

Impact of Cultural Competency on Treatment Adherence and Health Literacy For Persons of Color Living with HIV/AIDS

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Abstract

For decades, the American medical establishment has been a notable perpetrator in the mass marginalization of minority groups, leading to a variety of significant health disparities. Given that the existing healthcare institution is not culturally equipped to serve the evolving American demographic, experts have called for the greater usage of cultural competency in medicine; however, little research has been done to better understand how the degree of cultural competency of a health-care provider impacts the complex disease management for those living with HIV/AIDS. The aim of this research is to better understand how cultural competency can impact the health literacy and treatment adherence for persons of color living with HIV/AIDS. In addition to considering what factors shape patient experience and expectations, the research explores how many socioeconomic and cultural factors lead to low treatment adherence and health literacy. Also, the research considers the nuance in the patient-provider relationship and explores tools, such as partnerships with existing community institutions, that may strengthen the relationship. In order to regain the trust lost in the medical establishment by persons of color living with HIV/AIDS, the research suggests that a healthcare provider ought to self-reflect about the cultural, linguistic, and socioeconomic complexities in America that necessitate cultural competency. By practicing modernized cultural competency in medicine, healthcare providers can shape patient care and strengthen the patient-provider relationship, which may increase treatment adherence and health literacy rates for persons of color living with HIV/AIDS. Bringing attention to how cultural competency can impact treatment adherence and health literacy, the research urges the medical establishment to take educational and policy-related steps to effectively provide healthcare to historically underserved groups such as people of color living with HIV/AIDS.

Keywords: Cultural Competency, Treatment Adherence, Patient-Provider Relationship

1. Introduction

While the United States is known for its prowess in biomedical research, innovation, and entrepreneurship, it fails to have the same excellence in providing effective healthcare to minorities. The reality is that the nation's demographic composition continues to become more diverse, and the medical institution seems to have yet to catch up to this significant change. Not only does the diversification of the nation's population come with greater exposure to different ideas and cultures, but it also unfortunately comes with issues the medical institution may not have been properly equipped to handle in the past. Lack of health literacy is one of these issues, and it has been associated with poor patient outcomes, especially for persons of color, due to poor treatment adherence. For patients living with HIV/AIDS, treatment is highly complex and requires constant monitoring in order to adhere to antiretroviral therapy treatment; thus, poor treatment adherence is also a major issue for people living with HIV/AIDS. In addition, minorities often account for higher proportions of new HIV diagnoses. People of color living with HIV/AIDS often suffer additional barriers to care that result from stigma and other factors they may endure. In the past decade, the concept of cultural

competency in medicine has been pushed to the forefront of discussion and its application has been encouraged in many clinical settings. Focusing on persons of color living with human immunodeficiency virus(HIV) and acquired immunodeficiency syndrome(AIDS) allows for a better understanding of how the unique patient narrative can impact their health literacy and treatment regimen.

It is important to focus on persons of color living with HIV/AIDS in order to understand how the experiences of being a person of color in America interact with the significant stigma faced by those living with HIV/AIDS and the virus's complex management. By looking into how cultural competence can impact patient experience through the lens of health literacy and treatment adherence, experts in the field may better understand challenges to minority healthcare and can bring attention to new ways of incorporating cultural competence in the new age of medicine. This type of research has the potential of bringing attention to the steps the healthcare institution must take in order to effectively provide healthcare to historically underserved groups such as people of color and those living with HIV and AIDS. Although experts have already begun to emphasize the importance of cultural competence in medicine, it is vital for a healthcare provider to realize the cultural, linguistic, and socioeconomic complexities that comprise the need for a modernized framework of cultural competence that combats stigma and perceived discrimination people living with HIV/AIDS face. By practicing a higher degree of cultural competency in medicine and working with community institutions, health care providers can shape patient care and strengthen the patient-provider relationship, therefore increasing rates of treatment adherence and health literacy for persons of color living with HIV/AIDS.

2. Socioeconomic and Cultural Determinants of Low Treatment Adherence and Literacy

There are many ways that socioeconomic and cultural factors impact a patient's ability to access and apply medical care to their lives. Even though researchers have already studied how these factors can impact patient care, not much is known regarding whether cultural competency in medicine truly impacts patient adherence and addresses the socioeconomic barriers that limit care in the first place. Before addressing how cultural competence can potentially increase treatment adherence and health literacy, it is important to understand the socioeconomic barriers that may limit care and result in poor adherence levels. Many leaders in the fight to reduce HIV/AIDS incidence such as the Minority HIV/AIDS Fund have adopted a national HIV/AIDS strategy; however, this strategy has broadly been ineffective considering only ¼ of HIV-positive persons have reached the treatment goal set for viral suppression.

Considering that the National HIV/AIDS strategy has been relatively ineffective, it is vital to understand why persons of color continue to be impacted by lower levels of treatment adherence and health literacy. Although the National HIV/AIDS strategy has promoted anti-retroviral therapy(ART) via its core pillar of "treatment as prevention" for years, Arnold et al.¹ claims that HIV-positive black men who have sex with men and women(BMSMW) are still disproportionately impacted by lower treatment adherence because several socioeconomic barriers exist that limit access to regular care and treatment for this unique demographic. In order to participate in the Arnold et al.'s study, participants were required to participate in the Bruthas Project, which was a series of four individual counseling sessions with a black male counselor in which participants discussed their sexual risk behaviors with male and female partners and discussed what factors led to sexual decision making¹. The researchers then chose 25 HIV-positive men who already completed the Bruthas Project, and they interviewed the men on topics such as current living situation, diagnosis story, current access and use of HIV-related services and care, social support for living with HIV, doctor-patient relationships, other health conditions, and suggestions for treatment and care interventions for HIV-positive BMSMW¹. Through these interviews, the researchers investigated major barriers to care that exist for BMSMW, and after analysis of the interviews, the researchers identified several overarching themes that may contribute to poor access/adherence to care: competing needs and scarcity of affordable housing, side effects and breaks in treatment, historic distrust in the medical establishment, poor health literacy, provider-level relation to care, institutional characteristics, and disclosure and social support for living with HIV¹. In regards to competing needs, the researchers recognized that many BMSMW living with HIV often prioritize their immediate needs, often which are economic, over steps to improve their long term health such as treatment adherence to ART¹. Due to many economic and social realities, individuals often have to prioritize income over health and well-being. In fact, the sample group in Arnold et al.'s study had telling characteristics about participant economic and social realities; 17% of the sample were homeless in the last year, 84% experienced incarceration in their lifetime, 83% were unemployed, 20% did not know their CD4 count, and 28% did not know their HIV viral load¹.

Building upon these overarching themes and socioeconomic realities illustrated by Arnold et al.'s sample, barriers to care can also include factors that shape a person's knowledge about their HIV-positive status¹. In fact, Mogobe et al.⁷ interviewed several sample focus groups regarding facilitators and impediments for accessing HIV-related information and issues in treatment adherence, and the researchers found that many factors play into a person not

knowing their HIV status or failing to adhere to medication/treatment⁷. These factors included lack of access to health care facilities or providers, inability to pay for testing or transportation, belief that treatment is ineffective or unavailable, cultural and linguistic barriers, stigma towards HIV, and even confidentiality concerns⁷. Although these factors are significant, these are just a handful of the socioeconomic and cultural factors that may be barriers to a patient's ability to access and apply medical care⁷.

3. Role of Community Partnerships in Reducing Stigma and Improving Adherence and Literacy

In addition to the earlier mentioned factors that lead to disproportionate levels of treatment nonadherence and health illiteracy, it is vital to also understand the role stigma towards HIV/AIDS plays in communities of color. Stigma towards HIV and AIDS is especially prominent and detrimental in communities of color, and several researchers have attempted to reduce stigma by understanding and using tools that are already present in many communities of color. Thus, in order to overcome the stigma faced by those living with HIV/AIDS and increase health literacy and treatment adherence levels of people living with HIV/AIDS, many expert sources argue that community institutions can be potential partners in reducing stigma through community-based interventions and educational campaigns². Bradley et al.² argues that although stigma and many omnipresent social determinants of health in the African American and black community may impede strategies to promote and implement HIV education and HIV-prevention strategies, faith-institutions, which are highly regarded in the black community, can serve as potential partners in HIV stigma reduction efforts. Due to the significant emphasis the African American community places on religion in one's life, faith-institutions could serve as the ideal spot for HIV education and compassion programs².

Although many believe that faith-based institutions would be poor partners in HIV-prevention efforts without abandoning strict religious doctrine, the researchers argued that this notion is false; in fact, churches may show compassion and help promote education efforts without abandoning their conservative views of scripture, implying that church engagement in HIV-reduction efforts is an attainable goal². The researchers were able to come to this conclusion after developing and employing Project FAITHH in, a more culturally appropriate HIV stigma reduction intervention reflective of the identities of Christian African Americans from the rural Southern United States, which is the predominant demographic of rural Alabaman churches². The framework of the FAITHH intervention was based on the notion that stigma would be reduced via skill development, community empowerment, cultural competence, exposure to persons living with HIV(PLWH), social actions, and accurate information sharing². By adapting the curriculum of the Project FAITHH intervention through an extensive eight-stage process to cater to the rural Southern demographic targeted, the researchers found that the usage of existing faith-institutions in HIV reduction efforts was well-received by congregants in the churches where Project FAITHH was employed². Although feedback from the FAITHH anti-stigma condition suggested that treatment was well-received, the results of the testing phase were even more telling with the FAITHH intervention resulting in a reduction in congregants' personally held stigma towards HIV². Several participants reported that they learned important skills regarding stigma reduction, advocacy-focused activities, and showing compassion and support for PLWH².

In order to effectively achieve higher levels of treatment adherence and health literacy, the healthcare sector must understand the environment an intervention must foster in order to reduce stigma towards HIV/AIDS. A significant result of Project FAITHH in Bradley et al.² was that participants reported the benefit of having a cultivating learning environment with opportunities to apply stigma-reduction concepts learned and engage with others; this finding implies the benefit of involving members of the rural Alabama faith community in research regarding HIV stigma and the vital role community members can play. Recognizing the power that faith-based institutions may have in HIV-related stigma and education efforts, Patsdaughter⁸ adds to Bradley et al.²'s argument about using faith-institutions as partners in HIV-related stigma reduction efforts by calling for greater partnerships with other related organizations and community members that have been immersed in the culture of underserved groups. Patsdaughter⁸'s call for greater partnerships with community members that have been immersed in the culture of underserved groups reaffirms Bradley et al.²'s finding that fostering a cultivating learning environment with engagement opportunities was beneficial to HIV-stigma reduction interventions. Through these community partnerships, Patsdaughter⁸ also argues that access to healthcare programs can greatly increase, which may greatly benefit persons of color or other historically underserved communities.

The fact that Bradley et al.² and Patsdaughter⁸ both call for partnerships between the healthcare institution and the community emphasizes the importance of having a more culturally competent medical atmosphere. Community members may be any individuals with a deep shared understanding of the underserved patients they may serve,

whether the shared understanding derive from race, culture, ethnicity, language, or more. This definition may include a race-concordant healthcare provider that is also a community member that has been immersed in the culture of the underserved group/patient⁸. Thus, race-concordance may also be a viable tool in stigma reduction efforts through Bradley et al.² and Patsdaughter⁸'s argument.

In regards to the effectiveness of interventions such as Bradley et al.²'s Project FAITHH intervention, it is clear that adapting intervention methods to the targeted community can increase the degree to which the intervention is well-received and be far more effective in reducing stigma towards HIV. In the case of Project FAITHH, the community members' increase in education and health literacies regarding HIV greatly impacted their reduction in stigma towards HIV². By involving members of the rural Alabama faith community in research regarding HIV stigma, community members in Bradley et al.'s study² were able to engage in a cultivating learning environment, implying the benefit of community and institutional involvement in health literacy efforts. Thus, by using existing culturally-competent community institutions such as faith-institutions as partners in HIV stigma reduction efforts and education efforts, the healthcare establishment can potentially increase the health literacy of members in underserved communities by providing a dynamic environment that fosters health-related education².

4. Factors within Patient-Provider Relationship

In recent years, experts have emphasized the importance of strengthening the patient-provider relationship by understanding the variety of factors such as language patterns, cultural beliefs, and other related factors that shape patient experience and health literacy¹. However, in order to strengthen the patient-provider relationship, it is important to understand what defines a strong patient-provider relationship; studies such as Arnold et al.¹ suggest that provider characteristics and relation to care are extremely important to ensuring a strong patient-provider relationship and increasing treatment adherence. In fact, in the study, many participants who had high levels of treatment adherence attributed their positive adherence to the strong relationship they had with their health care provider in their interviews with the researchers¹. The major factors the participants identified to build a strong relationship between patient and provider were open communication and trust¹.

In addition to open communication and trust, another factor that shapes a strong patient-provider relationship is the effectiveness of patient-provider communication. In fact, although Arnold et al.¹ argues that open communication and trust are vital in a strong patient-provider relationship, Mogobe et al.⁷ emphasizes how ineffective communication also shapes the relationship one has with a provider because many reported issues of spoken language, use of technical language, and body language can impede patient care. In fact, at Mogobe et al.'s Botswana test site, most of the doctors were foreign and were unable to speak the local tongue of Botswana, while many of the patients could not communicate in English⁷. Although Mogobe et al. gave examples of how they overcame these issues of spoken language through usage of interpreters, the study also talked about how several ethical concerns existed in practical usage of interpreters such as ethical concerns regarding using family members as interpreters and not having an interpreter for all languages⁷. Through interviewing a sample of 32 healthcare providers and 30 professional care team members, Mogobe et al. discusses a significant paradox that providers face when using alternative solutions, such as interpreters and language tools, to combat ineffective communication⁷. No provider prefers using the alternative language solutions due to how impersonal medicine becomes; however, because of lack of access to interpreters of all languages, competency of a provider may be compromised and extremely dependent on the tools a provider has access to⁷.

In addition to effectiveness of communication, language patterns the provider expresses also can shape the patient-provider relationship. A health care provider's language patterns have been studied by experts in relation to the patient-provider relationship and have been found to be significant in patient experience. Mogobe et al. recognizes how the impacts of low health literacy and language can pose significant ramifications on people living with HIV from minority groups because the interactions between language and health literacy may act as a cross-cultural barrier⁷. In fact, the researchers discuss how providers should use simpler language by avoiding medical jargon and focus on using contextual language for those with lower health literacy in order to help facilitate effective patient-provider communication⁷.

Although dependent on preferred provider style, the ideal behind greater cultural competence in the healthcare sector is hope for a better shared cultural understanding between patient and provider. The findings of Saha et al.⁹ bring up an interesting point regarding how a shared cultural understanding impacts treatment adherence, implying it impacts a better cultural understanding can also strengthen the patient-provider relationship. Even though a shared cultural understanding may help promote treatment adherence and health literacy, the researchers found an unexpected negative association between greater provider cultural competency and outcomes among white patients; experts blame

this disparity on differences in preferences for provider interaction style because providers who score high on cultural competency levels often subscribe to the “relationship-centered” model of healthcare, which is particularly valued by cultural groups and minorities⁹. Although both Arnold et al.¹ and Saha et al.⁹ speak to how patients treated by race-concordant providers have greater shared cultural understandings and stronger patient-provider relationships, it is clear that this shared cultural understanding is also dependent on preferred provider interaction style, which may differ based on individual or even community values.

Other cultural values can also play a vital role in the strength of a patient-provider relationship. Although Ka’opua and Mueller⁵ agree with Arnold et al.¹ regarding the importance of the patient-provider relationship, they also suggest that the patient-provider relationship is especially strengthened for the Native Hawaiian community with a provider’s respect for family participation and a patient’s close personal connection with their provider⁵. Ka’opua and Mueller were able to come to this conclusion by studying 40 HIV-positive Native Hawaiians and 40 white-HIV positive adults that all reported access to social services and medical insurance that covered HIV care and HAART regimen⁵. After face-to-face interviews with the participants collecting a variety of information, such as assessment of current medication regime, treatment adherence to medications, self-reported health status, health-related beliefs (both general and Native Hawaiian culture-derived), perceived social support, depression symptoms, current alcohol and illicit substance use, and asking open-ended questions about participants’ experiences with HAART, the researchers were able to quantify the qualitative results through a variety of metrics such as the treatment adherence metric and the self assessment of overall adherence ratio⁵. They found that although there were no reliable and statistically significant ethnic differences in HAART adherence between the Native Hawaiian sample and their white counterpart sample, Native Hawaiians reported lower levels of adherence; the researchers also conducted a content analysis of the participant interviews and found results that suggested that Native Hawaiians believed family support was an extremely critical strategy to promoting adherence, endorsed the importance of a provider’s respect for family participation, valued a personal connection with their health care provider, and emphasized spiritual and relational harmony in medical treatment⁵. Recognizing the nuances in these expert sources, it is clear that the patient-provider relationship may be vital for a person of color’s care; however, the method of strengthening the patient-provider relationship may differ based on a combination of cultural, social, and individual values.

Although the presence of a shared cultural understanding between patient and provider can help facilitate a stronger patient-provider relationship, McQuaid and Landier⁶ emphasizes how provider bias can impact patient care by shaping a provider’s communication patterns with his or her patients, which later impacts treatment adherence. Healthcare providers may have unintentional biases that contribute to healthcare disparities, and these unintentional biases may impact perceptions of acceptance and support, or lack thereof, from providers and the healthcare institution⁶. This perception of acceptance and support, or lack thereof, is known as perceived discrimination and is an individual factor the researchers lay out⁶. The greater a patient’s perceived discrimination, the lower medication adherence they typically have⁶. Building upon the unintentional biases that healthcare providers may have, providers exhibit these unintentional biases via their communication patterns with their patients⁶. When comparing communication patterns towards minority groups and white counterparts, the researchers found that minorities often receive more verbal dominance and statements of direction from the healthcare provider, which deemphasizes patient-centered communication⁶.

Experts have proposed race-concordance for patients and providers as a potential method of overcoming unintentional provider bias. Many patients report how race-concordance helps them experience a greater cultural understanding, develop a more meaningful patient-provider relationship, and be more accountable to treatment regimens. For instance, a patient in Arnold et al.¹ spoke regarding how his clinic caters care to black men and treat them accordingly; the patient reports, “[The clinic is for] all Black men. And they treat us accordingly, I guess you know. I guess we’re different from everybody [else]...I ain’t never had a doctor like him. Never...Yeah, well... now I’m not prejudiced or nothing, but I feel like if you never walked in a Black man’s shoes, you don’t know what we go through. So, he’s an African-American doctor, so I can’t fool him. He’ll be like, “Man, please!” Do you know what I mean? Yeah, I can’t tell him nothing. But if I have a White doctor or a Mexican doctor, something like that? They care but they don’t care, do you know what I mean? You’re just a patient there... you’re a patient. My doctor? We’re personal. We’re real like that, yeah¹.”

In order to strengthen the patient-provider relationship, experts have identified many other ways to reduce unintentional biases and their ramifications on communication patterns and patient experience as a whole. For instance, diversification of the healthcare sector and cultural training seminars have been emphasized by the general public; however, experts in the field can truly speak to the impacts that such interventions can have. McQuaid and Landier⁶ also argued how although race concordance often yields longer visit lengths and better patient experiences, implicit biases are still present with the same communication pattern differences that exist in non-race concordant providers. The researchers provide several examples of interventions that may improve adherence and build the

patient-provider relationship such as cultural competence training for providers, patient-centered communication training for providers, language-concordant services, and implicit bias training for providers that promote awareness of key issues such as institutional racism, class differences, and societal privileges⁶.

5. Regaining Trust in the Medical Establishment

Although unintentional biases may impact the strength of the patient-provider relationship, many researchers have found other significant factors that emphasize the need to increase efforts to strengthen patient-provider relationships. The most significant of these factors is people of color's historic distrust towards the medical establishment in the United States. Mogobe et al.⁷ speaks to this medical distrust by highlighting that the reason patients of color with HIV/AIDS use complementary and alternative medicine(CAM) and traditional healing practices is due to historic distrust in western medicine. In fact, western medicine is often seen as a last resort for many people of color⁷. After further analysis of Mogobe et al.'s argument regarding medical distrust, it seems apparent that treatment nonadherence by people of color living with HIV/AIDS may not solely be caused by barriers to entry to HIV care, rather the treatment nonadherence may be deep-rooted in traditional cultural beliefs and low health literacy⁷. Looking at another significant underserved community, Sprick and Gentile¹⁰ take a different approach on addressing the historic distrust minority groups hold towards the medical establishment by recognizing that to this day, sexual and gender minorities still experience health disparities throughout their lives, especially in end-of-life care, with LGBTQ patients experiencing homophobia and transphobia from medical staff, disenfranchised grief, and forced outing by the staff. These experiences have led to many in communities of color and other underserved groups having immense distrust towards the medical establishment as a whole¹⁰.

Historical abuses against communities of color and other underserved communities have inadvertently promoted treatment nonadherence. In fact, McQuaid and Landier⁶ build upon this point by arguing that a major reason for treatment nonadherence in minority groups can be attributed to historical roots in medical abuse towards minority populations. This medical abuse has led to immense distrust in the medical establishment as a whole⁶. This distrust is highlighted by the researchers when they provided an example of how the false notions that HIV is a man-made virus and those on antiretroviral therapy are human guinea pigs are especially prominent in African American men with HIV/AIDS⁶. This example, in specific, implies that historical factors heavily impact cultural attitudes towards medical care and can impact a patients' acceptance of a healthcare provider's recommendations for their health, which in turn impacts patient medication adherence⁶. By working with existing and trusted community institutions, the healthcare sector can rebuild the trust lost in the medical establishment by communities of color.

It is vital to understand that cultural competency impacts patient experience, health literacy, and patient treatment adherence because the practice of cultural competency helps recognize differences in what the perception of medicine may be in different cultural and minority settings. Understanding the perception of what medicine is to a patient is vital when treating patients of diverse backgrounds. Although the alarming rate of HIV/AIDS in the Native Hawaiian community has often been associated to the poor adherence to treatment regimens, Ka'opua and Mueller⁵ claim that cultural differences that exist within the Native Hawaiian community and insufficient cultural competency in healthcare may be the true culprits that lead to poorer adherence to prescribed treatment because patient care for these communities has not been catered to the collective cultural identity and view of medicine that Native Hawaiians traditionally hold. For years, Native Hawaiians have been struggling to navigate the healthcare institution due to extreme cultural conflicts⁵. This cultural conflict is especially prominent considering past research that has shown that the Native Hawaiian community traditionally holds a collective identity and considers medicine to be holistic, rather than solely evidence-based like the basic approach of Western medicine⁵. Ka'opua and Mueller explain that treatment adherence seems to be lower for Native Hawaiians because most treatment regimens as complex as that for HIV highly active antiretroviral therapy(HAART) require significant lifestyle changes⁵.

Adding onto the existing complexity and long-term duration of HAART, the lifestyle changes required may be considered to be cultural impositions by the Native Hawaiian community. Both Ka'opua and Mueller⁵ and McQuaid and Landier⁶ emphasize the importance of medication and health belief in treatment adherence to Western medicine; however, McQuaid and Landier make a point about why many minority groups have high CAM usage rates in comparison to their white counterparts⁶. The article claims that the reason CAM usage is much higher in minority groups is that CAM is more similar to cultural traditions of minorities and groups' perception regarding what medicine should be⁶. Gaston⁴ agrees with McQuaid and Landier's reasoning for the high CAM usage rates in minority groups being that CAM is more similar to cultural traditions of minorities groups' perception regarding what medicine should be; however, she also argues that treatment adherence can also be impacted by a patient's belief that his or her provider should integrate the patient's culture into their prescribed HIV treatment⁴. Her finding derives from her study that

looked at African Americans' attitudes and perceptions toward provider cultural competence⁴. In order to recruit participants in her study, she went to clinic waiting areas and used recruitment scripts that were based on finding a participant that had the following criteria: he or she self-identifies as African-American, is at least 18, is diagnosed with HIV/AIDS, has received primary medical services from the clinic, be prescribed ART by a healthcare provider⁴. Through question-based survey instruments, the participants took part in the study, and the researcher used several different types of measures to quantify the participants' responses⁴. The role of culture was measured with a 6-item subscale that asked participants whether a healthcare provider should provide medical information that is reflective of their African-American culture, whether racial concordance was important, and any perceived discrimination by a provider; higher scores indicated stronger beliefs for integration of culture into HIV care⁴. Most importantly, medical self-care was measured via the Advice and Instruction scale, which measured self-reported adherence to medication, provider advice, and frequency of missed appointments⁴. After Gaston analyzed the data, the statistical analysis showed that the more that patients believed that their healthcare providers should integrate their culture into HIV treatment, the more adherent they were when they followed their providers' advice and instructions⁴. In fact, the mean score for the role of culture in HIV/AIDS care was 6.59 on the respective metric scale and 18.09 for health care provider trust⁴.

Mogobe et al.⁷ takes a different approach to understanding cultural traditions of minorities and looks at the type of care many minorities may be used to receiving rather than their perceptions towards provider cultural competence. For instance, many patients in Latin American countries receive episodic care rather than regular care; considering how HIV is a disease that requires constant care and daily adherence to treatment plans, patients in Latin America culturally may not understand the need for constant management of the HIV disease and may not adhere to it⁷. Although many other studies talk about being cognizant of certain cultural beliefs of patients, Mogobe et al. argues that providers will be able to recommend certain strategies to tailor treatment plans if they are cognizant of cultural beliefs their patients may hold; using the strengths of each culture to cater patient care may assist in relaying information to patients⁷.

Lastly, the practice of cultural competency in medicine can be an effective tool in increasing health literacy rates, regaining trust lost in the medical establishment, and increasing treatment adherence for people of color living with HIV/AIDS. Patsdaughter⁸ claims that healthcare providers should focus on understanding patients in a cultural context and expand the definitions of cultural groups because culture is much broader than race and ethnicity. She calls for the expansion of the definition of culture to encompass other learned, shared, and transmitted values and worldviews⁸. Saha et al.⁹ supports Patsdaughter's claim by arguing how a healthcare provider's cultural competency empirically yields better outcomes and care for patients of color with HIV and AIDS because greater cultural competency promotes better self-efficacy, treatment adherence, and patient trust. In the study, the researchers found that minority patients that were treated by providers that were more culturally competent were more likely to have higher self-efficacies and report complete adherence to antiretroviral therapy⁹.

6. Modernized Framework of Cultural Competency

Many experts express that cultural competency does not go far enough to address health disparities. In fact, Sprick and Gentile¹⁰ argue how cultural competence interventions do not go far enough and should be replaced with cultural humility interventions because cultural competency training sessions have several limitations that include false competence, measurement issues, and ecological fallacies. The researchers propose cultural humility as a better alternative to cultural competence training¹⁰. The researchers defined cultural humility training as training that "incorporates a lifetime commitment to self-evaluation and critique to redressing the power imbalances in the physician-patient dynamic, and develops mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations"¹⁰. The researchers emphasized the mutual respect taught in the humility approach compared to the check-box mentality of achieving certain competencies in the cultural competency approach¹⁰.

Curtis et al.³ agrees with Sprick and Gentile¹⁰'s argument regarding disposing the check-box mentality that cultural competency advocates in favor of and the self-reflective nature of the framework behind cultural humility training; however, Curtis et al. also argues that the healthcare sector should adopt their definition of cultural safety rather than cultural competency because cultural competency poses dangers of othering and perpetuating stereotypes in our society^{3,10}. Through an extensive literature review of 59 international articles on the definitions of cultural competency and cultural safety and further review of cultural competency legislation in New Zealand, the researchers were able to come up with and advocate for a comprehensive definition of cultural safety that overcomes the shortcomings of cultural competency³. The definition is as follows: "Cultural safety requires healthcare professionals and their

associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment” (pp. 14)³.

Curtis et al. explains that the main difference between cultural competence and cultural safety is an element of power; cultural safety takes into account a health care provider’s own power differences and asks providers to reflect on interpersonal power differences between them and the patient³. The researchers address how cultural safety concerns itself with recognizing the barriers to clinical effectiveness that arise due to the inherent power imbalance between a provider and a patient³. Rather than focusing on providers learning cultural customs of different ethnic groups, the concept of cultural safety calls for providers to self-reflect on power relationships, their own culture, biases, attitudes, assumptions, stereotypes, or prejudices that may impact the quality of healthcare they provide to a patient³. Instead of focusing on the ‘exotic’ culture of the patient, culture safety instead asks providers and the health care institution to focus on the culture of the clinician and the clinical environment. Although this self-reflective nature is similar to Sprick and Gentile¹⁰’s argument in favor of cultural humility interventions, Curtis et al. goes as far to argue that focusing on acquisition of cultural-knowledge, rather than promoting self-reflection of power, biases, and privilege is detrimental to the success of health inequity reduction efforts³. Despite the need for more research to be conducted, the suggestions of these relevant sources suggest that the traditional practice of cultural competency is not enough to increase treatment adherence and health literacy in patients of color living with HIV/AIDS; rather, there is a need for a new modernized framework of cultural competency to be practiced by providers that encompasses the basic tenets explained in the concepts of cultural competency, cultural humility, and cultural safety³.

7. Conclusion

The way in which cultural competency can impact treatment adherence and health literacy seems relatively clearcut; however, the answer is much more complex than expected. In order for a healthcare provider to truly be culturally competent, the provider must understand that many socioeconomic, linguistic, cultural, and related factors may be barriers to high antiretroviral therapy treatment adherence and satisfactory health literacy rates. Experts have argued that a provider can improve patient experience and strengthen the patient-provider relationship by being aware of the omnipresent power structures that exist in the medical institution today. By being aware of barriers to patient care and practicing cultural competence, providers can help positively impact patient experience, which in turn will help strengthen the patient-provider relationship and regain medical distrust that commonly exists in patients of color. Through a variety of efforts such as health force diversification and developing a shared cultural understanding, this strengthening of the patient-provider relationship has the potential of yielding superior patient outcomes; however, further empirical research must be conducted that studies the direct association between the practice of a cultural competence-based framework and treatment adherence level.

If a provider is cognizant of the variety of factors that lead to poor treatment adherence and literacy rates, that same provider may be able to truly self-reflect and evolve the practice of cultural competency to become more reflection-based, rather than cultural knowledge-based. This conclusion encompasses experts’ recent calls for a shift towards the practice of cultural safety and humility. This modernized framework of cultural competence addresses the unfortunate reality that providers cannot truly be culturally-competent because of the dynamic nature of culture in society. It also addresses the potential ‘othering’ minority groups may feel based on stereotypes perpetuated by a health care providers’ previous experiences with a member of the same community. By practicing a modernized cultural competency framework that encompasses the core tenets of cultural humility, safety, and competence, healthcare providers and the medical establishment as a whole can greatly increase patient experience and address many socioeconomic, institutional, and cultural factors that have historically impeded care for persons of color living with HIV/AIDS. Although more research must be done to directly quantify these conclusions, it is imperative that health departments in the government, the healthcare sector, existing community institutions, and other culturally-immersed community members of the targeted patient demographic must work together to truly make sustainable change and interventions in patient care. By understanding the perspectives of community members in an interventions’ targeted

community, providers can cater interventions to the specific needs of the community's demographic and better understand methods of making the intervention one that is successful. When practicing a modernized cultural competency framework through working with community institutions and community members, HIV/AIDS stigma reduction efforts may be more successful and health literacy rates may increase due to the framework and intervention providing a more cultivating, learning environment for community members and providers alike.

In order to usher in a new age of culturally-aware medicine and increase treatment adherence and literacy rates, the healthcare sector should focus on greater partnerships with local organizations to bolster education efforts to increase the health literacy of the layman, specifically for HIV/AIDS-related knowledge. In addition to this, health professional schools should take a greater role in educating their future health providers about the barriers that may impede care for persons of color living with HIV/AIDS. Although policy research still needs to be done to address specific ways to implement cultural competency frameworks within healthcare institutions, by recognizing the aforementioned barriers, health care providers can be more aware of their own potential implicit biases or cultural ignorance, and in conjunction with changes to health policy, greater research can be done to understand exact methods of increasing treatment adherence and health literacy of persons of color living with HIV/AIDS.

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