felt that cultural competency education is about right in SWCOPH's MPH program, but he added an interesting twist. He stated:

> Not too much, not too little, just right. Current level raised my awareness of the need for cultural competency and how to achieve it. More emphasis on cultural competency would make me uncomfortable in my own skin (i.e. make me feel, as an old white guy, even more 'politically incorrect' than I already do).

This response shows insight this student gained about his own "whiteness" due to the education and training he has already had in the MPH program. While he is reticent to have more, the education he did get helped at least raise his awareness of this majority/minority difference, something that often whites, even college-going whites, don't experience (Cabrera, 2014a).

Overall, current students felt there was too little or just the right amount of education in cultural competency at SWCOPH. They also recognized the importance of experiences (e.g. Peace Corps and service learning activities) to increase cultural competency in practice.

Current Students' Perspectives Discussion

From the above examples and quotations, current students' comments fit well into the PHCR framework with more counter-narrative themes, than narrative themes. The majority of comments revealed a good grasp of the concepts discussed in the cultural competency courses and how cultural competence relates to health disparities and social justice issues. They commented among one another on these concepts in ways that

showed perception of nuanced issues, along with depth of understanding. Interestingly, and not surprisingly, the minority students' comments fit the PHCR framework most closely. Data included comments about race as a social construct (focuses 1 and 3), structural determinism (focus 1), the social construction of knowledge (particularly when discussing the scientific method and how this impacts our understanding of health among minority populations; focus 2), the importance of voice (focuses 2 and 4), intersectionality (focuses 3 and 4), and even critical approaches to the concepts and critiquing the health care disciplines (focus 4).

Alumni Perspectives

Interviews were the only data set available to examine alumni perspectives. There were eight interviews total; six from white alumni, one from a Mexican-American alumnus, and one from a Hispanic alumnus (self-reported ethnicities). All were female. Looking at just the interviews from white alumni when answering the question, "How do you define your own culture and its impact on health and disease?," the range of responses revealed intellectual movement from being in the mainstream to understanding views from the margin (Ford, 2014) and so are presented under narrative as they are not quite counter-narratives. This data was unlike the other two populations (faculty and current students) and because of its uniqueness, full responses to this question are listed with comment. When answering questions about cultural competency in professional practice and its relationship to health disparities and social justice, all alumni responses revealed two counter-narrative themes.

In addition to the narratives and counter-narratives, a separate section that presents alumni perspectives on how they felt about the amount of cultural competency

training they had in their MPH program will be reported. This section is placed separately because while these responses do not fit neatly into a narrative or counter-narrative category, they do represent interesting data that informs the overall final analysis just as in the current student section.

Narrative

One narrative was seen in the alumni data and, as explained above, was revealed as participants defined their own culture and its relationship to health and disease. The range of responses is presented here in a way that exhibits this transition of thought, starting with those statements that expose a white as norm ideology and moving on toward those that begin to approach a counter-narrative stance. This process is for the first six of the eight responses which are from white females. The two minority alumni responses were short, but provided important information on perspective and are presented last in this section. These last two responses are from a Mexican-American female and a Hispanic female.

When asked to define their own culture and its impact on health and disease, some white respondents used normative language to define their culture, indicating a perspective from the mainstream – white as norm (Ford, 2014). Some respondents added other determinants of culture that make a difference in the lives of minorities, without directing these factors toward minority populations; e.g. economic, social, or cultural capital, revealing a beginning understanding of the differences between mainstream and marginal reality.

KD's definition was descriptive, but superficial – it dealt only with health issues and not more complex issues related to culture. KD's definition:

> My culture is Irish-American, but I'm also a native of Arizona. My Irish roots make me wary of substance abuse, which is a constant concern in our family and community. My Arizona roots make me cautious of skin cancer. I'm very careful to wear sunscreen and watch my skin for melanoma.

This respondent focused on the second part of the question, her culture's impact on health and disease more than how she actually defines her culture. Her definition was quite concise and not explanatory.

LY's definition of culture and how it impacts health and disease used stereotypical white language: "buck up" and "pull you[r] own weight". Her definition revealed a shift in action regarding health behaviors on her part as she aged. LY stated:

> I am Eastern European and we grow up being taught to "buck up" when we are sick and that you need to pull you own weight. Being ill means you are letting others down. This means you ignore things until you can't anymore or you are very good about preventative health so as not to become sick. I operated more from the first view most of my life but am now trying to be more proactive and preventative about my health

This response indicates an understanding that our perspectives impact the lens through which we see, and treat ourselves, and possibly, our clients, as public health practitioners (Kunda & Spencer, 2003), so may reveal her openness to seeing from different perspectives. This definition, however, was limited to her own personal actions.

RF was aware that "white culture" dominates our society, but did not delve any further into this awareness and how it impacts health and health care on a broad level; she kept it personal and individual. RF's definition:

> I come from the dominate white culture of western European descent with a multi-generational mid-western subcultural shellacked overtop. All of this means I trust in doctors and government on the whole to do the right thing although from time to time I'll entertain a conspiracy theory regarding the influence of money in medicine. Having a self-reliant streak in my cultural background leading to a family tendency to attempt to deal with medical issues via the supplements aisle at the natural foods store. Physicians, medicine and the like are necessary evils to be dealt with when absolutely necessary and when time and home remedies have failed.

RF's explanation of how her family tended to view the medical field is interesting. Such an opinion was not expressed in any other participant responses.

TF's comments revealed her awareness of the capital she has as a white person, but her comment about "not being an immigrant" comes across as racist (Trepagnier, 2010). She indicated some transition, however, by her last comment, "I recognize this" now that she is working in the field of public health. TF stated:

> I define my culture as "American Middle Class" maybe Mid-western. Bluntly, I am a basic white girl who grew up in a normal family with good values. I am lucky, fortunate and I appreciate it all. I was privileged to have access to primary and secondary health care whenever needed with private insurance; I was fully immunized as a child and adult, and was always fed a balanced diet along with all of the extras any child growing up would want. I think living in the suburban United States with

> a decent amount of money and not being an immigrant definitely impacted my health and disease in a positive way. Again, I am one lucky girl, and as an adult and public health grad I recognize this more than ever.

Trepagnier's (2010) research shows that as whites gain perspective on their own privilege, they are able to address the inequalities now brought to light by this revelation and show progress toward anti-racist behavior. TF briefly mentioned, later, that she works primarily with professionals, but did not explicate fully how this privileged perspective affected that work. Such comment could have been insightful as it could have shown how her academic preparation affected her view of and interaction with the "professionals" she now works with. Does she
engage discussion about privilege or simply ignore it in her practice?

EC was aware that socioeconomic status (SES) is a barrier to health access and quality, but saw herself as somewhere in the middle of having this capital – somewhat minimizing her privilege (Cabrera, 2014b). EC stated:

> I define my own culture as white American. I probably have had at least marginally better access and quality of care than people of other cultures, even people of other American cultures. However, my socioeconomic background was probably a limiting factor and I likely did not have as good access and quality of care compared with people of a higher SES of all cultures.

This assessment seems to imply that SES, not other descriptors, is the operational variable to health access and quality, rather than seeing race or racist behavior as playing a part. EC does not relate the concept of economic status to race, simply lumps all races

into her “American cultures” term.

EP, the last white respondent, did not really answer all the questions, but provided a summary statement about cultural competence in which she did relate an experience when she graduated from SWCOPH. She stated that when a Native American healer who “was to give a generalized blessing” to the graduates could not attend at the last minute, a faculty member stepped in and gave a very Christian/Jesus-based blessing, that she, as an atheist, found “very offensive.” It is clear that her stance was prompted by very personal reactions, but she went on to say:

> That it is important to understand how some cultures view health care, among many other aspects of life, but it is critical to remember that the most important thing is that each of us are individuals and to think that all Native Americans feel this way, all Hispanics would never want Hospice, and so on, really denies the individual the health care they need/want.

EP’s statement reflected a more critical view of cultural competency, but without more information from this respondent it is difficult to analyze her contribution to this study more fully. This statement could be seen as a counter-narrative, so was placed at the end of the white participants’ responses, as it reflects intellectual movement from the mainstream to the margin (Ford, 2014).

To show the differences between the white respondents and the two minority respondents, minority definitions of their own culture and its impact on health and disease follow.

LJ used passive language to describe “culture’s impact on health and disease.”

She did not say that *she* comes from a migrant farm worker family, but that "many may consider" this to be that culture. She also stated "the culture's" impact rather than using the possessive "my culture's" impact. LJ stated:

> I define my own culture as rural, Mexican-American. I think the culture's impact on health and disease is quite significant, as many may consider this culture to be that of the migrant farm worker (or descendants of the migrant farm worker). Many second and third generation Mexican-Americans who live in rural communities suffer from chronic health conditions, and often times do not have the resources they need to manage their health issues.

Comparing her response to the very active and possessive language used in white respondent's answers reveals quite a dichotomy between the two groups. She also stated that limited resources impact health, but does not explicate this statement further, which could have revealed more of her own perspectives on the issues of cultural competency in our current health care system. LB, the other minority alumnus, stated, "I define my own culture as a set of norms or practices that are traditionally followed by those in my community." This very short statement, although possessive, is quite nondescript.

Based on these two minority responses, it is difficult to tell why their responses were so different. It is also difficult to categorize these responses as anything but narrative as they do not go far enough to explicate any questioning of the status quo of white hegemony in health care. When comparing the white subjects' definitions against the minority definitions, the possessive nature of the white respondents' definitions can be viewed as an internalization of the white hegemony of the US; they felt free to speak

possessively of their culture – it's just the norm. Perhaps awareness of this white dominance created the reticence on the part of the minority participants to say more; they have been silenced before, so incentive to speak freely may have been limited.

Despite the initial responses of all alumni participants, answers to the questions about cultural competency, its importance in public health practice, its relationship to health disparities and social justice, and their academic experience of this concept were more lengthy and represented counter-narratives to the white hegemonic status quo of health care practice in the US. These counter-narratives follow.

Counter-Narratives

There were two basic themes that emerged from alumni data that represent counter-narratives: (a) education is not enough - to develop culturally competent health care practitioners and (b) racism and privilege – how these concepts occur in health care and help to maintain white dominance. These findings indicate that practitioners have found that experience is most valuable in promoting cultural competence, health equity, and social justice. They indicated that their academic experience helped them understand cultural competency, but that it was their experience in communities of cultures other than their own that increased their cultural competency. They indicated that despite academic preparation and experience, racism still exists in health care.

Education is not Enough. Campinha-Bacote (2002) has promoted the idea that cultural competency is an ongoing process that is never really completed; one never becomes fully culturally competent, but continues to gain proficiency in cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire as one works within health care. The following quotes from alumni indicate that they agreed

with this sentiment. RF stated that "I think the MPH program means well. It's a hard thing to teach, it must be learned over years." KD stated, "I don't think any outsider can really fully be culturally competent. There are always inside understandings of language and culture that only those born within the group fully understand." KD went on to say that cultural competence "required full cultural immersion" and she added that she had lived in two other countries prior to pursuing her MPH which helped her develop cultural competency for the groups she actually lived among. TF stated:

> I am not sure we were fully prepared for anything that was put in our path. I am not sure however, that we could ever be fully prepared, and a lot of CC [cultural competency] is somewhat 'on the job' training in some regards.

LJ explained more fully this need for more than classroom discussion of cultural competency:

> I had nine credit hours' worth of cultural competency based courses, and would have much rather been conducting field work, or doing intervention programs with the local community. I think there should be opportunities provided and/or required to do actual field work as part of the course requirements, in addition to the internship. I do not attribute my comfort with other cultures to any cultural competency training I received at SWCOPH. I felt my comfort with other cultures came from doing my own investigatory work (online, meetings with colleagues, reading scientific literature regarding the particular population) and understanding the history of the cultural group residing in the particular

> area/region, and also getting to know some community stakeholders within a particular cultural group.

EC felt the same way. She stated, "I did feel well-prepared to work with other cultures when I left SWCOPH, but due more to my own efforts to know and understand various communities rather than what I learned in the multiple cultural competency courses I took." EC also stated that while cultural competency skills are important to learn, she felt that there were more "critical skills," particularly changing policy that could impact many people, not just a specific group here and there.

These statements agree with Campinha-Bacote's argument on the importance of experience with diverse groups and continuing the *process* of becoming culturally competent. When asked about cultural competency's connection to health disparities and social justice, the theme of racism and privilege was commented on by seven of the respondents.

Racism and Privilege. Four of the alumni alluded to the concept of racism, while three alumni commented directly on this aspect of cultural competence and health care. Comments touched on many of the kinds of issues that are addressed directly in articles of health care and racism (Feagin & Bennefield, 2014; Washington, 2006), but did not use the terms racism or privilege directly in their responses. LB stated:

> Often members of non-English speaking cultures have poorer health outcomes. Health education campaigns often miss these non-English speakers, so adjustments must be made to ensure CC [cultural competency]. Different cultures face different challenges, and we must adjust and account for that.

LB does not mention what "adjustments" should be made, but mentions "non-English speakers' poorer health outcomes" and that they have "challenges." These statements alluded to disparities, which are linked to practices based on decreased health care access, quality, and resources for minority populations as discussed in the literature review.

When answering the question about a connection between cultural competence and social justice, LJ mentioned a television program she had seen that described a low income neighborhood that had unusually high rates of childhood asthma and upper respiratory illnesses. The program outlined the multiple contributions to this increased rate including the fact that the "agency responsible for maintenance and upkeep had an abysmal track record of response to renters' maintenance issues" and that the residents "organized a call to action, and worked to change policies" before the underlying causes of the health disparities were addressed. LJ went on to say, "I do not think it's [cultural competency] the most important lens to view public health's practice, training and research; rather using an *ethical* and scientific lens which welcomes discussion and analysis" [emphasis added]. Thus, LJ was aware of issues that create health disparities and points to the "ethical" underpinnings that could be included in "discussion and analysis" of such issues.

EP implies that health care professionals must not stereotype populations based on some cultural understandings they may have. She stated:

> It is important to understand how some cultures view health care, among many other aspects of life, but it is critical to remember that the most important thing is that each of us are individuals and to think that all Native Americans feel this way, all Hispanics would never want Hospice,

and so on, really denies the individual the health care they need/want.

While this statement addresses the issue of avoiding stereotypes, it also alludes to the dominant cultural norms, e.g., individual responsibility, that are used to view health care and its provision that can create disparities (Smedley, Stith, & Nelson, 2003).

EC commented that she has "had issues working with other cultures than my own primarily because of language barriers. Further, because of the historical context in which whites and American Indians have interacted, being white and working with Native communities does not come easily." EC mentions the "historical context" of American Indian and white interaction as creating a barrier to communication for her while working with this population. EC does not elaborate on this point, but there is a body of literature that discusses the distrust of Native Americans toward whites in health care for a variety of reasons which include racist actions (Brave Heart, Chase, Elkins, & Altschul, 2011; Castor, Smyser, Taualii, Park, Lawson, & Forquera, 2006; Whitbeck, Adams, Hoyt, & Chen, 2004). This topic is one that is prominent at SWCOPH due to its proximity to many different Native American tribes and faculty research with the tribes (personal observation). Indeed, both courses observed for this study included sections on Native American health care history and the racism experienced by Native American Tribal People.

Three of the alumni addressed racism and/or privilege more directly. When asked about connections between cultural competence, health disparities, and social justice, KD mentioned that the following public health issues are disproportionally high compared to other races for Native Americans: "Type 2 diabetes, suicide, alcoholism and obesity on the American Indian reservations of the US." She went on to say that American Indians:

> . . . do not have adequate health resources or education and as a result are dying in mass numbers. American Indians do not have social justice on their reservations at the moment. They are one of the forgotten people of the US. We have become so accustomed to the poverty of the reservation that we overlook it today.

Although KD does not use the term racist, her viewpoint is a harsh statement about the US health care profession's attitudes and actions toward Native Americans.

Another alumnus was less severe in her views about working with people from a culture other than her own. TF did, however, use the term privilege when she stated,

> I am fortunate to be relatively *privileged*, and I think that sometimes can affect the way that those who are *less fortunate* view me in the health care community. When working in the free clinic associated with our hospital, I try to always level with the patients. There is no *judgment*. Any of us could be there one day, and many of the patients *work very hard* for what they make, and unable to afford insurance. Over the years I have seen the clients change from a homeless population to a population of working professionals with jobs that don't provide insurance, or enough money to buy insurance privately. [emphasis added]

Although TF used some terms that indicate she is not fully "centering in the margins" such as "less fortunate" (signifying a privileged status) and "judgment" (connoting her authority to sit in judgment) and "work very hard" (the Horatio Alger myth), she realized that she is privileged; that her whiteness provided her a level of distance from the hardships her clients experience. While this quote could be put in the narrative section,

because of the above terms, I have included it here because of TF's awareness of her privileged status. This awareness is often the first stage to becoming race conscious (Trepagnier, 2010) which fits the PHCR framework.

RF was another alumnus who was quite direct in her statements about race and whiteness. In her definition of her own culture she stated, "I come from the *dominate white culture* of western European descent" [emphasis added] and in her description of academia and the public health field she stated:

> The MPH program is also full of *privileged white women* (myself included.) There are some with more experience outside the white box than others (thinking of the returned peace corps folks) but it's hard to separate yourself from a white upbringing. (I'm sure you hear the metaphor, a fish swimming can't see the water. So it is with white folks and our *privileged place* in the world.) I have no suggestion as to how to make the training better as I remain unconvinced it's something you can "train" people to be. [emphasis added]

RF was also critical of how academia tries to teach cultural competence. She went on to say that cultural competence:

> . . . sounds really great in classrooms and academic papers. 'We're going to train our students to be CC [culturally competent] and that will address health care disparities!' That's very reductive. We are talking about complex problems dating back millennia (white skin vs. dark, rich vs. poor, free vs. slave).

RF saw health disparities as occurring due to the economic systems that perpetuate the

existence of a large underclass that has almost no chance of breaking out of poverty. RF identified that health disparities occur due to a multitude of complex issues and that trying to teach such a complicated concept in a MPH program is "reductive." This response is the most overt statement to the questions asked and illustrates a very mature level of understanding of these issues. RF completed her responses by stating:

> The cultural project I did was probably slightly more helpful [than reading 'The Spirit Catches You and You Fall Down']. I worked with women at the Casa Paloma shelter in [city]. It made me uncomfortable, and I'd say that's a good thing.

RF's identification that being uncomfortable when working with cultures other than her own is a "good thing" shows a level of understanding of these issues that is quite mature (Airhihenbuwa, 2007; Trepagnier, 2010).

Amount of Cultural Competency Training in the MPH Program

This section lists interview responses from alumni when asked the question, "Do you think there is enough/too much/too little education on cultural competency in the MPH program?" Some of the quotations were used in the themes above, but for comparison with the current students' responses, alumni replies to this specific question are listed together in this section. While long, the alumni's full and direct quotations are presented here because they are candid and provide some context to their responses. Only seven of the eight participants answered this question. All alumni were female.

One respondent felt there was too little education on cultural competency in the MPH program. TF (white) stated:

> Honestly, it has been a decade since I graduated…so I am not sure I

> remember exactly what I had in terms of CC [cultural competency] education. I do think there likely could have been more. Thinking back on my MPH, I know that the community assessment helped me to realize a lot about CC, and especially, the area I worked with, about age sensitivity, as it was a predominately senior population. I think that the [SWCOPH] MPH program did a good job of discussing local aspects of public health, and we were prepared for what was happening in our own areas. The Epi classes were good for our local disease processes, and how different cultures could be affected differently by disease. However, I am not sure we were fully prepared for anything that was put in our path. I am not sure however, that we could ever be fully prepared, and a lot of CC is somewhat "on the job" training in some regards. When I worked with my internship, I worked mainly with professionals, and I think that I was prepared for this fully with the program.

Despite TF's initial statement about it being a decade since she graduated, she was able to provide quite a commentary on what she remembered. Like many faculty members and current students, she felt that actual experience was important to develop cultural competency.

One alumnus did not state a definitive too little/enough/too much, but her comments expressed that the program tried to teach this important concept. RF (white) stated:

> I think the MPH program means well. It's a hard thing to teach, it

> must be learned over years. The MPH program is also full of privileged white women (myself included.) There are some with more experience outside the white box than others (thinking of the returned peace corps folks) but it's hard to separate yourself from a white upbringing. (I'm sure you hear the metaphor, a fish swimming can't see the water. So it is with white folks and our privileged place in the world.) I have no suggestion as to how to make the training better as I remain unconvinced it's something you can "train" people to be.

This comment is actually quite insightful from the PHCR framework standpoint as it addresses how those in the mainstream don't even realize it, therefore cannot see and hear the voice of those marginalized; the foundation of race consciousness is missing. RF also mentioned the concept of privilege. Once again, this participant opines about the value of experience in developing cultural competency.

Three of the seven alumni felt that cultural competency education in the MPH program at SWCOPH was about right or "enough." LB's (Hispanic) response was very short. She stated, "Enough training in the MPH program. Yes, I feel well prepared to take culture into consideration in all program development." KD (white) stated:

> I did think this was effective, but I had also lived in two other countries prior to my MPH program. I felt culturally competent to the greatest extent with Mexico and Cameroon. So, I didn't think it was as big of a deal because I understood how to do it – which required full cultural immersion.

How much of KD's opinion came from her experience versus her recollections of her academic preparation is hard to evaluate, but her comment about the importance of

"cultural immersion" is reminiscent of several of the current students' comments and TF's above. LY (white) responded:

> Enough – we had a broad cross section of cultures in most of my classes – it was a natural part of the discussions. Yes – I had been through a lot of training in CC [cultural competency] prior to pursuing my MPH though.

Like many other alumni and current students, LY had her own experiences with cultural competency education prior to matriculation into the MPH program.

Two of the seven respondents felt that there was too much education on cultural competency in the MPH program. LJ (Mexican-American) stated:

> I thought there was too much training on cultural competency in the MPH program. I had nine credit hours' worth of cultural competency based courses, and would have much rather been conducting field work, or doing intervention programs with the local community. I think there should be opportunities provided and/or required to do actual field work as part of the course requirements, in addition to the internship. I felt well prepared to work with other cultures other than my own after graduation, but I do not attribute my comfort with other cultures to any cultural competency training I received at [SWCOPH]. I felt my comfort with other cultures came from doing my own investigatory work (online, meetings with colleagues, reading scientific literature regarding the particular population) and understanding the history of the cultural group residing in the particular area/region, and also getting to know some community stakeholders within a particular cultural group.

LJ's comments reflect others' remarks on the importance of actual experience rather than just classroom teaching to increase cultural competency. She listed additional ways she increased her own cultural competency. EC (white) also felt there was too much education on cultural competency in the MPH program. She stated:

> I think there is way too much cultural competency training in the MPH program. Perhaps it was the professor I had, but almost 25% of my MPH degree was taught by one faculty member and ended up being nearly identical classes focusing primarily on cultural competency. I feel I would have benefited much more from more research-intensive or methods-based courses. Cultural competency is critical for MPH students, but unless you are going into casework or international aid, I feel the current focus on cultural competency in [SWCOPH] takes away from other more important job skills. I did feel well-prepared to work with other cultures when I left [SWCOPH], but due more to my own efforts to know and understand various communities rather than what I learned in the multiple cultural competency courses I took as an MPH student.

EC echoed not only LJ's sentiment of the education being too much, but that her cultural competency was due to her own efforts, based on self-directed learning about a community, rather than anything she learned in school. She did state that cultural competency is "critical" but that there were "other more important job skills". What these skills might be were not mentioned.

Overall, the alumni comments about the amount of cultural competency education were different than those of the current students. While the current students' perspective

leaned more toward the right amount or too little, alumni's perspective leaned more toward the right amount or too much. Yet, both groups revealed the opinion that practical, in-the-field experience was important to cultivate cultural competency.

Alumni Perspectives Discussion

Based on the above findings from alumni data, it is difficult to explicate just how much alumni worked within or outside of the PHCR framework and its four focuses. While several alumni did indicate understanding of the issues of cultural competency and its connection to health disparities and social justice, there were still indications of less movement from the mainstream to the margins with the use of terms associated with white hegemony. Some of the respondents did allude to race as a social construct (focuses 1 & 3), critical approaches to the concepts of cultural competency, health disparities, and social justice (focus 2), and several respondents critiqued the public health profession's teaching of these concepts (focus 4).

CHAPTER 5: FINDINGS II

As described in chapter four, the purpose of this study was to investigate the perspectives on cultural competency education by faculty, current students, and alumni from a Master of Public Health (MPH) granting institution. To understand how cultural competency is taught by faculty and "caught" (internalized and practiced) by students, observation of a required cultural competency course for the MPH and interviews of faculty, students, and alumni were performed. While chapter four presented the findings of this study according to narrative and counter-narrative themes using the four focuses of the Public Health Critical Race (PHCR) praxis theoretical framework, this chapter utilizes the ten principles of the framework to dig even deeper into the data. This chapter will provide an overview of the research questions and how the narratives and counter-narratives were used to address the research sub-questions, as well as how using the ten principles of PHCR plus the narratives and counter-narratives were used to answer the primary research questions. Each population group will then be presented individually revealing how the findings answered the research questions according to the PHCR framework. This chapter concludes with a combined perspectives section that integrates the findings as a whole.

Overview

Ford and Airhihenbuwa (2010b) introduced the public health critical race (PHCR) praxis theory to address racial and ethnic disparities in health care. PHCR is based on critical race theory, a theoretical framework that has been used in many other fields (e.g., legal studies, education, feminist studies) to address racial issues. Ford and Airhihenbuwa claimed that research about health disparities and/or racial issues in public health that is

not based on a critical race theory foundation will not move anti-racist studies forward. Their aim in introducing PHCR was to increase the use of PHCR in public health research. PHCR has four focuses and ten principles (Table 1). This chapter will answer the following three primary research questions, supported by sub-questions:

1. To what extent do faculty members teach cultural competency in a MPH program?

    Sub-question (a) To what extent do faculty members address racial/ethnic health disparities and issues of social justice as a part of cultural competency education?

    Sub-question (b) To what extent do faculty reflect on their own race consciousness?

2. How do students perceive the importance of cultural competency in future practice?

    Sub-question (a) To what extent do students' attitudes about cultural competency change over the course of a semester in a class that emphasizes culture?

    Sub-question (b) To what extent do students see racial/ethnic health disparities as a part of cultural competency and an issue they need to address as future practitioners?

    Sub-question (c) To what extent do students perceive the field of public health as a field that promotes social justice?

3. What do alumni from the same program say about cultural competency in practice?

Sub-question (a) To what extent do alumni express that the curriculum in their program prepared them effectively for practice with minority groups?

Sub-question (b) To what extent do alumni see any connections between cultural competency and racial/ethnic health disparities or issues of social justice?

Sub-question (c) To what extent has alumni's work experience influenced their perspectives on these issues – has practice reified their long-held beliefs or has their education changed these beliefs?

According to critical race theory, narratives are the stories that are accepted as normal, natural; the status quo of a culture, discipline, or population. Ford (2014) defines this status quo as the mainstream perspective (Figure 2). Counter-narratives, then, are stories that challenge the status quo; provide a minority perspective of a culture, discipline, population, or phenomenon. Counter-narratives align with Ford's (2014) perspectives from the margin (Figure 2). While the findings suggest, based solely on the number of narratives versus counter-narratives, that the minority voice is represented, taught, and caught within this MPH program, when evaluated more precisely against the ten principles of PHCR, a more nuanced story emerges. This more refined analysis reveals room for improvement in the teaching of cultural competency. I will explicate how the data from the actual classes revealed strong attention to addressing issues of racialization in our health care system, some reasons why teaching this subject may be so difficult based on the data and additional literature, and reveal how this data and framework points to ways to teach cultural competency that may help culturally sensitive health care practitioners to emerge. Such pedagogical practices that help accurately and

practically acknowledge health inequities and social injustices in the health care field can address problems mentioned by DasGupta, et al. (2006) and Feagin and Bennefield (2014) as presented in chapter four; to accept our power as teachers and acknowledge the white racial framing that occurs in our current academic institutions, respectively. It is this analysis that will be presented here in chapter five. Table 1 lists the ten principles – (a) race consciousness, (b) primacy of racialization, (c) race as social construct, (d) ordinariness of racism, (e) structural determinism, (f) social construction of knowledge, (g) critical approaches, (h) intersectionality, (i) disciplinary self-critique, and (j) voice - as well as a comparison between the conventional approach (the status quo of current public health practice) and the PHCR approach (critical of current public health practice) associated with each principle. Chapter four delineated how these ten principles were used to view the data, while chapter five presents the findings of such a review. It is this comparison of the conventional versus PHCR approach that undergirds the critical analysis of the findings in this chapter. The following sections will briefly summarize the findings according to narratives and counter-narratives to address the research sub-questions, then utilize a more critical approach using the ten principles along with these narratives and counter-narratives to answer the primary research questions. Each section will conclude with a summary of that population's perspective in relation to the study as a whole, with some additional comments based on my observations of the classes directly. The chapter will conclude with a combined perspectives discussion.

Faculty Perspectives

Based on the findings, faculty perspectives presented a more critical than mainstream view, as there were two narrative (that's not my job and minorities must

make adjustments) and four counter-narrative (health equity as a social determinant of health, service learning - to increase interaction with and appreciation of diverse peoples, thinking critically – power and privilege, and addressing racism and whiteness) themes that emerged from the data. One of the narrative themes, minorities must make adjustments, even took into account that while there is a white hegemony in health care, there are ways of helping minority populations "maneuver" in this dominant world, so this narrative perspective could be viewed as a way to help address the mainstream-margin gap rather than simply ignore it. However, analyzing the findings utilizing the ten principles of PHCR, a slightly more mainstream, or conventional, approach emerged.

Sub-question (a): To what extent do faculty members address racial/ethnic health disparities and issues of social justice as part of cultural competency education?

Faculty members teach, or state that they teach, cultural competency, often with an emphasis on health disparities and social justice issues, not just in one course, but throughout the MPH program curriculum. Although one narrative theme suggested that two faculty members feel that the epidemiology/biostatistics concentration may not need to address these issues, the online course observed during the study period suggests otherwise. The discussion questions chosen for week six of the online course specifically addressed the construction of variables in research, their definitions, use, and publication; reinforcing some faculty opinions that such variables need to be carefully considered in light of the history of racial injustices.

Many of the faculty members recommended service learning projects as a way to allow students to immerse themselves in under-resourced communities to learn about health problems from the minorities' perspective, and to open the eyes of students to the

resource hierarchy that exists. Faculty stated that after such exposure, students could then evaluate the use of variables and categories used for these populations and how these variables and categories are used in research and publications; do they provide valuable, helpful information for minorities or do they engender stereotypes that get perpetuated in the literature and in health care practice?

Many faculty members also stated that they encouraged students to think critically about all aspects of public health: work, research, and publishing. This attitude was evidenced during the course observations, with both professors providing discussion questions, activities, assignments, and test questions that reflected this critical engagement of the coursework, as discussed in chapter four.

Based on direct observation of the two classes, the professors exhibited their assumptions that cultural competency was highly tied to issues of health disparities and social justice. Students were assigned literature and topic discussion questions that exposed them to these connections historically, as well as encouraged them to consider these topics' interconnectedness when doing a service learning project and as they developed presentations and papers. Both professors challenged students to think critically of many aspects of public health throughout the semester.

Sub-question (b): To what extent do faculty members reflect on their own race consciousness?

This question is more difficult to answer from the data, but many of the white professors openly mentioned privilege and power, white's dominance in health care, and ways to address the problems in health care created by this hierarchical system. Faculty members spoke openly about these issues whether they were white or of color reflecting

their awareness of race and racialized issues in health care.

Analysis based on the ten principles of PHCR

Despite what the counter-narratives revealed, there was evidence of the conventional approach (status quo of public health practice) compared to the PHCR approach (Table 1) when looking more critically at the data using the PHCR ten principles. Examples of both approaches from the data follow.

Race Consciousness. Many faculty members mentioned poverty as *the* public health issue that needs to be addressed, according to the PHCR framework, this is a conventional approach. Very few mentioned their own racial biases or how they address race *directly* in their own teaching and research. These responses align with the conventional approach to public health research. Three of the faculty interviewees and the face-to-face professor did discuss community-based participatory research which does address biases and the emic versus etic approach to populations under study, which aligns with a critical approach. Dr. Z also commented directly on the issue of racism in the US historically and how the Civil Rights era was not that long ago. She tried to help the students understand that race is an ever-present factor in health care discussions and practice.

Primacy of Racialization. The topics of racialization and racism were evident in the data, but were discussed somewhat cautiously; there were no definitive, unabashed quotations directed at racism and specifically structural racism. Structural barriers were mentioned and structural racism inferred, but no one stated this as frank racism. While white privilege and resource allocation were mentioned as contributing factors to health inequities and social injustices that should be addressed; and policy changes, such as the

Affordable Care Act (ACA), were a part of the solution; faculty members seemed to fall short of calling racism the defining characteristic of US health problems (Ford & Airhihenbuwa, 2010b), which would have been more critical. Faculty members talked about these being "difficult issues" or these topics tend to "challenge their comfort level" and so are treated perhaps more superficially than they could be. The observed classes did address racism more directly, but there were still elements of objectivity in the data rather than subjectively asking students about their part in maintaining the status quo; or stating white ideology as being the cause of such racialized elements of health care. These discussions were fairly sanitized from the harsh realities of racisms' effects. Such modest discourse could be due to just how difficult discussions about racism can be. Taboada (2011), Reason, Scales, and Millar (2005), Cabrera (2012), and Spanierman and Cabrera (2015) all discuss the difficulties related to addressing racism directly, but also provide ideas for doing so, as well as recommendations for dealing with the emotional aspect for whites when confronting racism. These resources could help faculty manage such troublesome discussions. I did not observe any emotionally difficult discussions Dr. Y or Dr. Z had to contend with, but what class discussions did deal directly with racism were handled with apparent ease by both professors. I know Dr. Z has had many years of experience with students and Dr. Y was mentored by a faculty member, also with years of experience teaching these issues, which may have contributed to the ease with which they did handle these discussions.

Race as Social Construct. The online course did address this topic very directly, particularly in the discussion regarding how human DNA is more diverse among those within socially constructed racial categories than between individuals in these categories,

and Dr. Y posed queries to students' postings that may have helped students move beyond these social categories to thinking more critically about how we construct and read race in studies and in practice.. Explicit mention of racism as the basis for inadequate resource allocation or health care access was mentioned by several faculty members, particularly as related to the ACA.

Ordinariness of Racism. There were no direct quotes stating that racism is rare, but there were also no direct data that encouraged using "racism as a routine exposure" as part of one's research. The course professors' assigned readings, activities, videos, etc. were fairly direct in addressing this ordinariness of racism issue. The faculty I observed did not explicate how such ordinariness of racism occurs, nor ask minority students in the class, if they would be willing, to share such microaggressions to heighten white students' understanding of this principle. This absence of discussion could be due to several factors: faculty may be sensitive to not placing a minority in the position of speaking for their collective ethnic group (Davis, Dias-Bowie, Greenberg, Klukken, Pollio, Thomas, Thompson, 2004); they were aware that not all students were developmentally ready for such difficult discussions (Weidman, DeAngelo, & Bethea, 2014), or perhaps they did not feel comfortable venturing into such challenging territory (Reason, Scales, & Millar, 2005). It could also be that faculty realized the developmental process students go through within this specific MPH program and went as far as they needed to go in this particular course, knowing that students would be exposed to the issues of health inequities and social injustices in other courses and through other out of classroom experiences (personal observation). The exact mechanisms at work here are difficult to determine.

Structural Determinism. Data did support that faculty members addressed the issue of the status quo of health care being "a white man's world" that minorities have difficulty accessing and navigating. There were also several quotes from interviews and from class documents and discussions regarding the importance of policy to change this status quo, including enactment of the ACA. Many of the assigned readings spoke to the issue of how difficult it can be for minorities to navigate the health care system which is a barrier to adequate health care and can be a contributing factor to health disparities. For this principle to be revealed more fully in a classroom setting, faculty could mention that changes in health care often bring about systemic changes that simply reinforce the hierarchical nature of our health care system rather than making real and lasting changes for minority populations and provided examples. Such challenging subject matter may have gone above and beyond this one course's objectives as simply making students aware of such barriers is a first step in helping them acknowledge such structural barriers.

Social Construction of Knowledge. This aspect of PHCR was discussed in both courses encouraging students to think about how knowledge of groups is obtained, discussed, and published. Dr. Y, the online professor, often asked questions to help students think about their a priori assumptions about a population and Dr. Z, the face-to-face professor, frequently mentioned her displeasure at the deficit model so common in health care research. Both professors also used articles from minority journals. Dr. Z and a few faculty members in interviews also pointed out that the community has expertise that we should acknowledge. The one male professor that stated our health care system is based in "the white man's world" and had a PhD student working to address this very issue with minority groups, reveals movement toward a more equitable approach to

knowledge production.

Critical Approaches. While similar to social construction of knowledge, this aspect of PHCR has to do with accepting our own biases and, when confronted with research questions, considering a multitude of possible explanations, rather than just accepting and citing our own first impressions; e.g. how does culture *x* explain this phenomenon according to our current scientific paradigm? This concept includes asking questions about what researchers can learn from the researched in ways that are humble, not paternalistic or condescending. Dr. Z was the most vocal about looking at communities of color from a resilience standpoint rather than a deficit model and was very much aware of the negative history of researchers among many minority communities and openly discussed this topic. A few faculty members also mentioned this aspect of research and the need for change in this area, the need for students to be aware of the power differential between researchers and researched and to be respectful of communities they study.

Intersectionality. Again, this aspect was mentioned by few faculty members, and may contribute greatly to the discussions about racism and health inequities in other classes. This particular concept was not discussed much in the current course. Helping students see how multiple oppressions can occur when individuals inhabit several "inferior" rungs on the social hierarchical ladder and how such oppression really affects a person's health can be very instructive. Again, this concept may not have been seen as appropriate, nor students not developmentally ready for, due to its complexities.

Disciplinary Self-critique. While many faculty members agreed that public health as a discipline should be addressing issues of cultural competency, health

disparities, and social injustice in health and stated that research is changing within public health to address these issues, the overarching perspective was that this is slow work that requires diligence and care in presenting alternative views. Some faculty members did mention organizations, like the World Health Organization and Centers for Disease Control, which are carrying out and funding better quality research to address issues of inequalities. The professors of both classes also encouraged students to think critically about their work. As this is the one required cultural competency course, being introductory, this may not have been the most appropriate course to get into more detail than was provided. However, to more firmly enact this principle, courses providing more practical skills for students to address issues of inequality and injustice when they experience them in practice could help students better prepare to stand up against the status quo when they experience it in practice settings, enabling more socially just health care to occur.

Voice. This aspect of the PHCR principles is one that was mentioned in terms of having minorities be a part of research that is being done in their communities, increasing the number of minorities in public health and academia teaching public health, and the importance placed on increasing the number of minority students in the MPH program itself. When minority students in each class brought up a differing or alternative view to something being discussed, they were allowed space to say what they wanted to say and overall were treated with respect by fellow students and the professors. However, the discussions never really developed into deep, controversial discourses. I have to wonder what would have happened if these discussions invoked "skepticism or anger" (Ford & Airhihenbuwa, 2010b) if a minority student challenged an accepted, privileged

perspective; how would the professors have handled it? It is difficult to determine to what extent voice plays a role in this MPH program based on the data. Certainly faculty members talked about the importance of working *with* and not *for* a community and many expressed their belief in the importance of community involvement in all aspects of research and program development, but determining the extent to which this actually happens is difficult. Listening to minority groups appeared to be a value among faculty members in teaching and many faculty members are involved in community based participatory research (CBPR) where communities are active participants within the study design, data collection, analysis, and publication. In addition, seeing posters of faculty and student research as well as attending internship conferences and faculty talks, it was evident that giving voice to marginalized communities is a value at this college.

Primary research question: To what extent do faculty members teach cultural competency in a MPH program?

Reviewing the sub-questions through narratives, counter-narratives, and against the ten principles of the PHCR framework to answer the primary research question regarding faculty members' perspectives, the data show that faculty members do teach cultural competency and discuss issues of health disparities and social injustice, but the transformative work of education to practice can be more challenging for educators. As one faculty member put it, they discuss these "difficult issues" with students, but when viewed very critically through the PHCR principles, their efforts could go further to impact students' perspectives on these issues in a lasting way. Students may become sensitized to these issues through education and interactions with communities of color, but to become real activists in instituting change to hasten progress in the area of health

inequities and social injustices in the health care field seems to take more than academic preparation. Fine (2006) quotes Apfelbaum (2001) when discussing oppression and resistance. Fine emphasizes Apfelbaum's assertion that researchers must "think through the conditions under which relatively privileged people are willing to hear and act on oppression" (p. 87). It is through *action* that lasting, real change is made. Hytten (2006) echoes this sentiment when she speaks of cultural studies making "a difference in the real world…beyond the walls of the academy" (p. 235). She mentions the hard work of "balancing academic and activist work" (p. 235). Is this hard work why progress in health disparities issues is taking such a long time? Our academic endeavors address these issues, but may not go far enough to enlist strong *action* on the part of future practitioners; or the action that does occur is too limited in its time or scope. This limitation could be why so many faculty members highlighted the importance of service-learning or CBPR experiences, these experiences provide students with an introduction to action. The face-to-face course did include a service-learning experience with reflection (Murray-Garcia, Harrell, Garcia, Gizzi, & Simms-Mackey, 2005) and the online course required a team-researched paper to develop a health program that required cultural sensitivity to design, enact, and evaluate. Again, this limited scope may be primarily due to the introductory nature of this cultural competency course. It may be too, that while faculty promote good academic and activist work, they are unable to help students navigate the overwhelming institutionalized racism that exists in the workplace, once the student reaches that arena as a health care professional. The professors of the course I observed did a great job of helping students learn about this aspect of public health by providing challenging discussions and required readings, and even experience cultural

competence in some way, but once students leave the insulated environment of academia, it may become difficult not to fall back into old, perhaps not so activist, practice. Faculty may not even be aware of this gap, from academia to workplace, thus how could they address it?

Despite this criticism, it is important to note that the most common thread throughout the faculty data was that education about these issues throughout the MPH curriculum and being exposed to under-served communities through service learning projects or through CBPR was paramount according to the responses of most faculty members. Faculty members promoted the capability of such experiences to be transformative experiences for students. This emphasis on education, exposure to, and experience with under-served communities is how faculty members recommended teaching cultural competency in this MPH program.

Current Students' Perspectives

Based on the findings, current students also had a more critically-based perspective about cultural competency as there were two narratives (white as the norm and increasing awareness) and five counter-narratives (service learning, reciprocal learning, intersectionality, systemic/ institutional issues, and racism/white as the norm) gleaned from the data. One narrative theme (white as the norm) represented the status quo of our current health care system, while the other narrative theme (increasing awareness) showed somewhat of a transition between mainstream and margin thinking as students were learning about cultural competency through the MPH program, similar to the faculty narrative theme of "minorities must make adjustments." Analysis of the current student data against the PHCR ten principles revealed that while progressive

thinking was occurring, the conventional approach was still evident. Current student data did match the more critical PHCR approach better than did the faculty data; which may be due to the sheer volume of student data versus faculty data. This section, as in the faculty section, will answer the sub-questions via the narrative and counter-narrative data, present an analysis against the PHCR ten principles, then answer the primary question based on all the data taken together.

Sub-question (a): To what extent do students' attitudes about cultural competency change over the course of a semester in a class that teaches cultural competency?

This sub-question was difficult to answer for two primary reasons. The first reason is that I did not get specific data from specific students at the beginning, middle, and end of the semester for direct comparison. Particularly from the online courses' discussions, however, I could see some growth in the area of seeing from another's viewpoint over the course of the semester as students freely provided feedback to one another and challenged each other directly at times with what they saw as mainstream thinking. There were some examples of this enlightened thinking in the data presented in chapter four when students stated their realizations from the readings and from one another. The narrative theme of "increasing awareness" presented many of these student responses. The second reason is that several of the students entered this course with quite a bit of experience, personal and professional, with cultural competency: several students had Peace Corps experience, several had already been involved with service-learning projects, and several were from marginalized communities themselves. These students shared their knowledge of marginalized peoples' experiences and their actual voices as marginalized people, during the classes. So, it was apparent from both courses'

discussions that students freely discussed racial issues during the semester and the intensity and complexity of the deliberations increased during the semester, with students freely discussing concepts that were new to them. But to what extent this signaled internal change during the semester was not really answered. The fact that such discussions took place is a good indicator that space to feel free enough to raise difficult issues was provided in the classroom. Indeed, the one Mexican female who stated that she felt more free to express her opinion in this course unlike other courses she had been in is indicative of the freedom students felt to express their opinions, particularly the minority students, in this course.

Sub-question (b): To what extent do students see racial/ethnic health disparities as a part of cultural competency and an issue they need to address as future practitioners?

To answer this sub-question, I turned primarily to the counter-narratives discovered in the data and to the responses to the question of how much/little cultural competency training students felt they got in the MPH program. Many students expressed the importance of working within communities and utilizing community beliefs, experience, and knowledge as a way of providing culturally competent care that was also respectful of the culture. The "service learning" and "reciprocal learning" themes explicated these views.

The "systemic/institutional issues" and the "racism/white as the norm" themes were quite direct in their presentation of how students saw the connection between health disparities, social justice, and cultural competence. The findings within these themes were actually surprising to me at first, as I found the students' comments more advanced

than I had expected. In other words, many of the students easily spoke about white privilege, power and hierarchy, ordinariness of racism, and intersectionality – concepts that I did not expect these students to have understood to the point of discussing them as knowledgeably as they did in this introductory class. Knowing, however, that many of them had prior experience with communities of color seemed to be the main factor increasing the complexities and depth of understanding of their responses to and thinking about such concepts. The fact that the minority students did express challenging queries and comments during discussions, particularly toward students espousing mainstream opinions, also added to this advanced complexity.

The need for new language, or words, to discuss the issues of cultural competency, health disparities, and social injustices, was also mentioned by several students. This perspective revealed that students see interconnections among these three concepts, but also that as future health care professionals they have a responsibility to adopt or create new language as they practice. While adopting this responsibility to act may or may not have happened for the students, those that do move on to research may keep this discussion in mind and help develop a "new language;" operationalizing study variables in new and more culturally respectful ways. Ford (2014) stated this need for new language in her speech to the Center for Health Equity and Urban Science Education (CHEUSE) of Columbia University, stating that PHCR provides a process for "developing a lexicon for talking about racism in more sophisticated and nuanced ways." Such language may help to move the field of cultural competency forward in ways that promote health equity and social justice that have not yet been done. The fact that students mention the need for new language or new words is quite promising in this

regard.

Sub-question (c): To what extent do students perceive the field of public health as a field that promotes social justice?

Reviewing the counter-narrative data shows that students advocated social justice issues and iterated that public health should be the field that promotes social justice, even to the point of being the vanguard of such advancement in some students' opinions. Student data from the counter-narrative themes oft-mentioned issues of social justice and claim that researchers and practitioners should be aware of such matters and address them directly. The advanced nature of student responses was another area that surprised me, but I contribute these advanced opinions to the fact that many of the students had prior experience with communities of color, as in the sub-question above. Their comments about power and privilege, racialized research, and their comments that put voice to minority plights in health care, showed their strong sense of the importance of social justice in health care practice and research.

Analysis based on the ten principles of PHCR

Despite what the counter-narrative themes revealed, there were still evidences of the conventional approach to public health compared to the PHCR approach when looking at the current student data more critically according to the PHCR ten principles. This finding may be expected as many of these students were in their first semester of the MPH program. Examples of these differences follow.

Race Consciousness. When discussing the social determinants of health, many students mentioned non-racial issues as the cause of health disparities and social injustices in health, but many of the students also mentioned white privilege, power,

hierarchical thinking, and "white as the norm" as problematic and contributory to disparities and injustices. Many also questioned the sanctity of "the scientific method" – claiming that it is neither objective nor race-neutral. Over the course of the semester, many of the minority students, and students with extensive experience with cultures other than their own, increased the intensity and complexities of their replies in class and in the online discussions. Apparently they felt more comfortable discussing these issues more pointedly within this environment as the semester progressed. I would say that movement from the conventional approach to a more PHCR approach did occur over the course of the semester. Apparently, the classroom environment was comfortable enough for students that it engendered an increase in students' freedom to voice criticism of mainstream thinking and increased white students' awareness of their own biases and privilege.

Primacy of Racialization. With one of the online assignments directly aimed at discussing race, racism, and racialized research, students had to comment directly on this topic. It was interesting that the two physicians in the online group were the most vocal about how important research on race and the use of race/ethnicity in treatment was. Their comments inspired many other students to question this assumption and cite works that challenged these assumptions, mentioning the historical basis of many of these problematic presumptions. These challenges helped students think more critically about how racism operates in the US today (and even globally as some students mentioned) and how such racism impacts the institution of health care practice and research. These challenges came primarily from the minority students in the classes and the students with extensive experience with cultures other than their own.

Race as Social Construct. As mentioned in the faculty section, the online course directly addressed this concept. The students, however, went further than the faculty during discussions about this concept. There were, again, several students who continued to claim race and racial identity is important in health care research and treatment, but many students disagreed with this assertion, claiming that using race and racial/ethnic identity tends more often, to lead to unequal treatment and stereotyping of people of color and reminded the group that how race is defined in studies is also problematic. Interestingly, this issue was more adequately addressed by students than any other principle and it was in discussions about race as a social construct where students tended to bring in citations from minority journals and other readings that addressed the negative racialization of past health care research. This area was probably the most critically astute on the part of current students; their awareness of the social construction, and abuse, of the concept of race was evident in their contributions to class discussions.

Ordinariness of Racism. As with the faculty data, this concept was not really addressed with current students. While there were some contributions regarding this concept in terms of stereotyping individuals based on a label and thinking that all individuals in a population were alike, this concept was not delineated as completely as it could have been. Minority students added the most data to the discussions about this principle, but again, there was a missed opportunity to discuss the topic more openly and extensively to increase white students' awareness of this important contribution to the discussion of cultural competence, health disparities, and social injustices.

Structural Determinism. This was another area where the student discussions among one another went further than did the faculty data. Many students commented on

the fact that US health care is based on treating the individual; expecting the individual to make behavior changes to improve health and how this idea may be antithetical to many cultures' ideas of health and wellness. Discussion around this topic was another area where many of the minority or culturally experienced students enhanced the discussions, adding their voice to how the structures of US health care (i.e. research, community engagement, treatment, etc.) often hurt, not help long-term, communities of color. Many students mentioned segregation, inattentiveness to issues important to minorities, and privileged status thinking (e.g. biological determinism or colonization ideology) as contributors to disparities.

Social Construction of Knowledge. This was another area ripe for discussion among students, particularly with the online class. While there were still several students in both classes who espoused the objectivity and race-neutrality of research and the scientific method, many more students contested these assertions, again bringing in articles from minority journals and providing their own minority voices. Several students also talked about classism and the problem with the deficit model of minorities in health care research and programming. The students went even further than the faculty in exploring this concept, with minority and culturally experienced students again making the largest contribution to contesting white hegemony in health care.

Critical Approaches. This principle was also mentioned primarily by minority and culturally experienced students. Minority students discussed the ways that research often downplays or negates their culturally positive attributes (calling positive health outcomes a "paradox"; something that is a "mystery" or "inexplicable"). Culturally experienced students talked about how paternalistic health care programs can be or how

whites tend to portray a superior attitude when working with minority populations. There was even a discussion of Marxist thinking and Yosso's (2005) concept of capital in minority populations among students. So there was an element of critical thinking that was evidenced in the current student data. Unfortunately, the discussion did not seem to impact some of the white students who demonstrated mainstream thinking as they did not contribute much to these discussions; it tended to be minority and culturally experienced voices commenting to one another. To have engaged the white students more, or even challenged them directly for more of a response, would have increased the critical nature of these discussions. As the semester progressed, minority voices were more prominent in some of these more racially charged discussions than earlier in the semester when a few of the white students would engage in the discussions to a larger extent; i.e. there would be more back and forth among students in the postings. Toward the end of the semester, minority students' postings were longer and more intellectually complex than the white students' postings indicating that they were more engaged in the discussion; had more to say. Perhaps white students were silenced, did not want to appear racist or be accused of such, or just did not know that to say (Cabrera, 2012). It is difficult to draw definitive conclusions about their limited postings during this time compared to earlier in the semester from the data.

Intersectionality. This was another concept that was addressed by students, but only a few contributed to this discussion. Because it is so essential to health care practice to acknowledge ways that people are multiply oppressed, it is too bad that this PHCR principle was not more fully explored and addressed once the topic was brought up by those few students. This could be because it was such a new concept to many of the

students.

Disciplinary Self-critique. This was another concept that was not directly or adequately addressed by the students. While they mentioned aspects of health care research, access, and treatment, they didn't always bring these ideas back around to the actual discipline – to what the discipline of public health could do to address the issues of racism directly. Two students, however, not only mentioned the importance of addressing racism within the discipline, but also increasing the number of minority health care workers. One student even commented on the problem of "sky-rocketing tuition and increasing exclusivity of higher education" as contributing to the lack of diversity in the health care professions. Students were likely still looking at these subjects from a student (academic) perspective, rather than placing themselves within that future world of practice as they discussed these issues.

Voice. This was another area where minority and culturally experienced students did have an impact. Whether their contributions changed perspectives of less-critical students or not is difficult to assess, but as the semester went on the discussions in class and online became more challenging and thought-provoking. One minority student even stated that she voiced her opinions more openly than in other classes she had attended to increase white students' understanding of their privilege and power. Based on the data, this MPH program did provide space for minority voices.,

Primary research question: How do students perceive the importance of cultural competency in future practice?

Reviewing these sub-questions and the analysis based on the ten principles of PHCR to answer the primary research question for students' perspectives, students

opined that exposure to and experience within communities of color were the primary ways to increase cultural competency, education alone could not create culturally competent professionals. This opinion did not negate academia's importance as they stated that the amount of cultural competency education they got in the MPH program was too little, or just about right *if* that education contained some aspect of working *in* cultures other than one's own. In addition, many students in the online course mentioned how much they had learned from other students about cultural concepts and health care practices that they had previously known nothing about. Thus, students stated that education *plus* experience or exposure was important to developing cultural competency. Like faculty, they recommended service learning projects and community based participatory research as good methods to increase cultural competency. They also promoted the idea that the field of public health should be addressing health disparities and social justice issues and even promoting such activities within the wider field of health care. Student data, when compared to faculty data, tended to be more critical of public health education and practice, as student responses matched the PHCR approach more closely than did the faculty data. The balance between student data that lined up with the conventional approach versus student data that lined up with the PHCR data leaned more toward PHCR, but there were still students who espoused the conventional approach. This imbalance is likely due to the fact that minority and culturally experienced students voiced their opinions in challenging queries and longer postings/discussions over the semester and their opinions tended to line up more closely with the PHCR approach. Overall, the emphasis on education (particularly service learning and reciprocal learning), exposure, and experience is how students perceive the importance of cultural competency

in future practice.

Alumni Perspectives

Based on the data from alumni of this same MPH program, it is difficult to fully explicate their perspectives as a whole. A higher number of respondents with a greater diversity in gender and ethnicity might have made this data more explanatory. But some conclusions from the data I did get can be illustrated. Once again, I want to answer the sub-questions first using the narrative and counter-narrative themes found in this data, analyze the data using the ten principles of PHCR, and then pull those analyses together to answer the primary research question.

Sub-question (a) To what extent do alumni express that the curriculum in their program prepared them effectively for practice with minority groups?

Alumni tended to be more middle-of-the-road in their responses between mainstream and margin as compared with faculty or current students. Alumni viewed their actual experience prior to entering the MPH program and their own initiative in learning about other cultures as more beneficial in gaining cultural competency, than their academic preparation. They did mention education about minority groups as important, but really emphasized actual experience with groups, other their own cultural group, as the most critical piece of that education. The idea of being imbedded within populations was mentioned several times in alumni data. They leaned more toward "about right" or "too much" (versus "too little" and "about right" as did the current students), in terms of their perspective on the amount of education they received in their MPH program. Did their practical experience influence their perception as they looked back to their academic preparation? Having alumni with only one to five years of

experience might have provided a different view of academic education as such alumni would have had to lean on that academic preparation more in the initial years of their practice. While that was originally the specific population of alumni I wanted to interview, difficulty in garnering participants precluded having only such subjects for this study. Overall, alumni felt that it was their experience, rather than their academic preparation, that helped them gain cultural competence with groups other than their own.

Sub-question (b) To what extent do alumni see any connections between cultural competency and racial/ethnic health disparities or issues of social justice?

Alumni responses to this question were more direct and each respondent stated that they do see connections among these concepts. To what extent was variable; some saw these issues from a very race conscious, critical perspective, while others still viewed them from a dominant ideological stance, with some movement toward an increased race consciousness as evidenced by their definitions of their own culture and its relationship to health and disease. If the two minority alumni had provided more information, or more in-depth answers to this question, I might be able to answer this question more definitively. The "racism and privilege" counter-narrative theme speaks to this sub-question most directly. Alumni comments ranged from the difficulty of language barriers to the white hierarchical nature of US health care and the privilege this bestows on whites to the distinct poorer outcomes such hierarchies confer upon minority peoples; so alumni show an awareness of the connections between cultural competency, health disparities, and social justice.

Sub-question (c) To what extent has alumni's work experience influenced their perspectives on these issues – has practice reified their long-held beliefs or has their

academic education changed these beliefs?

This question is much more difficult to answer than answering sub-questions a or b. Based on the responses as a whole, some of the alumni stated that they grew culturally by working with diverse groups prior to their academic program; all were exposed to cultural competence during their academic program; and many stated they have continued growing in cultural competency based on their professional practice. As stated in the alumni perspectives section of chapter four, however, each participant appeared to be at a different level of cultural competence. Whether these differences are due to academic preparation, or lack thereof, or exposure to diverse groups in professional practice, is impossible to explicate based on the data. What is safe to say, based on their responses, is that public health practitioners do work with many diverse groups, so teaching about cultural competency, health disparities, and social justice issues is important. It was also evident that current students seemed to have more critical views of health care than the alumni. This finding could indicate that actual practice tends to reify the status quo of white hegemonic health care rather than academic education changing their practice. This critique is exactly what DasGupta, et al. (2006) spoke to; the hierarchical nature of health care systems tends to perpetuate itself.

Analysis based on the ten principles of PHCR

With a smaller amount of data from alumni, analyzing this data against the PCHR principles did not help explicate alumni perspectives much beyond what the narrative and counter-narrative themes did. Alumni tended to state understanding of the importance of cultural competency and its connections to health disparities and social justice, but their responses seemed to be more limited, than transformative.

Race Consciousness. Based primarily on the definitions of their own culture that each alumna provided, their race consciousness seemed somewhat limited. Their definitions were rather superficial and white-normative. Even one of the minority alumna's definition tended to be stated from the viewpoint of how the majority culture "consider this culture to be." Answers to some of the other questions did reflect a more race-conscious perspective, specifically from one alumna who talked about the white dominance among health care providers and the ideology this dominance creates in health care. Most of the respondents indicated that they work with people of color, so perhaps their responses were just too short to reveal their own race consciousness more fully.

Primacy of Racialization. Some alumni comments stated the impact of racism directly on health inequities, but the majority of the statements related to this concept were about language or "challenges" and "barriers," not a direct acknowledgement of access and resource allocation due to racism.

Race as Social Construct. This concept was not really addressed in the data, but interestingly no one even mentioned that race is a contested concept. No one questioned my use of the term "disparities" or "social justice" and what that meant. Any mention of race was made with the assumption that it was clearly understood in a certain way by the alumna and by me.

Ordinariness of Racism. This concept was not really addressed in the data.

Structural Determinism. Some of the alumni did mention that policy factors and systemic issues contribute to health inequities and social justice problems. One alumna was quite direct in her analysis of Native Americans as "the forgotten people of the US," stating that this group is under-resourced and exists in poverty due to larger factors than

individual responsibility. Another alumna mentioned how she felt that policy changes would be far more impactful than smaller group programs to address issues of health inequalities. It did seem that experience working with cultures other than their own increased alumni's awareness of the larger issues affecting health disparities and social justice issues in the health care field, just as in the current student data.

Social Construction of Knowledge. This concept was not really addressed in the data. No alumna really mentioned research, variable production, or evidence-based practice in their responses. Such limited data specific to this principle makes it difficult to interpret alumna's understanding of this concept.

Critical Approaches. This concept was addressed in some way by the alumni who mentioned that they took initiative in learning about the cultures they were working with through readings, discussions with other professionals, discussions with contacts in the community, etc. This action alludes to the practice of not taking current practice recommendations at face-value, but questioning the status quo to determine how the communities themselves perceive health issues. Other alumni alluded to this idea, but seemed to fall back on their own mainstream viewpoint when it came to practice; mentioning language barriers and judgements as being the main problems in practice.

Intersectionality. No alumni really mentioned this concept in their responses.

Disciplinary Self-critique. Many of the alumni talked about the importance of teaching cultural competency and in addressing issues of health disparities and social justice, but stated that these concepts are difficult to teach. They stated that immersion in a cultural group is how cultural competency education can be done, not academic teaching. None of the alumni, however, really spoke to the issue of critiquing the public

health field as a whole.

Voice. While there was a little evidence of this principle in the data (e.g., the issues about Native Americans poorer health outcomes with no one to speak for them; the idea of avoiding stereotyping groups), it was limited. Even the two minority alumni did not take advantage of the questions to challenge the white hegemony of health care. Even their other responses distanced them from really questioning the racialized nature of our health care system. Again, this could be due simply to the length of their responses; more lengthy responses may have shown more of this principle in the data.

Primary research question: What do alumni from the same program say about cultural competency in practice?

Reviewing responses to these sub-questions as a whole and the ten principles analysis, I can answer the primary research question in this way: while alumni statements mentioned the importance of education about other cultures, they emphasized not only exposure to such cultures, but particularly experience within other cultures as the way to achieving an adequate level of cultural competency. Even with this summary of responses, however, alumni tended to comment that one can never be fully culturally competent, that one must continually work on understanding and interacting with minority communities in ways that promote cultural competency and cultural humility. Overall, the alumni responses were not as critical as the faculty or current students' perspectives. Such difference may indicate that practice reified their own perspectives on working with cultures other than their own or, because white hegemonic ideology is so pervasive in health care, that years of experience within that field blunted their responses that might challenge, or call into question, the current practice of public health.

Combined Perspectives

Based on the above analyses from chapters four and five, the most pertinent outcome of this data is that the perspectives of faculty, current students, and alumni from SWCOPH in regards to cultural competency, while variable due to the nature of their position within and outside of academia, have a distinct similarity: all three groups felt that cultural competency is important to teach in a MPH program and that there are connections between cultural competency, health disparities, and social justice issues. Their responses overall, fit within the conventional approach as well as the critical (PHCR) approach as explained by Ford and Airhihenbuwa (2010b; Table 1). This finding shows that this particular course in the MPH program does introduce students to critical discourse about race and its problematic use in our current health care system. While there were differences in exactly what role cultural competency education can play in addressing health inequalities and social injustices, these groups agreed with the Institute of Medicine reports (Smedley, Stith, & Nelson, 2003; Smedley, Butler, & Bristow, 2004) that it does have a role. Each group also recommended service learning projects and community based participatory research as tools to help expose students to cultures not their own and mentioned the importance of reciprocal learning that should be highlighted during such experiences.

Despite exhibiting discussions and understandings of critical concepts, the actual responses by all population groups, when analyzed against a more detailed critical framework (the ten principles of PHCR), revealed the difficulties in extending such critical pedagogy from the classroom to practice. It was difficult to assess whether or not internalizing these concepts was occurring for students not as culturally sensitive as some

of the other students. It was also difficult to assess to what extent academic preparation helped alumni practice in culturally sensitive ways. This study did demonstrate the beginnings of teaching cultural competency in critical ways as evidenced by several counter-narratives in each population and individual responses throughout the data, but more might be done to further expand cultural competency education. Using the findings and analyses from this study, as well as the critical PHCR framework for praxis and the literature on this subject together, a pattern for developing more critical praxis in academic teaching of cultural competency, health inequalities, and social justice health issues can be developed. This conclusion, as well as implications for future research and practice, is the topic of the next chapter.

CHAPTER 6: CONCLUSIONS AND IMPLICATIONS

The purpose of this case study was to qualitatively analyze the perspectives on cultural competency education by faculty, current students, and alumni from one Master of Public Health (MPH) granting institution – South West College of Public Health (SWCOPH; a pseudonym). Looking at this topic through the public health critical race (PHCR; Ford & Airhihenbuwa, 2010b) praxis theoretical lens, asking questions about health disparities and social justice from the perspectives of (a) faculty who teach or have taught cultural competency coursework, (b) current students over the course of a semester in a required cultural competency course, and (c) alumni from this same program who are now practicing within populations different from their own, provided instructive perspectives on teaching and learning cultural competency and how these three populations see cultural competency's connection to issues of health inequalities and social injustices within the health care field. Using a critical framework to evaluate data from direct observation of a required cultural competency course, documents from this course, and interviews from all three subject populations, helped to identify narratives that maintain the status quo of the current white hegemony of US health care and counter-narratives which challenged the status quo. Further analysis against the PHCR framework revealed strengths as well as some gaps in teaching cultural competency as it relates to health equity and social justice. This study provided insight into the larger question of pedagogical practices in cultural competency classes that influence perspectives and praxis. This chapter provides an overview of the study and research questions; summarizes findings and reveals how this study extends previous research; then presents implications for future research and practice. This chapter ends with some

concluding remarks.

Overview and Research Questions

Health disparities in access, treatment, and outcomes between majority and minority populations in the US have continued despite decades of research, policy, and practice attention (Dilworth-Anderson, Pierre, & Hilliard, 2012). Cultural competency education has been viewed as a way to improve health care treatment and outcomes for minority populations (Haughton & George, 2008; Kardong-Edgren & Campinha-Bacote, 2008; O'Connell, Rickles, Sias, & Korner, 2009; Smedley, Stith, & Nelson, 2003). Cultural competency has been defined as "the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds" (Betancourt & Green, 2010). Public health as a discipline has been addressing social justice issues since its inception (Rosen, 1993). Indeed, the Association of Schools and Programs of Public Health (ASPPH) has created criteria for MPH programs that includes cultural competency and associated core content that addresses education regarding health disparities and social justice issues (ASPPH, 2014). With this background in mind, this study set out to investigate how cultural competency is taught by faculty, caught (internalized) by students, and practiced by alumni. The following research questions were addressed:

1. To what extent do faculty members teach cultural competency in a MPH program?

    Sub-question (a) To what extent do faculty members address racial/ethnic health disparities and issues of social justice as a part of cultural competency education?

Sub-question (b) To what extent do faculty reflect on their own race consciousness?

2. How do students perceive the importance of cultural competency in future practice?

Sub-question (a) To what extent do students' attitudes about cultural competency change over the course of a semester in a class that emphasizes culture?

Sub-question (b) To what extent do students see racial/ethnic health disparities as a part of cultural competency and an issue they need to address as future practitioners?

Sub-question (c) To what extent do students perceive the field of public health as a field that promotes social justice?

3. What do alumni from the same program say about cultural competency in practice?

Sub-question (a) To what extent do alumni express that the curriculum in their program prepared them effectively for practice with minority groups?

Sub-question (b) To what extent do alumni see any connections between cultural competency and racial/ethnic health disparities or issues of social justice?

Sub-question (c) To what extent has alumni's work experience influenced their perspectives on these issues – has practice reified their long-held beliefs or has their education changed these beliefs?

Through analysis against the PHCR framework's four focuses (Figure 1) sub-

questions were answered using the narrative and counter-narrative themes that emerged from the data. This process also aligns with Ford's (2014) description of doing research from the margin, or minority, perspective rather than from the mainstream, or majority, perspective (Figure 2). Combining this initial analysis with a secondary more in-depth, critical analysis of the data against the PHCR framework's ten principles (Table 1) the primary research questions were answered. A summary of these findings follows.

Summary of Findings

This section presents conclusions drawn from the findings, from chapters four and five, that answer the research questions for each population and for the study as a whole. Next, an overarching schematic that portrays the findings as a whole will be presented. Then how these findings extend previous research will be addressed.

Faculty Perspectives

Faculty members of SWCOPH do teach cultural competency concepts and relate this to issues of health inequities and social justice. Issues of racialized research, the negative stereotyping of minorities through the deficit model, racism and its negative impact on health, as well as other equity and justice topics are addressed, but when evaluated against the PHCR framework, there appears to be room to make these issues more real to students, especially white students. This study reveals that one required cultural competency course is likely not enough to create culturally sensitive practitioners; faculty members even point to the fact that cultural competency should be woven throughout the whole MPH program. Ways to increase the reality of racism to students would include helping students not only realize the impact of these issues, but their part in perpetuating the hierarchical white hegemony of our current health care

system; then providing practical ways to dismantle this system to allow for truly equitable health care to occur. As one faculty member put it, they discuss these "difficult issues" with students, but when viewed very critically through the PHCR fram ework, their efforts may not go far enough to impact students' perspectives on these issues in a lasting way. Students may become sensitized to these issues through education and interactions with communities of color in service learning or internship practicums, but to become real activists in instituting change to hasten progress in the area of health inequalities and social injustices in the health care field seems to take more than academic preparation. Fine (2006) quotes Apfelbaum (2001) when discussing oppression and resistance. Fine emphasizes Apfelbaum's assertion that researchers must "think through the conditions under which relatively privileged people are willing to hear and act on oppression" (p. 87). It is through *action* that lasting, real change is made. Hytten (2006) echoes this sentiment when she speaks of cultural studies making "a difference in the real world…beyond the walls of the academy" (p. 235). She mentions the hard work of "balancing academic and activist work" (p. 235). Is this hard work why progress in health disparities issues is taking such a long time? Our academic endeavors address these issues, but do not go far enough to enlist strong *action* on the part of future practitioners; or the action that does occur is too limited in its time or scope. How much can a higher education institution do to create agents for change in this area? Faculty who taught the course I observed, certainly had no problem providing literature that challenged students to think critically about the issues of cultural competency, health inequities, and social justice and provided space in the classroom for minority voices to be heard, but will these students be able to translate what they've learned into a just and

equitable practice? Such a transformative experience is an ambitious undertaking, but this data did reveal faculty's passion for attempting to address these issues in the curriculum. Several authors have shown how creating space for minority voices in the classroom and allowing white students to feel uncomfortable with some of these issues, while simultaneously helping whites "stand in the shoes" of minority individuals, can increase the impact a curriculum has on transformative thinking and action (Chow, Pederson, Haworth, Brokman, & Benice, 2009; Cushman, Delva, Franks, Jimenez-Bautista, Moon-Howard, Glover, & Begg, 2015; Griffith, Yonas, Mason, & Havens, 2010; McDowell, 2004; VanHerk, Smith, & Andrew, 2011).

Perhaps this introductory course was setting the stage for such progressive growth throughout the rest of the MPH program; something this study did not investigate. What did occur during this semester was a credit to the passion of the professors of this course in role-modeling equitable behavior and challenging students to think critically of research and health care practice.

The most common thread throughout the faculty data was that education about these issues throughout the MPH curriculum and being exposed to under-served communities through service learning projects or through community-based participatory research was paramount to increasing students' cultural competency. These responses may indicate that the full MPH program does build on this initial course, but that is not what I studied; I investigated this one required cultural competence course, as it was possible some students would not take other courses that covered the topic. This emphasis on education, exposure to, and experience with under-served communities is how faculty members recommended teaching cultural competency in this MPH program.

Current Student Perspectives

Students opined that exposure to, and experience within, communities of color were the primary ways to increase cultural competency; education alone could not create culturally competent professionals. This opinion did not negate academia's importance as they stated that the amount of cultural competency education they got in the MPH program was too little, or just about right *if* that education contained some aspect of working *in* cultures other than one's own. Thus, students stated that education *plus* experience or exposure were important to developing cultural competency, not experience or exposure alone. Like faculty, they recommended service learning projects and community based participatory research as good methods to increase cultural competency. They also promoted the idea that the field of public health should be addressing health disparities and social justice issues and even promoting such activities within the wider field of health care. Student data, when compared to faculty data, tended to be more critical of public health education and practice, as student responses matched the PHCR approach more closely than did the faculty data. The balance between student data that lined up with the conventional approach versus student data that lined up with the PHCR approach leaned more toward PHCR, but there were still students who espoused the conventional approach. This imbalance is likely due to the fact that minority and culturally experienced students voiced their opinions while challenging conventional opinions and practices, so their opinions tended to line up more closely with the PHCR approach. The actual classroom observation did show how much minority and culturally experienced student voices were represented. The face-to-face classroom discussions and the online postings revealed, at times, lively discussions about difficult issues. While

there were never any outbursts during these discussions, there was somewhat confrontational dialogue among students. Faculty never had to intervene as these discussions never got even the least bit out of control, but that students felt safe enough to engage in even that depth of discussion revealed how important the classroom environment is to promote such discourse. Whether such exchanges helped students grow internally in the area of cultural competence is difficult to assess, but they certainly had good exposure to concepts that might have been challenging to them. Overall, the emphasis on education (particularly prior to and during service learning and reciprocal learning experiences), exposure, and experience is how students perceive the importance of cultural competency in future practice.

Alumni Perspectives

Alumni tended to state understanding of the importance of cultural competency and its connections to health disparities and social justice, but this understanding seemed to be more abstract, than transformative. Their responses were more intellectual than practice-based. Alumni were aware of the topic of the study and so their opinions about the topic were exposed in their responses to the questions, but that was where responses stopped; alumni delineated very few specific behaviors they use in practice that are culturally sensitive. Alumni emphasized not only exposure to such cultures, but particularly experience within other cultures as the way to achieving an adequate level of cultural competency, but did not detail what those experiences look like as action. Even with these responses, however, alumni tended to comment that one can never be fully culturally competent, that one must continually work on understanding and interacting with minority communities in ways that promote cultural competency and cultural

humility.

Overall, the alumni did not reflect as critical responses as the faculty or current students' perspectives. This difference may indicate that practice reified their own perspectives on working with cultures other their own or, that because white hegemonic ideology is so pervasive in health care years of experience within the field blunted their responses that might challenge, or call into question, the racialized practices of public health. Their seeming pessimistic views of how academia could prepare a professional for future culturally competent health care practice points to a possible disconnect between academic preparation and actual practice. Does academic preparation or actual practice within communities of color become more transformative for future health care practitioners? Can academic institutions do more to create agents of change in the area of health equality and justice in the classroom? (Godwin & Heymann, 2015). As mentioned above, these are difficult, but important issues for higher education institutions.

Combined Perspectives

The most prominent outcome of this data is that the perspectives of faculty, current students, and alumni from SWCOPH in regards to cultural competency, while variable due to the nature of their position within and outside of academia, have a distinct similarity: all three groups felt that cultural competency is important to teach in an MPH program and that there are connections between cultural competency, health disparities, and social justice issues. Their responses overall, however, still demonstrated more of a conventional academic approach rather than a more critical (PHCR) approach as explained by Ford and Airhihenbuwa (2010b; Table 1); although direct observation of the required cultural competency course did demonstrate how much of the issues of race,

racialized research, viewing communities as resilient rather than deficient, and other such topics were introduced to students. Direct observation also revealed how open the classroom environment was to challenging discussions and minority voices. It may be that for this one semester course, setting the stage for a critical evaluation of public health that becomes the foundation for further growth throughout the MPH program is what I witnessed, but I could not confirm this possibility as my investigation was limited to the one required course.

While there were differences in exactly what role cultural competency education can play in addressing health inequalities and social injustices, these groups agreed with the Institute of Medicine reports (Smedley, Stith, & Nelson, 2003; Smedley, Butler, & Bristow, 2004) that it does have a role. Each group also recommended service learning projects and community based participatory research as tools to help expose students to cultures not their own and mentioned the importance of reciprocal learning that should be highlighted during such experiences.

Despite exhibiting understandings of critical concepts, the actual responses by all population groups, when analyzed against a more detailed critical framework (the ten principles of PHCR), demonstrated that critical pedagogy is occurring in a preliminary way in this cultural competency course. To investigate the MPH program as a whole based on the faculty and alumni responses would be unfair as there simply was not enough data to state definitively what is happening overall in the program. What can be said of the program overall, based on (a) observation in the classroom, (b) discussions with the professors of the course, (c) hallway posters marketing upcoming speakers and faculty and student research projects, and (d) observation of the students' internship

presentations, is that this MPH program (a) emphasizes working *with* communities rather than *for* communities, (b) values cultural competency and diversity in faculty and student populations, and (c) embraces the concepts of health equity and social justice.

This study demonstrates the beginnings of teaching cultural competency in critical ways as evidenced by several counter-narratives in each population and individual responses throughout the data, but more might be done in this course; i.e. direct "dismantling racism" workshops (Griffith, Yonas, Mason, & Havens, 2010) that could help increase white students sensitivity to racial issues and give an additional platform for students of color to express their lived experiences. These types of activities could also then be extended to how this dismantling could impact health care practice in the future.

While minority students and culturally experienced students were observed to be further along on the developmental stage toward a critical praxis (Weidman, DeAngelo, & Bethea, 2014), these findings should not suggest that MPH applicants without prior cultural experience should be excluded from such programs. What this does suggest is that such programs find ways to engage students in more critically evaluating our current health care system and continue to offer experiences with communities of color, but with an academic preparation that includes exposure to critical thinking about the health care system and the introduction of practical skills for addressing issues of health disparities and social justice within institutions of health.

Using the findings and analyses from this study, as well as the critical PHCR framework for praxis and the literature together, a pattern for developing more critical praxis in academic teaching of cultural competency, health inequities, and social justice health issues can be developed. How such praxis can be developed is the subject of the

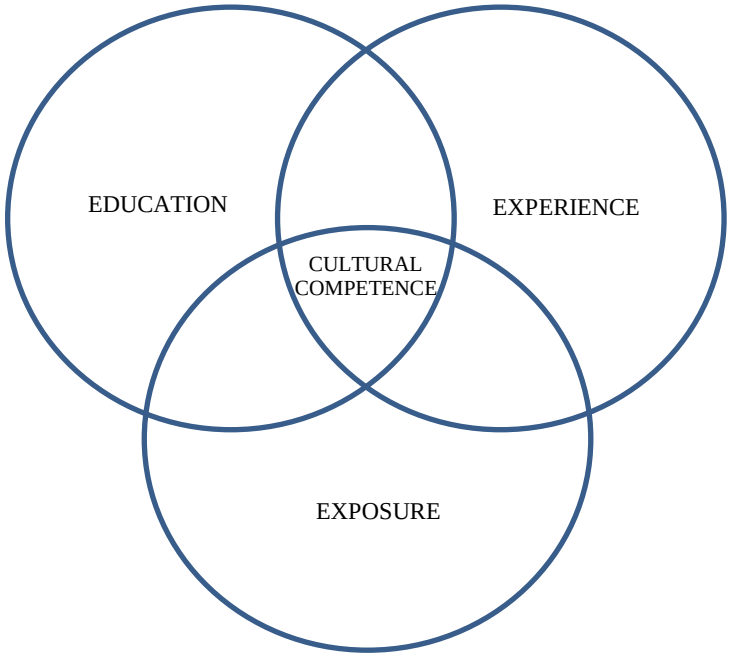
next two sections.

The Triple "E" Format

Critical race theory (CRT) has not just a theoretical role to play in research, but has an advocacy role as well (Ford & Airhihenbuwa, 2010b). As Ford and Airhihenbuwa (2010b) state, "CRT … aims not only to understand inequities, but to eliminate them. Thus researchers rely heavily on the findings to develop strategies for addressing inequities" (p. 1391). While this study does not definitively meet this action aspect of PHCR, the implications for practice do have an advocacy component to them in that the findings indicate a pattern that MPH programs can follow to evaluate and improve their cultural competency education of students. All three data populations emphasized the importance of education, exposure, and experience in developing cultural competency and agreed with the Institute of Medicine (IOM) reports (Smedley, Stith, & Nelson, 2003; Smedley, Butler, & Bristow, 2004) that improving cultural competency can diminish health inequities and address social injustices. Figure 3 is a graphic display that depicts what this data revealed about the relationship among these three aspects of teaching and learning cultural competency based on the data from this study. I have termed it the triple "E" format due to its three essential components of education, exposure, and experience.

Each large circle depicts one of these components: education – learning about other cultures' histories, health beliefs and practices, and historical interactions with dominant cultures; exposure – brief encounters with cultures other than one's own, e.g. brief service learning projects; experience – more than just brief encounters with cultures other than one's own, e.g. Peace Corps, long-term service learning or internship projects (where one is "imbedded" within the culture to a large extent, working with the

Figure 3: Development of cultural competency through academia; the triple "E" format



population intimately). Each large circle can stand on its own – one can learn a great deal about another culture, but without exposure or experience with that culture, it remains just book learning. One can have exposure to a culture, but without intentionality, that exposure is limited to simply that – exposure; e.g. like a tourist. And one can have experience with a culture, even living among a people group other than one's own, but could remain entirely separate from that other culture in many ways; not be truly imbedded in the culture. It is, therefore, in the overlapping regions that a person can begin to work toward cultural competency.

When intentional education and exposure meet, such as in brief service learning projects prefaced by academic coursework, cultural competency may be enhanced; as evidenced in the current students' service learning presentations. When intentional education and experience meet, such as in Peace Corps involvement, cultural competency

appears to be greatly enhanced; as evidenced by those current students and alumni who mentioned these experiences. And when intentional exposure and experience meet, such as community based participatory research where a researcher works with and within a community, utilizing community partners and working to establish larger resources for the community (partnerships, policy change, etc.), cultural competency is also enhanced. But it is when these three components come together – intentional education about a culture, exposure to the culture and the multitude of elements impacting that culture and their health, and longer term experience within that culture, working within the culture itself, that cultural competency can really begin to take hold in a learner's life. It is in the intersection of these three powerful components where the following can and may take place: the promotion of cultural humility (Tervalon & Murray-Garcia, 1998), the beginnings of the dismantling of a white individual's notion of colorblindness (Bonilla-Silva, 2010), and the desire to act in ways that diminish inequalities, e.g. to interrupt racism (Trepagnier, 2010) and to become a racial justice ally (Reason, Scales, & Roosa Miller, 2005).

The idea of intentional work in the area of cultural competency education cannot be overstated as evidenced by the literature review and the fact that health disparities and social injustices still exist in the US (see literature review and references). But MPH programs can utilize this diagram and the PHCR framework to evaluate their own programs, and to strengthen their commitment to the ideals of cultural competency, health equity, and social justice. It is this use of the PHCR framework in this new, unconventional way that highlights how this study extends previous research; the subject of the next section.

Extending Previous Research with the PHCR Framework

This study shows that the PHCR framework, although advanced for use in developing community programs from a critical perspective, can be used to evaluate curriculum dealing with cultural competence and its relationship to health inequities and social justice. In fact, PHCR is a perfect theoretical framework to do just that as it addresses and encompasses many of the issues surrounding race such as whose knowledge is of value (Apple, 1990); allowing minority voices to speak (Hytten, 2006); addressing the systemic issues in health care (Feagin & Bennefield, 2014); and researching from within the margin, rather than the mainstream (Fine, 2006; Ford, 2014). In addition, the authors, Ford and Airhihenbuwa, advocate its use in public health (2010b) to promote racially equitable health care. Interestingly, the concept of generalizability helps show that the way this theoretical framework was used in this study is appropriate and could be used to evaluate cultural competency curriculum in other MPH programs; ultimately to increase the likelihood that such improved, critical curriculum could produce more racially conscious health care practitioners.

Fine (2006) describes two types of research generalizability: theoretical generalizability and provocative generalizability. She defines these terms as such:

> Theoretical generalizability refers to the extent to which theoretical notions or dynamics move from one context to another. Provocative generalizability would offer a measure of the extent to which a piece of research provokes readers, across contexts, to generalize to 'worlds not yet,' in the language of Maxine Greene; to rethink and reimagine current arrangements. (p. 98)

Thus, using the PHCR framework fits as theoretical generalizability – this framework designed for program development was used for curriculum evaluation. Narrative and counter-narrative themes were gleaned from the data as in any other critical study using the four focuses of the PHCR framework (Figure 1). Then the data was further analyzed using the ten principles and examples from these principles that line up with the conventional approach in public health versus the critical (PHCR) approach (Table 1). Utilizing the theoretical framework in this way proved quite useful and provided good analysis of all data – documents, observations, and interviews. I returned to the framework again and again during data collection and analysis to avoid my own white racial framing ideology (Feagin & Bennefield, 2014), so that I could "see" that data from the margin, rather than the mainstream, perspective (Ford, 2014). Indeed, I had to do this to prevent "being too white" as an Asian-American friend informed me when reviewing some sections of my early analyses. Due to my "whitenss" I did have an Asian-American friend, who is familiar with critical race theory but not public health literature, review several of the early drafts of my findings chapters.

Fine (2006) goes on to explain how theoretical generalizability should include "serious and sustained conversation with those who are assaulted by oppression, resisting it and/or cleaning up the mess created by widespread social injustice" (p. 99). While this study did not include such conversations, the current student data, particularly from the online class, included quite a bit of critical, challenging, and resistive discourse. Many of the minority and culturally experienced students challenged some of the other students who provided comments that represented the status quo. These critical comments revealed examples that more closely matched the PHCR approach and confronted the

conventional approach being espoused by students who represented a more white hegemonic stance to the issues being discussed. Interviews also did allow for some of these types of conversations to occur; they were just not as lengthy and involved as Fine describes in her article (2006). Nevertheless, several aspects of her description of theoretical generalizability apply to this study.

Provocative generalizability can apply to this study *if* reading this study moves readers to act. When "researchers' attempts to move their findings toward that which is not yet imagined, not yet in practice, not yet in sight" (Fine, 2006, p. 100), provocative generalizability occurs. This reader movement also represents the action phase of Focus 4 of the PHCR theoretical framework. Fine goes on to explain that provocative generalizability encourages readers to act, providing ideas on what can be done to change the existing landscape. She likens research to art – that research should stir the emotions, not just the intellect, so that action results. While this study is not in and of itself an action, it is hoped that by showing other researchers how the PHCR framework can be used to evaluate curriculum, such researchers will do so, then move beyond evaluation to action – actually creating more critical cultural competency curriculum; curriculum that truly "centers in the margins" (Ford, 2014) those voices that have traditionally been left out of the discourse.

Thus, both theoretical and provocative generalizability provide an explanation of how this study extends previous research with the PHCR framework. Both concepts can be seen at play in this study and can be used to further such work even beyond what this study accomplished. Implications for future studies are the topic of the next section.

Implications for Future Research

While this study did find that the PHCR framework can be used to evaluate an aspect of an academic program as well as its intentioned function in developing public health programs for under-served communities and communities of color, there are additional aspects of this study that lead to recommendations for future research. The primary recommendation is to use this framework to evaluate other MPH programs utilizing three populations (faculty, current students, and alumni) to see if other programs reveal similar themes. If so, development of a curriculum evaluation tool combining PHCR with the triple "E" format may prove helpful in establishing curriculum that meets the standards for MPH cultural competency programs that provide education with a strong health equity and social justice element. If further research reveals dissimilar themes, the PHCR framework and triple "E" format can be expanded, revised, and improved upon to develop such a tool. This tool can then help administrators establish cultural competency education for public health care workers of the future who will be working with a very diverse population (Pardasani & Bandyopadhyay, 2014), that truly engenders action; that is public health practice that is culturally sensitive and leads to health equity and social justice.

I believe that research that looks at each of these three populations within a single MPH program provides much more information on how cultural competency is taught and caught (internalized) by students, then practiced by alumni and is a methodological approach that should be replicated in other studies. Such studies could also add more directed and in-depth interpretation to explicate some of the questions not fully answered in this study. Additional studies could also utilize the cultural competency assessment

tools already in existence to determine not only the change in attitudes, beliefs, and skills during a semester, but also how exposure and experience impact cultural competency prior to coursework in academia. Evaluating alumni from such programs to get more input from practitioners as to what works and what is less helpful from cultural competency education and what their recommendations are to improve curriculum and learning would also enhance and improve curriculum development; adding to the triple "E" format and the PHCR framework. Such studies could also help new professionals maintain a more critical practice during their early years, rather than succumbing to the perspectives and practices of the entrenched white hegemony of our current health care system. Studies that start with a critical race framework, developing curriculum, providing this curriculum, then evaluating its effectiveness on practice with graduates of the curriculum would prove quite useful in promoting cultural competency education that promotes equity and justice ideals, while helping practitioners enact these ideals in health care institutions of all types.

The bottom line: this study showed that MPH programs can provide cultural competency education that (a) encourages students to strive for lifelong learning in this area as each participant group mentioned that cultural competence is a process, not something that one "gets"; and (b) can contribute to health equity and social justice for minority populations *if* intentional education, exposure, and experience are part of the curriculum and/or student background, as each participant group stated that this education could lead to more racially just health care.

Based on the study's findings that showed cultural competency curriculum could match a critical framework more closely (and that there is a framework that can be used

to do this), and the fact that moving beyond study to action is an important aspect of critical work, another important implication for future research is that of creating a cultural competency curriculum that is based on the PHCR framework and then testing it. Such research could prove far more constructive in moving past talking *about* becoming a more racially equal and just discipline, toward actually *doing* more racially equal and just public health. Hytten (2006) describes this action-oriented approach when she states, "Critical pedagogues argue that schooling should fundamentally be about individual growth and social transformation; what we do in classrooms should be connected to efforts to challenge social inequalities and to build a better society" (p. 222). Having the PHCR framework for such curriculum development in public health is a great foundation for such future research and curricular change. Utilizing the PHCR approach examples of the ten principles (Table 1) as the genesis for developing curriculum is a great starting point. The faculty and current students' emphasis on service learning and CBPR experiences does point to the fact that they are sensitive to these issues and that action toward addressing these concepts *is* important, and happening, in public health.

One other aspect of this study that leads to options for future research came about from the one face-to-face class discussion where a white student was effectively silenced early in the semester for what her classmates considered was her minimization of minority experiences. Did she gain anything from the course or were her beliefs simply entrenched? I should have made a point to interview her later in the semester, but did not. There are standardized and verified tests of cultural competency that I could have used (Harrowing, Gregory, O'Sullivan, Lee, & Doolittle, 2012; Holmes, Zayas, & Koyfman, 2012; Stone, Francis, van der Riet, Dedkhard, Junlapeeya, & Orwat, 2014), but chose not

to. Such evaluations are primarily limited to service-learning types of experiences that may be short- or long-term and evaluate differences in attitudes, skills, and knowledge, but do not do so from a critical framework standpoint. Since they do not come from a critical perspective these evaluations may miss important nuances about culture, race, and ethnicity that may prove important in the actual practice of culturally competent health care that leads to decreasing health disparities and social injustices. Use of evaluation tools such as the Cultural Competence Assessment which has a Cultural Awareness and Sensitivity subscale and a Cultural Competence Behaviors subscale, have proven helpful in evaluating cultural competency (Hall, Guidry, McKyer, Outley, & Ballard, 2014), but are not connected to health disparities and social justice *practice*, something I wanted to assess. Such evaluations may, however, prove useful for other researchers who want to focus on other aspects of cultural competency learning or who want to combine curriculum development with evaluation of change not only in a students' knowledge, attitudes, and skills, but in their practice as well.

Implications for Practice

I began this study because my own MPH and PhD academic experience opened my eyes to my own "whiteness" and to a world I did not even "see" – the ordinariness of racism and its negative effects on communities of color in education and health care, as well as all other institutions in the US. Evaluating the cultural competency curriculum of a MPH program for how truly "critical" it was revealed room for improvement, but also provided a tool for such improvement – the Public Health Critical Race (PHCR) praxis framework. Not only can this framework be used to evaluate a curriculum, it can be used in developing better, more race-conscious curriculum. In creating a more critical

curriculum, the promise of cultural competency education to generate more racially conscious health care practitioners, rather than reproduce the current white hegemonic ideology of the US health care system, could be realized. Many researchers believe cultural competency education can accomplish the development of more race-conscious, culturally sensitive practitioners, but perhaps one reason this has not happened is that the curriculum was still being developed based on a white racial framing (Feagin & Bennefield, 2014) – developed from the mainstream, rather than the margin (Ford, 2014). Bergsma's (1997) dissertation related to the social control exhibited in medical education revealed the strong entrenchment of the white male hegemony of health care, but I have to admit, my own study in the field of public health did show quite a bit of movement from her findings to my findings 18 years later. Particularly in the area of students having more say during classroom discussions and professors role-modeling more racially conscious behaviors and providing challenging readings and discussion questions shows that some improvement has been made over these last two decades. Of course, as mentioned previously, public health tends to be in the vanguard of such practice, so this is not surprising.

Using the PHCR framework, in combination with other critical race theorists scholarship, can allow curriculum to be developed from the margin. Some additions to such curriculum development could include discussions of how whites view these issues – do they participate as fully as they would like or do they feel uncomfortable talking about race and racism (Trepagnier, 2010); do whites fear being labeled a "racist" for voicing their opinions (Spanierman & Cabrera, 2015); are whites sensitive to these issues and therefore afraid of "saying the wrong thing" (Cabrera, 2012)? Addressing minority

students', as well as white students', perceptions of race and racism in a classroom that promotes cultural competence, health equity, and social justice takes skill. Faculty that not only teach, but live, such concepts, however imperfectly, contribute to student development in this area, as evidenced by the classroom discussions I observed. Having faculty engaged in research with communities of color and reflecting on their work, with humility, in classes helps students see these concepts in action. Development of the student body culture toward equity and justice with reminders of such issues (e.g. faculty and student research posters, Social Justice conference, etc. as in this MPH program) can also contribute to more firmly establishing skills that students can put into practice in their futures. Such socialization within the academy, as well as promoting such action outside the academic experience, can help students develop a culturally responsive identity (Weidman, DeAngelo, & Bethea, 2014).

Ultimately, equitable health care for minorities that is also socially just will likely not happen if academia does not pave the way for such change in practice; but academic research is only the beginning of change. Practice that utilizes academic research to push the boundaries of our current health care system toward such equity and justice must, and is, taking place. Even in overseeing students' research projects, faculty can remind students to practice in culturally sensitive ways. For example, faculty can make sure the student researcher has developed a plan for giving back to the participants they are researching in a way that is culturally appropriate and, if possible, determined by the community the student is studying. This action is a form of critical praxis that, if begun during academic studies, can help students experience such praxis, then feel more capable of exhibiting race-conscious practice in the field as health care professionals. In addition,

partnerships between academic institutions and health care professions that reveal how this change can be accomplished can make huge strides "toward that which is not yet imagined, not yet in practice, not yet in sight" (Fine, 2006).

This study's findings, therefore, helped to reveal some pedagogical practices that may help promote the development of culturally competent health care practitioners; things evidenced in this MPH program based on observation, interviews, and documents. To illustrate these implications more clearly, I have listed culturally sensitive practices I observed below:

* Faculty can role-model culturally competent practice (in the classroom, in their own research, and in their mentoring of students). Faculty uncomfortable themselves with this aspect of teaching may require training.

* Faculty can introduce race and race-related literature to students through required readings – historical, experimental, and current; particularly literature from non-white authors and ethnic and international journals.

* Faculty can promote a safe space in the classroom for difficult discussions of race and race-related issues in health care. Faculty can monitor such discussions to avoid devolution to stereo-typing or name-calling and challenging students with thought-provoking questions or concepts, while allowing for uncomfortable reflections of students and openly addressing them in non-threatening ways.

* Faculty can introduce students to community-based participatory research and its importance in promoting culturally sensitive studies.

* Faculty can require students to participate in, reflect on, and present their experience with a service-learning project.

* Administrators can promote a culturally sensitive MPH program – diversity of faculty, staff, students, research, internships, etc. Administrators, faculty, and staff can create a culture within the academic program that helps student experience cultural competence regularly and consistently.

* Faculty can connect students to agencies and organizations where culturally competent health care and research can take place to the benefit of student *and* community. These experiences can provide great opportunities for student reflection, gentle faculty challenges, and praxis.

* Faculty can establish cultural competence, health equity, and social justice as expectations of students as future health care professionals.

* Administrators can maintain good ties with alumni and invite them to speaker conferences (like SWCOPH's Social Justice symposium) to help alumni maintain a culturally sensitive stance.

Some additional practical ways this can be done based on this study's findings and the literature follow. All of these recommendations should be done in a safe classroom setting with faculty knowledgeable in dealing with race and race-related issues:

* Have students work in diverse groups on projects.

* Have students reflect on challenging historical cases.

* Provide scenarios of actual practitioner-patient interactions that are covertly racist and have students discuss in small groups, then come together to discuss as a large group. Faculty can make sure to highlight perspectives from white and non-white students and ask about this divergence, guiding students to critically

evaluate the differences and what they can mean in terms of health care practice.

* Faculty can utilize any number of very recent books as required readings or have several small groups of students each read a different book, provide questions about the book to discuss in the small groups, then have each small group present an overview of the book and their discussions. Examples of such books might be: “Black Man in a White Coat” by Damon Tweedy (2015) or “Between the World and Me” by Ta-Nehisi Coates (2015). Introducing white students to works by non-white authors who engagingly describe daily life in a white society may help white students see past their own whiteness.

* Administrators can work to not only maintain good ties with alumni, but develop specific programs (e.g., short continuing education programs via face-to-face and/or on the web) to reinforce racial justice ally practices in institutions, thus promoting action in practice.

* Dismantling racism workshops could be introduced to faculty, staff, and students to evaluate their own program as well as establish racial justice ally policies and practices.

Situating this Study in the Literature

It is hard for health care organizations to look at themselves as contributors to health disparities, but there is evidence that this is the case (Griffith, Yonas, Mason, & Havens, 2010). By being willing to look at this possibility honestly and address it head-on, change can happen. Griffith, Yonas, Mason, and Havens (2010) talk about using a dismantling racism approach – evaluating organizations from a racism standpoint; how well the organization is doing in terms of eliminating racism – to help organizations deal

with their own issues of racism directly and powerfully, then adapting policies, procedures, and organizational culture to decrease health disparities. These authors state:

> In the context of health educators and other practitioners who have chosen to work with underserved populations and communities, it borders on heresy to suggest that they do not provide the best, highest quality care to all their patients. Nonetheless, the data shows that they may not. (p. 375)

This statement might apply to public health academic institutions as well. Despite their best efforts, they are apparently still producing practitioners who have not reversed the decades long tide of health disparities and social injustices in health care as evidenced by the literature (see literature review). Interestingly, in 2015, Cushman, et al., describe a one-day workshop for incoming MPH students to address, on the individual level, critical issues of cultural competence. The article describing this workshop reflects many of the principles my study is based on. Thus those institutions willing to evaluate their curriculum and organizational practices against a critical framework and engage many voices in this process, particularly minority voices, may be able to present cultural competency education that does lead to practices that address and eliminate health disparities and social injustices.

Furlong and Wight (2011) explain this concept further. They proffer that all health sciences academia is based on a white male-oriented foundation. They use Maslow's hierarchy of needs, a classic concept in psychology and sociology, as an example of a well-accepted belief that is actually white-culture based and not true in Indigenous cultures. These authors state that white writings problematize minority cultures from the outset – casting minority cultures as having a lesser form of

development than white culture. They claim that if a profession does not critique itself and place "the other" as expert and act as "informed not knowing" professionals, then students graduating from such programs will simply maintain this superior attitude, not making true changes in the practice of the profession. They state that "cultural competence" will not "disrupt" the status quo, but that utilizing "critical awareness" in programs can change the profession, making it more conducive to forming "intercultural partnerships with Indigenous persons" (p. 52). Utilizing the PHCR praxis framework for curriculum development in a MPH program is a way to help students develop this "critical awareness" that may lead to the disruption of white hegemonic practices in health care, ultimately leading to improved equality and justice for minorities. These authors further contend that if there is no critical component to academia then there will be no change and the reproduction of the status quo continues. This assessment again begs the question as to why we have not made much progress in decreasing disparities. Furlong and Wight (2011) state that we have great difficulty questioning our own assumptions and accepting that other's knowledge may have more value than our own, yet:

> Being able to de-centre one's own cultural location entails a complex and dynamic interrogation of 'where I am coming from' – a critical dialogue entailing an engagement with one's social, cultural, ideological, and professional dimensions. Of its nature, this dialogue is likely to be, at least from time-to-time, uncomfortable because such a review de-centres broader cultural biases and privilege. (p. 50)

In addition, Feagin & Bennefield (2014) declare that to suggest that historical racism

does not linger on is naïve. They state, "Comprehensive research and other educational efforts to *publicly voice* experiences of people of color with institutionalized racism in health-related institutions – and their policy solutions – constitute one step" (p. 13; authors' emphasis) toward moving away from a white racial framing of the institution. According to Feagin and Bennefield (2014), rather than continuing to use racialized research that problematizes individuals of minority races and their culture, "we need to forthrightly problematize the unhealthy racist framing and damaging discrimination of white public health officials and health care personnel" (p. 13). This action can be done by creating curriculum using a critical framework, like the PHCR, and other critical race theorists work as a starting place. The faculty, current students, and alumni in this study reveal promise in promoting such practice as they did exhibit many counter-narratives, openly discussed these "difficult issues," avoided stereo-typing and name-calling, and faculty role-modeled culturally sensitive behavior in the classroom. Perhaps the next steps to insure equal and just practice expansion via academic preparation are to evaluate MPH programs against a critical frame and to help graduates confidently take their academic preparation into their own futures as health care professionals knowing that they have a safe place to return to for reinforcement and support as alumni of a racially equitable and just institution.

Moving Forward with Practice

Curriculum for MPH programs must comply with the Association of Schools and Programs of Public Health (ASPPH) criteria for critical content of the core for a MPH program. In its revised final report (2014), the following are included in their list for "the core for a 21st Century MPH Degree":

- Biological, environmental, socio-economic, behavioral, cultural, and other factors that impact human health, influence the global and societal burden of disease, and contribute to health disparities.
- Characteristics and organizational structures of the U.S. health care system and how they compare to health care systems in other countries.
- The cultural context of public health issues and respectful engagement with people of different cultures and socioeconomic strata. (p. 5)

In addition, the ASPPH website lists a "MPH Core Competency Model" (ASPPH website, n.d.). This model includes a description of the five traditional core skills of public health graduates plus seven interdisciplinary skill areas. From the "Diversity and Culture" area, which is defined as "The ability to interact with both diverse individuals and communities to produce or impact an intended public health outcome" (ASPPH website, n.d.) come the following recommended skills for MPH graduates:

- Describe the roles of, history, power, privilege and structural inequality in producing health disparities.
- Explain how professional ethics and practices relate to equity and accountability in diverse community settings.
- Explain why cultural competence alone cannot address health disparity.
- Discuss the importance and characteristics of a sustainable diverse public health workforce.
- Use the basic concepts and skills involved in culturally appropriate community engagement and empowerment with diverse communities.
- Apply the principles of community-based participatory research to improve

health in diverse populations.

- Differentiate among availability, acceptability, and accessibility of health care across diverse populations.
- Differentiate between linguistic competence, cultural competency, and health literacy in public health practice.
- Cite examples of situations where consideration of culture-specific needs resulted in a more effective modification or adaptation of a health intervention.
- Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.

While these skills address health disparities and social justice issues in what can be considered a critical way, how they are interpreted and enacted by administrators and faculty is what truly matters. If administrators and faculty develop curriculum that meets these skills from a white racial framing perspective (Feagin & Bennefield, 2014), what students learn from such classes may only reproduce the white hegemonic ideology of the US health care system. If instead, decision-makers choose to address these skills and develop curriculum from a critical race frame, the PHCR praxis and/or other racially conscious processes, e.g., dismantling racism workshops (Griffith, Yonas, Mason, & Havens, 2010) or the "Self, Social, and Global Awareness: Personal Capacity Building for Professional Education and Practice" (SSGA) workshop (Cushman, 2015), they may actually create transformative classrooms; classrooms where cultural work has a critical theory aspect to it and can create "a vision of education for democracy and social justice" (Hytten, 2006, p. 235) in health care; "to what might be" (Fine, 2006, p. 100).

Concluding Remarks

This study is important primarily because it demonstrated how a critical theory developed for use in public health programming could be used to investigate curriculum – an example of theoretical generalizability (Fine, 2006). Not only did the PHCR framework work well to analyze data from documents, direct observations of classroom discourse, and interviews from three different populations, its utility for adaptation to other academic institutions became apparent during the study. The findings of this study revealed that although cultural competency instruction in this MPH program included much that was critical, e.g., discourse that challenged the status quo of our current health care system, there was more that could be done to provide a more radically critical curriculum. By utilizing the PHCR framework, and other critical practices as mentioned above, to develop curriculum, rather than just investigate and evaluate it, this framework shows great applicability to future research and practice.

For those public health program administrators and faculty who truly want to establish transformative, critical experiences in a MPH program to promote health equity and social justice in health care, this study demonstrates a way to accomplish this. This study provides tools to begin evaluating old curriculum and creating new, transformative curriculum. The faculty, student, and alumni perspectives from this study showed great promise for such pedagogy; faculty and current students revealed much action and discourse that promoted racial jusice. All that is needed is for agents of change to carry this process forward in their own institutions and into the workplace.

APPENDIX A

STUDY QUESTIONS FOR EACH SUBJECT POPULATION

Faculty Questions

Original interview questions

1. How do you define "cultural competency" (CC)?

2. How do you introduce this topic in courses you teach?

3. How do you determine the curriculum for courses that include CC?

4. Do you see any connection between CC and health disparities (HD)? Explain/give examples.

5. Do you see any connection between CC and social justice (SJ)? Explain/give examples.

6. Do you ever have difficulty discussing the issue of CC in classes? Explain/give examples. How do students respond to the topic of CC, HD and/or SJ in your course(s)?

7. How do you feel your level of CC influences the topics of CC, HD, and SJ in your course(s)?

8. Do you think the public health (PH) profession does a good or poor job of addressing CC, HD and SJ? Explain/give examples.

9. Do you discuss the idea of self-reflection and discipline self-critique in your classes? Explain/give examples. How do students respond to this topic? Explain/give examples.

10. Do you feel there has been progress in health care in the areas of CC, HD and SJ? Why/why not?

11. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything related to this topic.

Condensed questions for at-the-door requests for interviews

1. What is your opinion of or perspective on cultural competence and its relevance to public health and health care in general? Do you see any relationship to or interrelationship among CC, health disparities and social justice? As a faculty member,

do you see teaching CC as important? To what extent do you teach about CC, HD and SJ?

2. While we have made progress in the area of HD, the general consensus in the literature is that we have not made as much progress as we should. Why, in your opinion, have we not made more progress in the areas of CC, HD and SJ? What, in your opinion, will it take to make major progress in these areas?

Demographic information requested

Major area(s) of research interest: _____
_____
Gender: M F Years teaching: _____ PH Concentration: _____
Race/ethnicity/culture:_____

Current Student Questions

Original invitation with questions provided/sent to current students

As a fellow student, I cordially invite you to express your opinion/perspective on cultural competence, health disparities and social justice.

Please read the questions below and take *as much or as little time* as you would like, providing *as much or as little* opinion/perspective as you would like on each or the topic as a whole. I would be happy with any and all input you have to provide. I am particularly interested in your perspectives on numbers 3-6.

1. How do you define your own culture and its impact on health and disease?
2. How do you define "cultural competency" (CC)?
3. How important do you think this topic is in public health (PH)? In your specific area of
   concentration?
4. Do you think there is enough/too much/too little training on CC in the MPH program? Explain.
5. Do you see any connection between CC and health care disparities? Explain/give examples.
6. Do you see any connection between CC and social justice? Explain/give examples.
7. Do you foresee having any kind of issues, positive or negative, with working in cultures other than your own as you plan your future as a PH professional? Explain/give examples.
8. Do you think it is valuable to examine the PH profession, its practice, training, and research, from a CC standpoint? Explain/give examples.
9. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything related to this topic.

The fine print: This request is made as part of a dissertation project which has been reviewed by UA IRB and deemed a program evaluation, requiring no formal consent process, thus by providing input you agree to be included in the research. No personally identifiable information is needed or requested, nor will be part of the information reported. Only demographic information will be asked. Your name will be immediately removed from any correspondence you provide.

Background: This study will investigate, qualitatively, how cultural competency training of public health professionals is taught by faculty and "caught" by students in a case study of one Master of Public Health (MPH) program, using interviewing, document analysis and classroom observation to analyze attitudes and beliefs about cultural competency in health care from faculty, student and alumni perspectives.

You may email me any input you have on this topic at smsedig@email.arizona.edu or arrange a face-to-face interview by contacting me via phone at 629-4659 or via email. I have chosen this method as arranging meetings has proven difficult – this way anyone can participate and do so at their own convenience, at any time, add more to their contributions any time during this semester, etc.

If you would like to provide any input, please also answer the following:

1. Previous courses on CC taken:
2. Previous experiences you've had with cultures other than your own:
3. MPH concentration: *Biostatistics, Environmental Health Sciences, Epidemiology, Family & Child Health, Health Behavior & Health Promotion, Health Services Administration, Public Health Policy & Management, or Public Health Practice*
4. Gender: male female
5. Age:
6. Race/ethnicity/culture:

Condensed version of questions

1. How do you define "cultural competency" (CC)?

2. How important do you think this topic is in public health (PH)? In your specific area of concentration?

3. Do you think there is enough/too much/too little training on CC in the MPH program? Explain.

4. Do you see any connection between CC, health care disparities and social justice? Explain/give examples.

5. Do you foresee having any kind of issues, positive or negative, with working in cultures other than your own as you plan your future as a PH professional? Explain/give examples.

6. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything we have discussed or anything we have not discussed but should have during this semester.

Demographics:
Previous experiences you've had with cultures other than your own (e.g. Peace Corps):
_____
MPH Concentration: _____ Year in school: _____ Gender: M F
Age: _____ Race/ethnicity/culture: _____

Alumni Questions

Invitation with questions sent via email to alumni

As a fellow MPH alumnus, I cordially invite you to express your opinion/perspective on cultural competence, health disparities and social justice.

Please read the questions below and take *as much or as little time* as you would like, providing *as much or as little* opinion/perspective as you would like on each or the topic as a whole. I would be happy with any and all input you have to provide. I am particularly interested in your perspectives on numbers 4-7.

1. How do you define your own culture and its impact on health and disease?
2. How do you define "cultural competency" (CC)?
3. How important do you think this topic is in public health (PH)? Explain/give examples.
4. Do you think there is enough/too much/too little training on CC in the MPH program? Explain. How would you change the training if you could? Explain/give examples. Did you feel well-prepared to work with cultures other than your own when you started? As you worked in the field? Explain/give examples.
5. Do you see any connection between CC and health care disparities? Explain/give examples.
6. Do you see any connection between CC and social justice? Explain/give examples.
7. Have you had any kind of issues, positive or negative, with working in cultures other than your own? Explain/give examples.
8. Do you think it is valuable to examine the PH profession, its practice, training, and research, from a CC standpoint? Explain/give examples.
9. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything related to this topic.

The fine print: This request is made as part of a dissertation project which has been reviewed by UA IRB and deemed a program evaluation, requiring no formal consent process, thus by providing input you agree to be included in the research. No personally identifiable information is needed or requested, nor will be part of the information reported. Only demographic information will be asked. Your name will be immediately removed from any correspondence you provide.

Background: This study will investigate, qualitatively, how cultural competency training of public health professionals is taught by faculty and "caught" by students in a case study of one Master of Public Health

(MPH) program, using interviewing, document analysis and classroom observation to analyze attitudes and beliefs about cultural competency in health care from faculty, student and alumni perspectives.

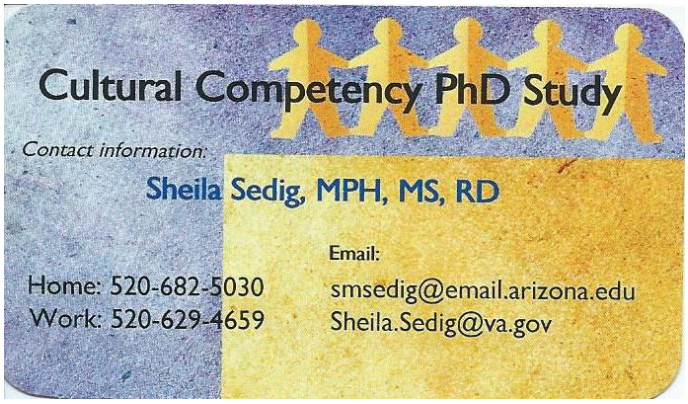
You may email me any input you have on this topic at smsedig@email.arizona.edu or arrange a face-to-face interview by contacting me via phone at 629-4659 or via email. I have chosen this method as arranging meetings has proven difficult – this way anyone can participate and do so at their own convenience, at any time, add more to their contributions any time during this semester, etc.

If you would like to provide any input, please also answer the following:
Demographic questions:
Year graduated: _____ Years that you've worked in the PH field: _____
Courses on CC taken: _____
Previous experiences you've had with cultures other than your own: _____
_____
Cultures you currently work with that represent those other than your own: _____
_____
Major areas of PH interest: _____
Gender: M F Age: _____
Race/ethnicity/culture: _____

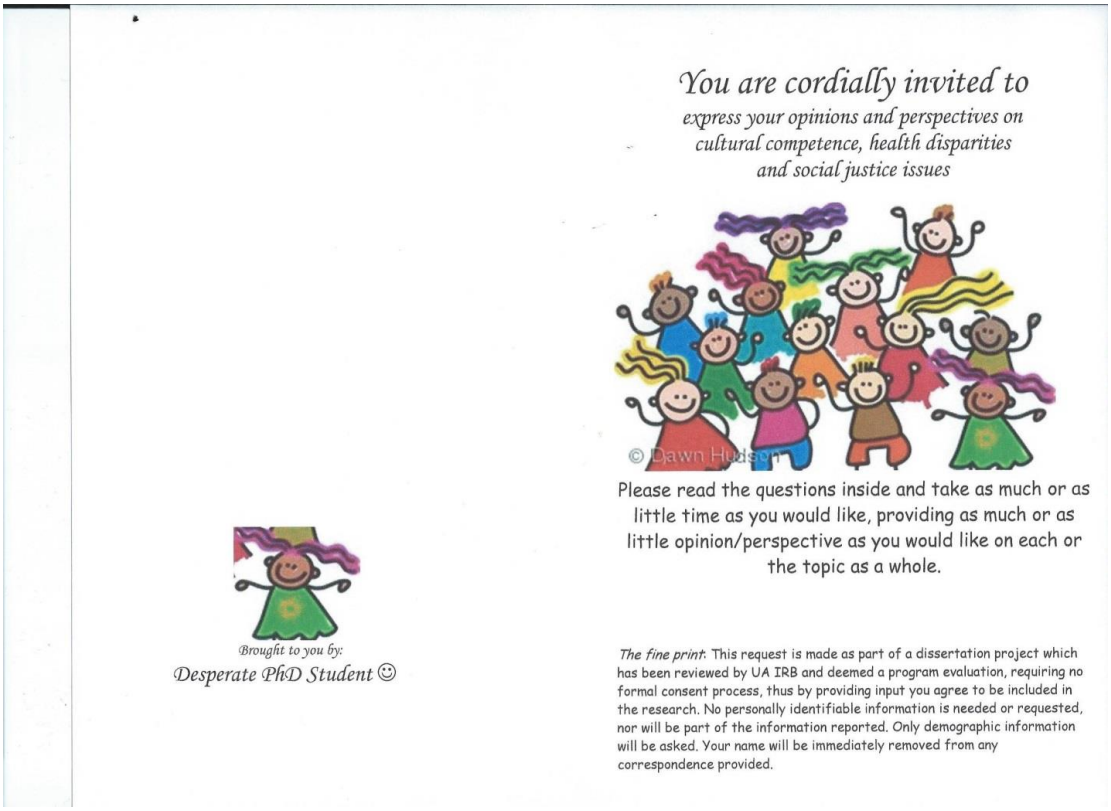
APPENDIX B

RECRUITMENT MATERIALS

Business Card used for Contact Information



Invitation card placed in faculty members' office mailbox – copied, folded, put in envelope (front page and last page)



Invitation card placed in faculty members' office mailbox (continued) – copied, folded, put in envelope (inside left and inside right pages)

Background: My name is Sheila Sedig, a MEZCOPH graduate and current PhD candidate in Higher Education. This study will investigate, qualitatively, how cultural competency training of public health professionals is taught by faculty and "caught" (internalized) by students in a case study of one Master of Public Health (MPH) program, using interviewing, document analysis and classroom observation to investigate attitudes and beliefs about cultural competency in health care from faculty, student and alumni perspectives.

I am currently "observing" both the face-to-face and online version of CPH 577 and would like to gather as many faculty members' perspectives as possible. You may email me any input you have on this topic at **smsedig@email.arizona.edu** or arrange a face-to-face interview by contacting me via phone at **629-4659** or via email. I have chosen this method as arranging meetings has proven difficult – this way anyone can participate to the extent they want to and do so at their own convenience. If you choose to participate, please do so no later than April 1, 2014. Thank you!

Questions:

1. How do you define "cultural competency" (CC)?
2. How do you introduce this topic in courses you teach?
3. How do you determine the curriculum for courses that include CC?
4. Do you see any connection between CC and health disparities (HD)? Explain/give examples.
5. Do you see any connection between CC and social justice (SJ)? Explain/give examples.
6. Do you ever have difficulty discussing the issue of CC in classes? Explain/give examples. How do students respond to the topic of CC, HD and/or SJ in your course(s)?
7. How do you feel your level of CC influences the topics of CC, HD, and SJ in your course(s)?
8. Do you think the public health (PH) profession does a good or poor job of addressing CC, HD and SJ? Explain/give examples.
9. Do you discuss the idea of self-reflection and discipline self-critique in your classes? Explain/give examples. How do students respond to this topic? Explain/give examples.
10. Do you feel there has been progress in health care in the areas of CC, HD and SJ? Why/why not?
11. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything related to this topic.

Demographic information:
Major area(s) of research interest: _____
Gender: M F Years teaching: _____ PH Concentration: _____
Race/ethnicity/culture: _____

Invitation card provided at the end of the semester for current students

Thank you! So much for allowing me to "observe" the class this semester. I can see that the future of Public Health is in good hands.

How do you define "cultural competency" (CC)?
How important do you think this topic is in public health (PH)? In your specific area of concentration?
Do you think there is enough/too much/too little training on CC in the MPH program? Explain.
Do you see any connection between CC, health care disparities and social justice? Explain/give examples.
Do you foresee having any kind of issues, positive or negative, with working in cultures other than your own as you plan your future as a PH professional? Explain/give examples.
Is there anything else you would like to say about this topic? Feel free to expand or expound on anything we have discussed or anything we have not discussed but should have during this semester.

Demographics:
Previous experiences you've had with cultures other than your own (e.g. Peace Corps): _____
MPH Concentration: _____ Year in school: _____ Gender: M F Age: _____
Race/ethnicity/culture: _____

Email to: smsedig@email.arizona.edu (all personally identifiable information will be immediately removed from any correspondence I get)

Invitation card sent to alumni – copied, folded, put in envelope

As a fellow MEZCOPH MPH graduate I cordially invite you to

express your opinions and perspectives on cultural competence, health disparities and social justice issues

Brought to you by:
Desperate PhD Student ☺

Please read the questions inside and take *as much or as little time* as you would like, providing *as much or as little opinion/perspective as you would like* on each question or the topic as a whole.

The fine print: This request is made as part of a dissertation project which has been reviewed by UA IRB and deemed a program evaluation, requiring no formal consent process, thus by providing input you agree to be included in the research. No personally identifiable information is needed or requested, nor will be part of the information reported. Only demographic information will be asked. Your name will be immediately removed from any correspondence provided.

Background: My name is Sheila Sedig, a MEZCOPH graduate and current PhD candidate in Higher Education. This study will investigate, qualitatively, how cultural competency training of public health professionals is taught by faculty and "caught" (internalized) by students in a case study of one Master of Public Health (MPH) program, using interviewing, document analysis and classroom observation to investigate attitudes and beliefs about cultural competency in health care from faculty, student and alumni perspectives.

I am currently "observing" both the face-to-face and online version of CPH 577 and would like to gather as many alumni perspectives as possible. You may email me any input you have on this topic at **smsedig@email.arizona.edu** or arrange a face-to-face interview by contacting me via phone at **629-4659** or via email. I have chosen this method as arranging meetings has proven difficult – this way anyone can participate to the extent they want to and do so at their own convenience. If you choose to participate, please do so no later than April 1, 2014. Thank you!

Questions:

1. How do you define your own culture and its impact on health and disease?
2. How do you define "cultural competency" (CC)?
3. How important do you think this topic is in public health (PH)? Explain/give examples.
4. Do you think there is enough/too much/too little training on CC in the MPH program? Explain. How would you change the training if you could? Explain/give examples. Did you feel well-prepared to work with cultures other than your own when you started? As you worked in the field? Explain/give examples.
5. Do you see any connection between CC and health care disparities? Explain/give examples.
6. Do you see any connection between CC and social justice? Explain/give examples.
7. Have you had any kind of issues, positive or negative, with working in cultures other than your own? Explain/give examples.
8. Do you think it is valuable to examine the PH profession, its practice, training, and research, from a CC standpoint? Explain/give examples.
9. Is there anything else you would like to say about this topic? Feel free to expand or expound on anything related to this topic.

Demographic information:
Years you've worked in the PH field: ____ Gender: M F Age: ____
Previous experience working with cultures other than your own (e.g. Peace Corps): _____
Cultures you currently work with that represent cultures other than your own: _____
MPH Concentration: _____ Race/ethnicity/culture: _____

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FOOTNOTES

[1] Health disparities and social justice/injustice often co-occur in public health writings. Why this is the case is best illustrated by Levy & Sidel's (2006) definition of social injustice and how these social injustices can lead to health disparities. These authors cite two definitions for social injustice in their book "Social Injustice." Their first definition: "the denial or violation of economic, sociocultural, political, civil, or human rights of specific populations or groups in the society based on the perception of their inferiority by those with more power or influence" (p. 6). Their second definition is based on the Institute of Medicine's definition of public health: "what we, as a society, collectively do to ensure the conditions in which people can be healthy. This second definition of social injustice refers to policies or actions that adversely affect the societal conditions in which people can be healthy" (p. 6). Thus, because public health is designed to address population-level health issues from the macro-level (e.g., policy, governmental, environmental) to the micro-level (e.g., family, individual) and everything in between (Association of Schools of Public Health, n.d.), both of these definitions encompass the full range of the public health discipline. Levy & Sidel's book goes on to describe just how such social injustices create health disparities. This helps explain why health disparities and social justice/injustice are seen by public health practitioners and researchers as co-occurring phenomena. This connection is also explained further in the literature review as one moves from "Era Two" to "Era Three" in the "History of Cultural Competence in Health Care" section and then further through the "Summary of Literature Review."

[2] I have used the phrases "cultural competency education" and "cultural

competency training" throughout this dissertation interchangeably. As a dietitian for over 30 years and as a MPH graduate myself, I have seen the terms "education" and "training" used interchangeably in health care settings and academic writings throughout my professional and academic careers. In health care, all education is seen as a form of "training for practice" whether that education is intellectual *or* skill-based or both.