Introduction to Structural Competency

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November 14, 2024

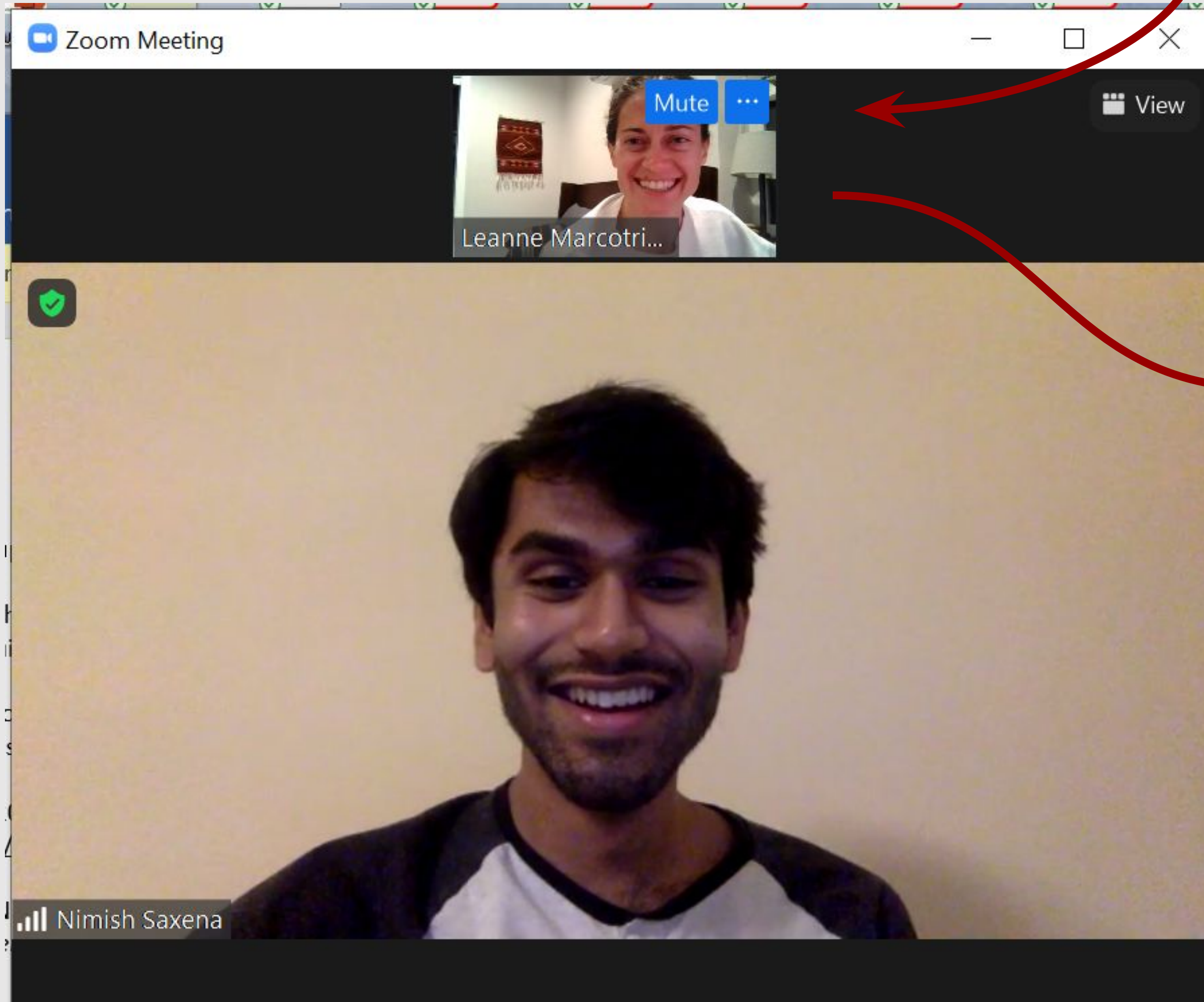
Facilitator Introduction

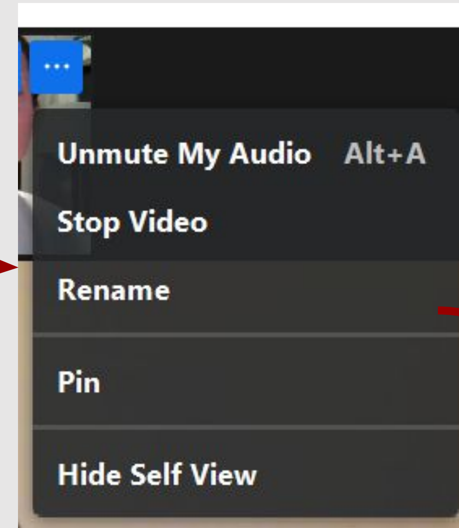
Lea Marcotrigiano, MD, MPH (she/her)

- Family Physician at Highland Hospital Urgent Care and the Alameda Health System Refugee Clinic
- Alumnus of the UCSF HEAL Initiative Global Health Equity Fellowship 2016-2018
- Member of the Structural Competency Working Group since 2018

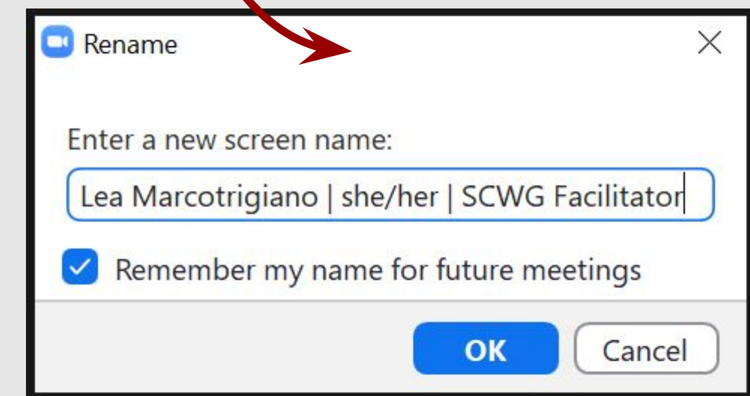
Please introduce yourself

1) In Chat: Please share your name, profession/work role





2) In Zoom: How do you want us to address you? Please add pronouns.



Structural Competency Working Group

Origins → Today

2014 in Berkeley, CA

Focused on integrating structural competency into the training and practice of healthcare

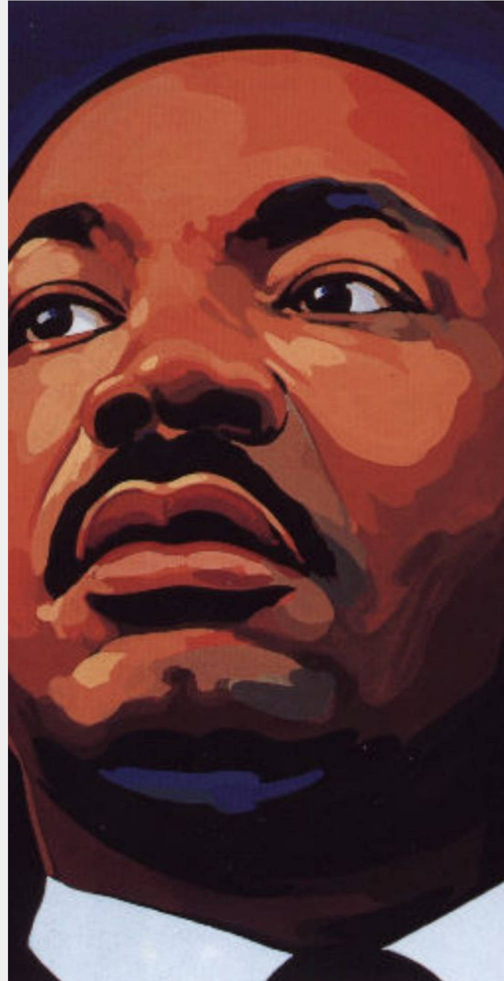
We are: health professionals, social scientists, community health activists, administrators, patients, graduate and professional students

80+ trainings since 2015, for all kinds of health professionals & across all stages of training and practice

Expanding nationally via online trainings, broadening our scope to include a wider range of health care settings

Positionality

Beloved Community



Our goal is to create a beloved community and this will require a qualitative change in our souls as well as a quantitative change in our lives.

Rev. Dr. Martin Luther King, Jr.

PAINTING: KAREN DE COSTER

Applying Beloved Community Principles

Step	Description
Learn about	Learn about the history and culture of the communities we serve
Recognize	Recognize our interdependence: work in partnership to advance the well-being of others
Use	Use our strengths and privileges to intervene on injustice in solidarity across difference
Listen and Lead	Listen and lead with our hearts
Create	Create spaces that support intellectual honesty, deep dialogue, solidarity and structural intervention

Objectives

By the end of this session, participants will be able to:

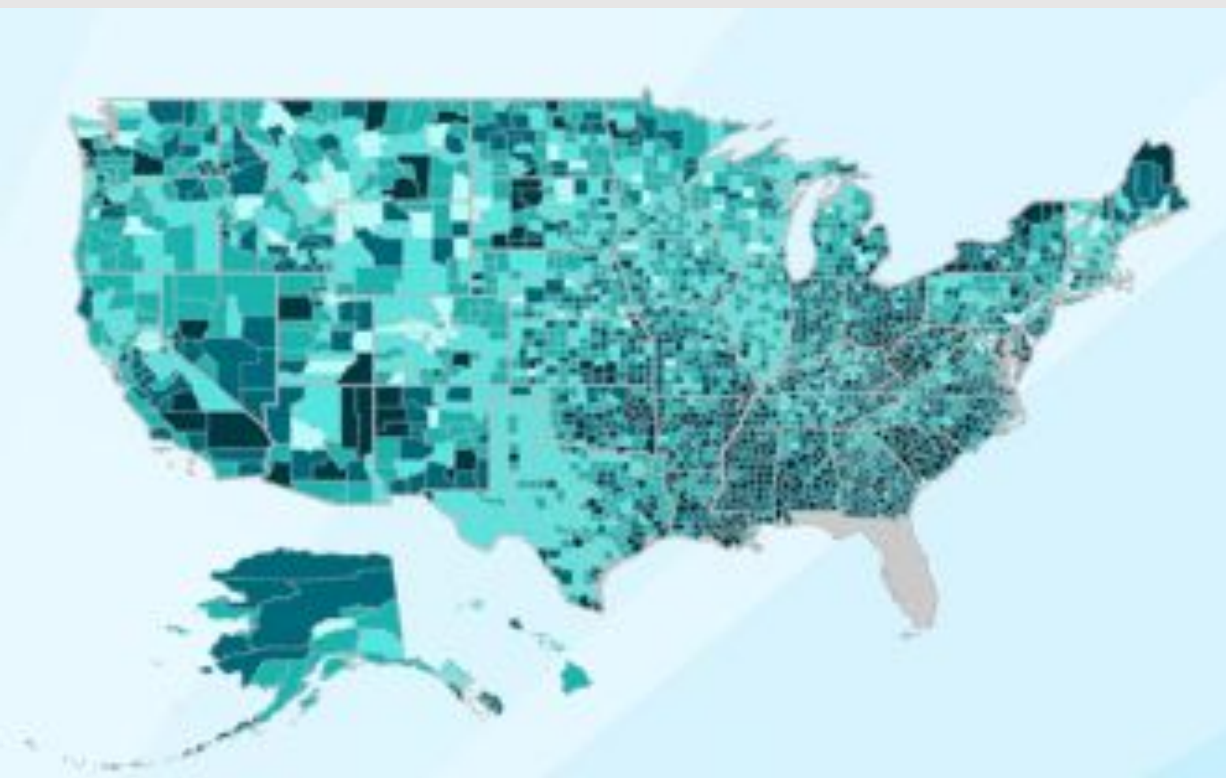
- Define **social structures** and the framework of **Structural Competency**
- Identify the ***impact* of structures** on individual and community health
- Describe ***structural humility*** as an approach to apply in and beyond the health care setting

SOCIAL STRUCTURES AND HEALTH

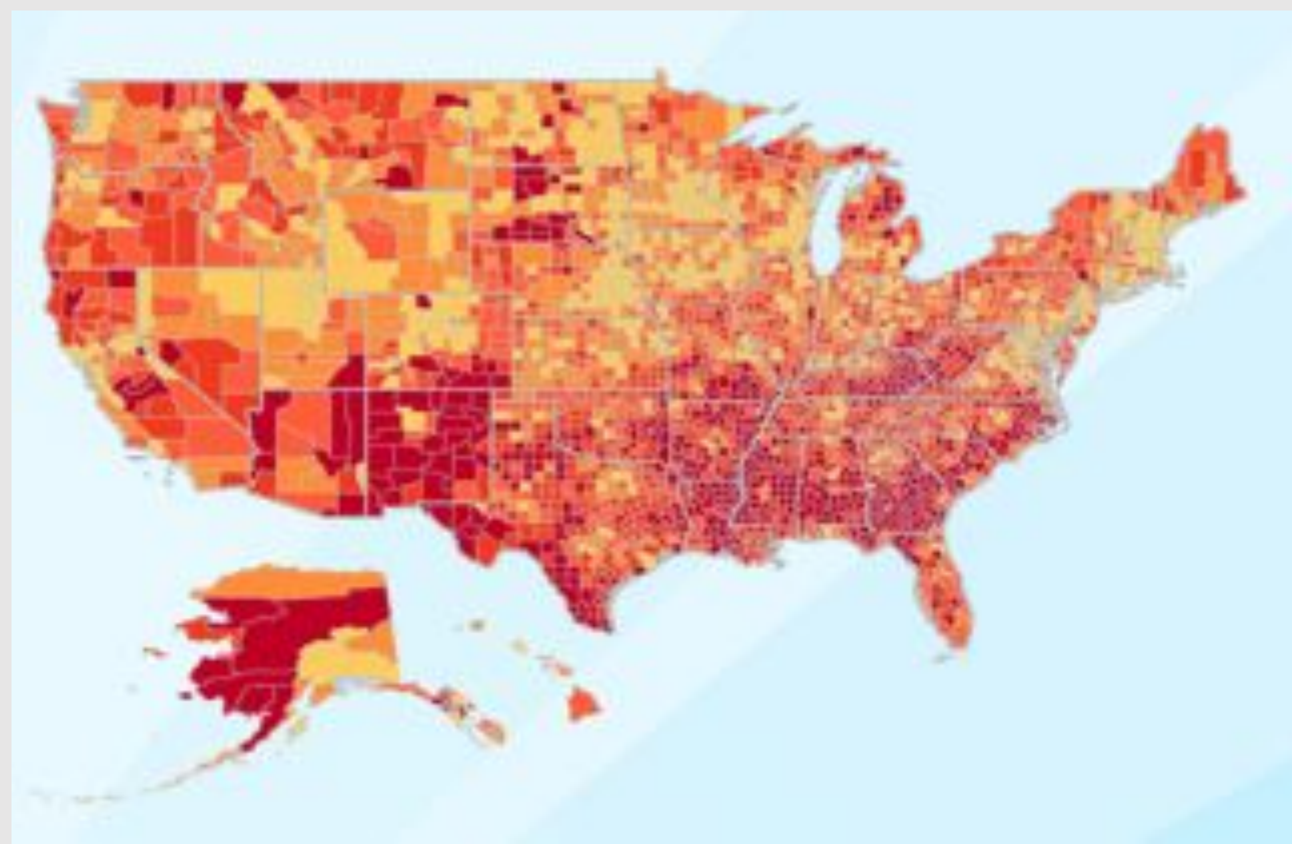
Social Structures

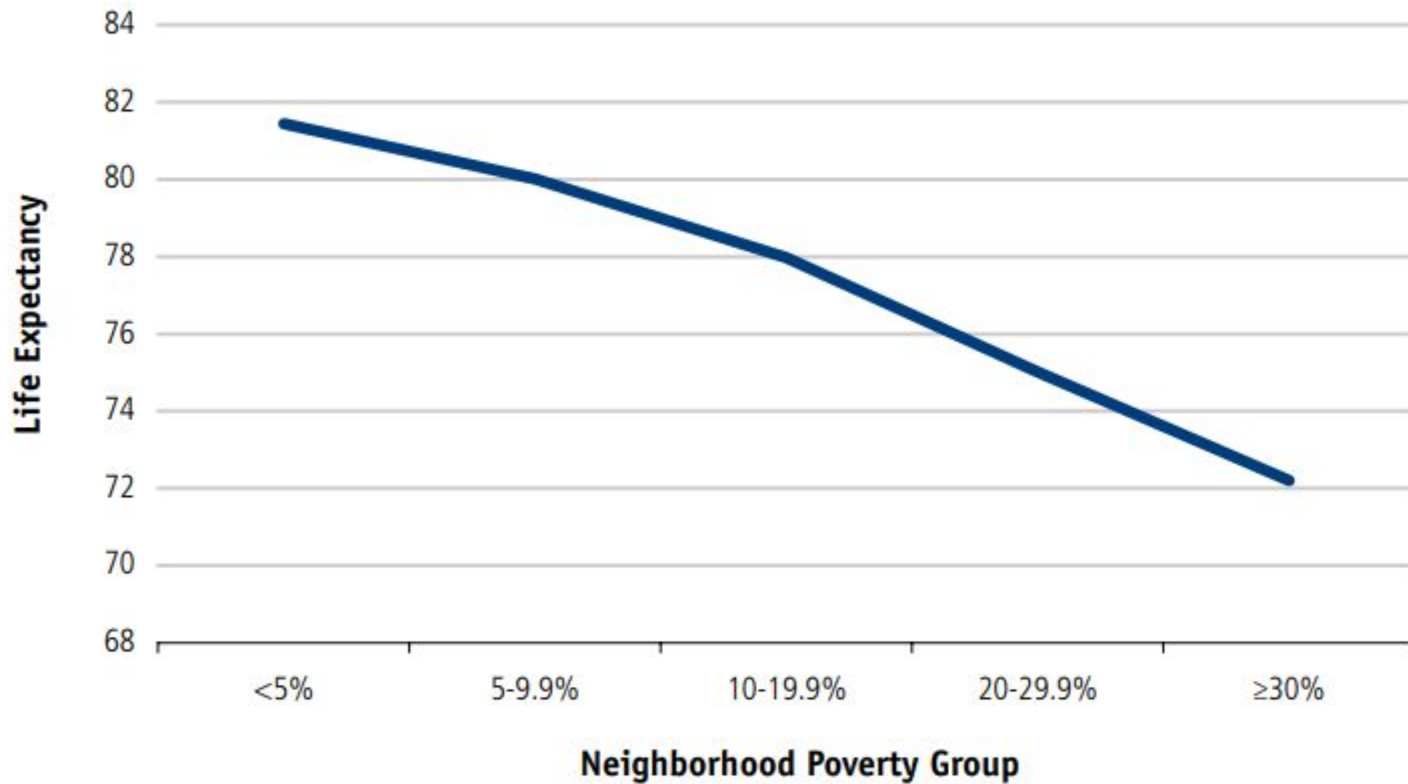
The **policies**, **economic systems**, and **other institutions** (judicial system, schools, etc.) that have produced and maintain modern social **inequities** as well as **health disparities**, often along the lines of social categories such as **race**, **class**, **gender**, **sexuality**, and **ability**.

County-Level Diabetes Prevalence, 2021
(source: CDC)



County-Level Poverty Rates, 2021
(source: US Census)





Bay Area Life Expectancy For All Nine Counties

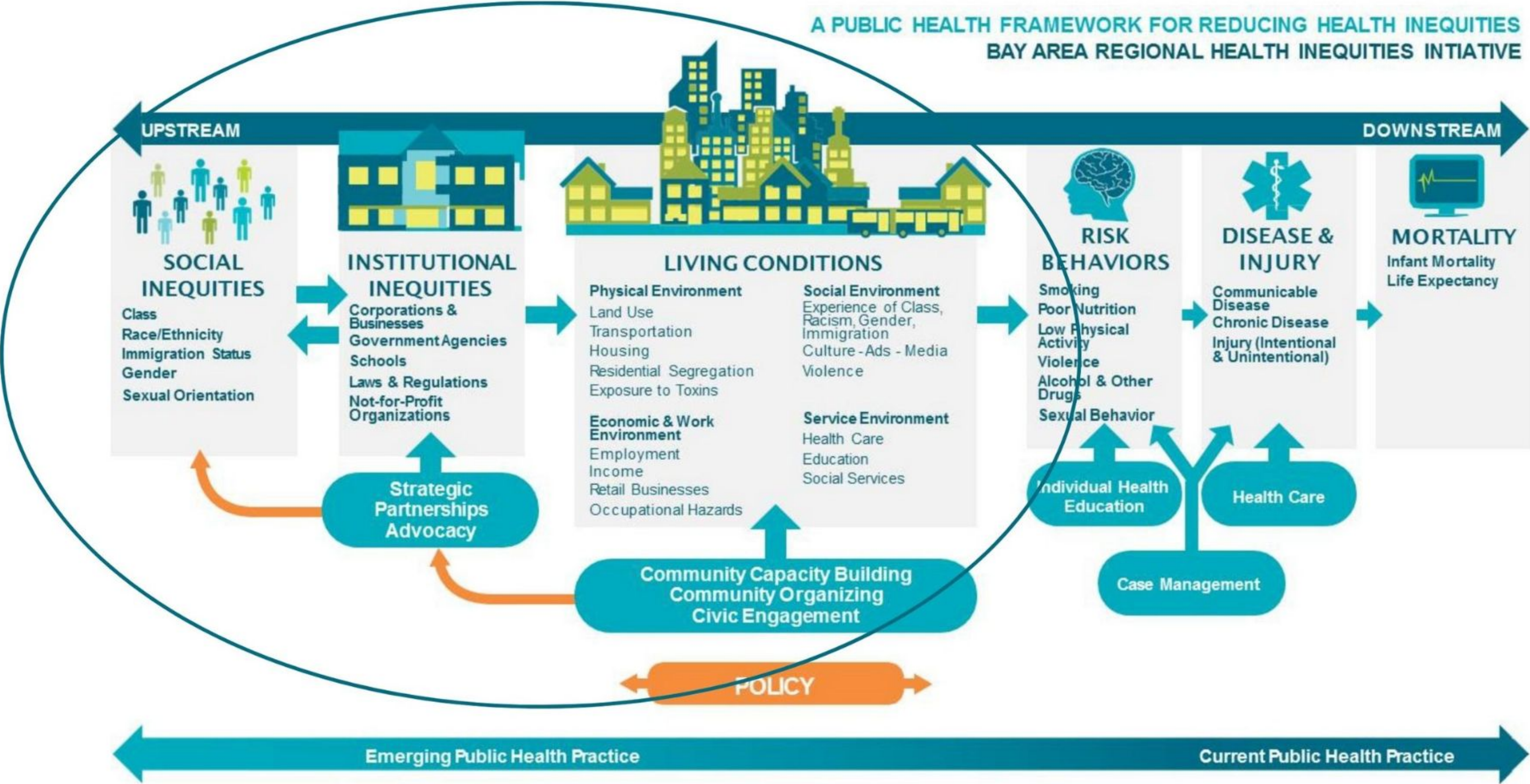
Data from 1999-2001

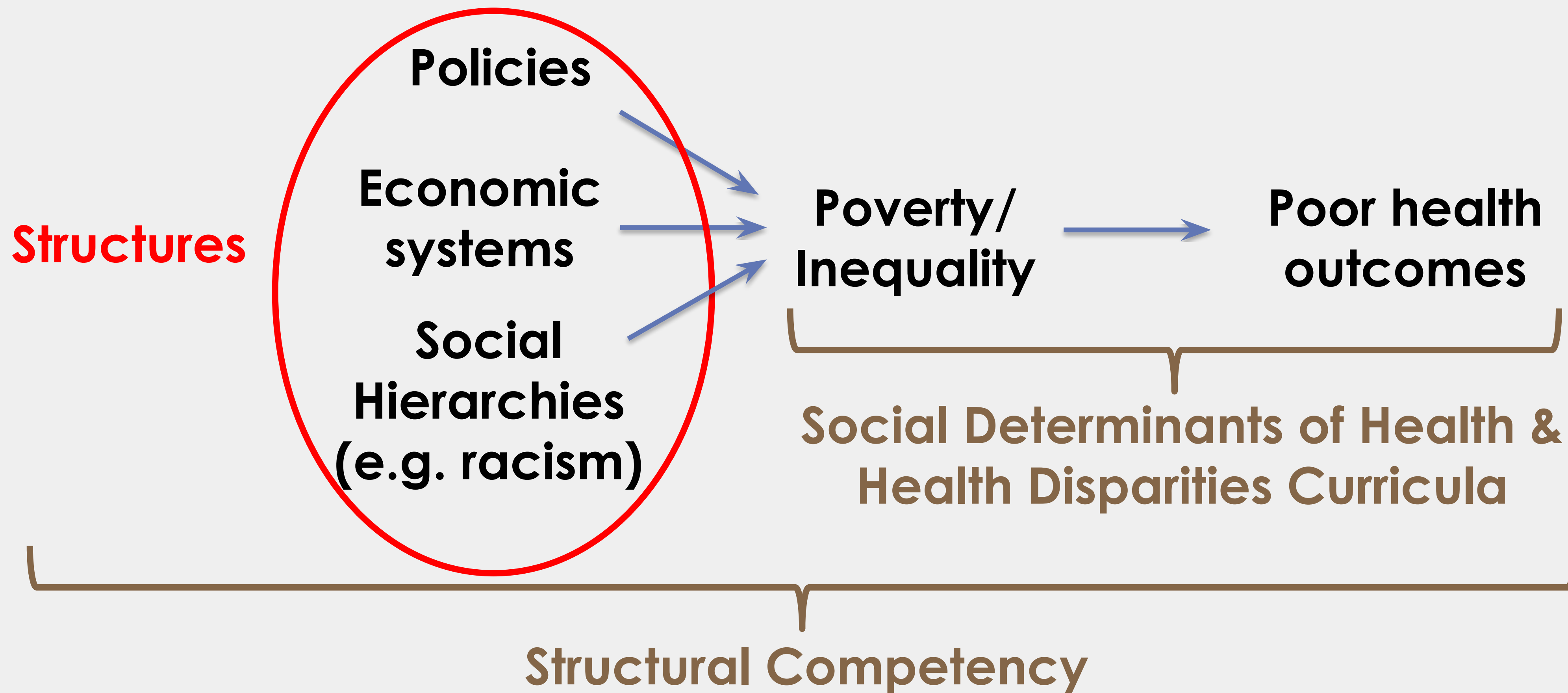
Health Inequities in the Bay Area - Bay Area Regional Health Inequities Initiative (BAHRII, 2008)

Why are people poor/ sick?

"No one has a right to work with poor people **unless they have a real analysis of why** people are poor."

- Barbara Major, Former Director, St. Thomas Community Health Center, New Orleans


A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INTIATIVE
UPSTREAM
DOWNSTREAM
SOCIAL INEQUITIES
Class
Race/Ethnicity
Immigration Status
Gender
Sexual Orientation
INSTITUTIONAL INEQUITIES
Corporations & Businesses
Government Agencies
Schools
Laws & Regulations
Not-for-Profit Organizations
LIVING CONDITIONS
Physical Environment
Land Use
Transportation
Housing
Residential Segregation
Exposure to Toxins
Economic & Work Environment
Employment
Income
Retail Businesses
Occupational Hazards
Social Environment
Experience of Class, Racism, Gender, Immigration
Culture - Ads - Media
Violence
Service Environment
Health Care
Education
Social Services
RISK BEHAVIORS
Smoking
Poor Nutrition
Low Physical Activity
Violence
Alcohol & Other Drugs
Sexual Behavior
DISEASE & INJURY
Communicable Disease
Chronic Disease
Injury (Intentional & Unintentional)
MORTALITY
Infant Mortality
Life Expectancy
Strategic Partnerships Advocacy
Community Capacity Building
Community Organizing
Civic Engagement
Individual Health Education
Health Care
Case Management
POLICY
Emerging Public Health Practice
Current Public Health Practice



"Structural determinants of the social determinants of health"

"If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?"

—*Rudolph Virchow, 1848*

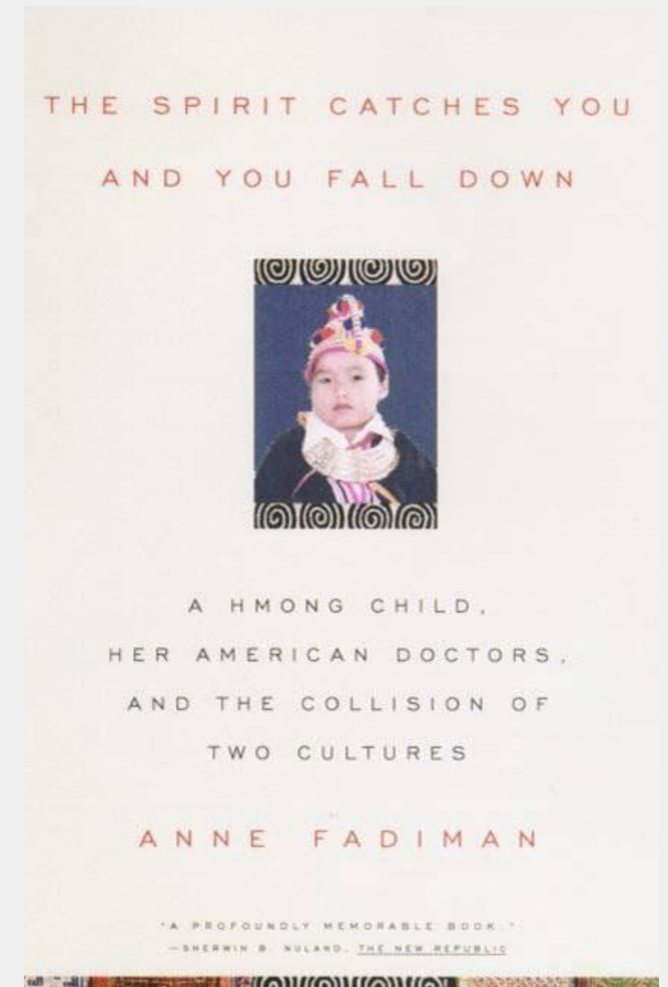
ORIGINS
OF
STRUCTURAL COMPETENCY

Cultural Competency

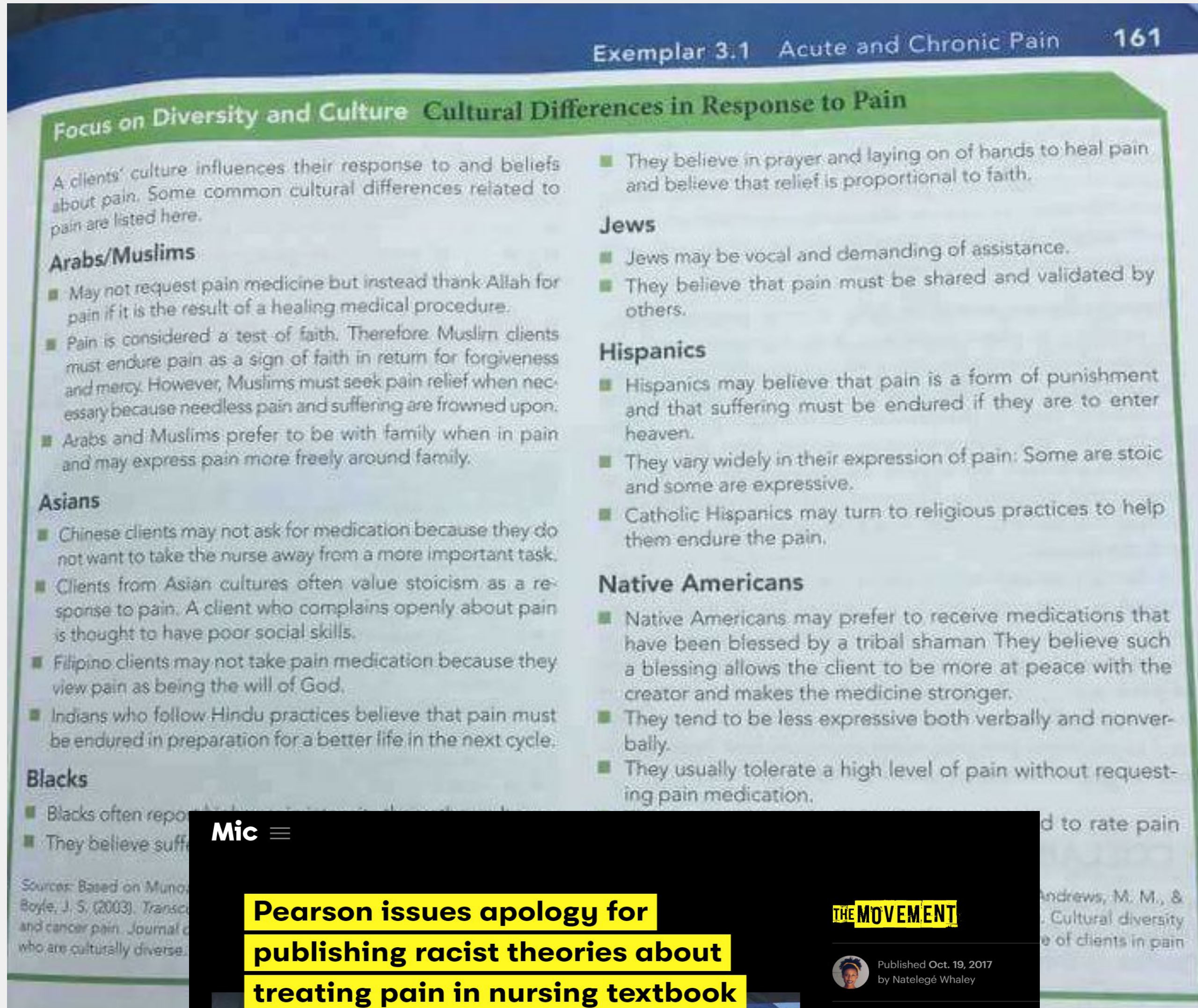
- Motivation: The health care team and patients can misunderstand one another if they have different understandings of illness and health

- Cultural competency ideally helps the health care team to recognize that their own views are also culturally determined

- But it often became “list of traits” to memorize (not about white people or the health care team…)



Cultural Competency: Critiques



Exemplar 3.1 Acute and Chronic Pain 161

Focus on Diversity and Culture Cultural Differences in Response to Pain

A clients' culture influences their response to and beliefs about pain. Some common cultural differences related to pain are listed here.

Arabs/Muslims

- May not request pain medicine but instead thank Allah for pain if it is the result of a healing medical procedure.
- Pain is considered a test of faith. Therefore Muslim clients must endure pain as a sign of faith in return for forgiveness and mercy. However, Muslims must seek pain relief when necessary because needless pain and suffering are frowned upon.
- Arabs and Muslims prefer to be with family when in pain and may express pain more freely around family.

Asians

- Chinese clients may not ask for medication because they do not want to take the nurse away from a more important task.
- Clients from Asian cultures often value stoicism as a response to pain. A client who complains openly about pain is thought to have poor social skills.
- Filipino clients may not take pain medication because they view pain as being the will of God.
- Indians who follow Hindu practices believe that pain must be endured in preparation for a better life in the next cycle.

Blacks

- Blacks often repo
- They believe suff

- They believe in prayer and laying on of hands to heal pain and believe that relief is proportional to faith.

Jews

- Jews may be vocal and demanding of assistance.
- They believe that pain must be shared and validated by others.

Hispanics

- Hispanics may believe that pain is a form of punishment and that suffering must be endured if they are to enter heaven.
- They vary widely in their expression of pain: Some are stoic and some are expressive.
- Catholic Hispanics may turn to religious practices to help them endure the pain.

Native Americans

- Native Americans may prefer to receive medications that have been blessed by a tribal shaman They believe such a blessing allows the client to be more at peace with the creator and makes the medicine stronger.
- They tend to be less expressive both verbally and nonverbally.
- They usually tolerate a high level of pain without requesting pain medication.

How might learning from this book affect how nurses and others provide care?

What are the long term implications of publishing a text like this?

Cultural Competency: Critiques

"In attempting to address racial and ethnic disparities in care through cultural competence training, educators too often conflate these distinct concepts. This leads to an inappropriate collapsing of many of the forces affecting racial and ethnic minority populations—such as poverty, violence, and racism—into the less threatening concept of culture."

—Gregg and Saha, 2006

SCWG
Structural Competency Working Group

Cultural Humility

- Developed out of a concern that some approaches to cultural competency were lists of stereotypes

- "A commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves"

—Tervalon and Murray-Garcia, 1998

SCWG
Structural Competency Working Group

Structural Competency

"A shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions."
–Metzl and Hansen 2014

The capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.

Structural Competency

5 Core Elements as defined by Metzl and Hansen

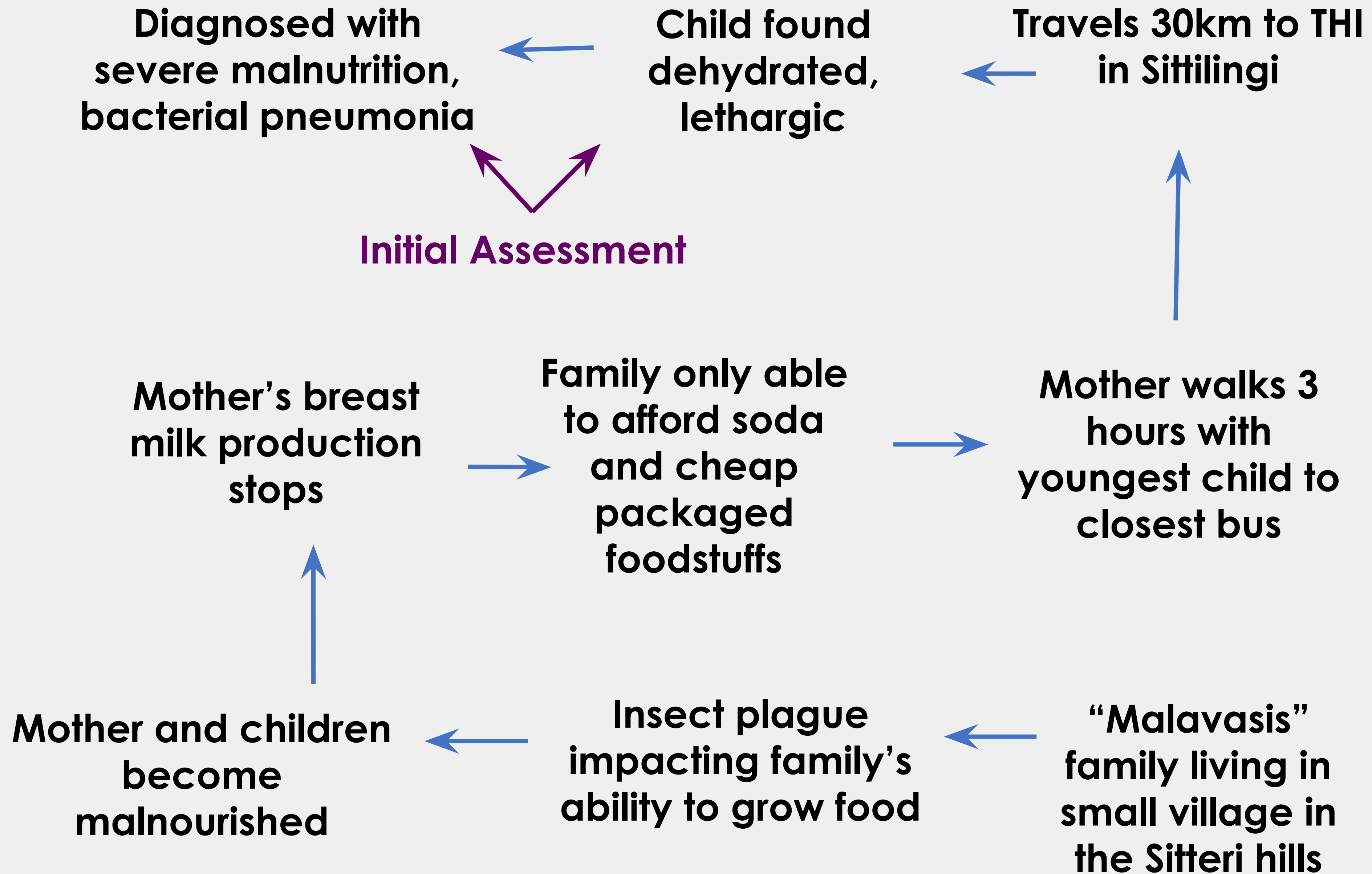
1. Identify ***specific*** ***structures*** and recognize the ***influence of structures*** on health status, patterns of health, and on the practice of healthcare
2. Define and describe structural competency as a framework using a ***shared vocabulary***
3. Rearticulate "cultural" presentations in ***structural terms***
4. Respond to the influences of structures in the health care setting and beyond (***structural interventions***)
5. Develop ***structural humility***

Structural Humility

Structural humility cautions providers against making assumptions about the role of structures in patients' lives, instead encouraging collaboration with patients and communities in developing understanding of and responses to structural vulnerability.

—Based on talk by Helena Hansen, April 2015

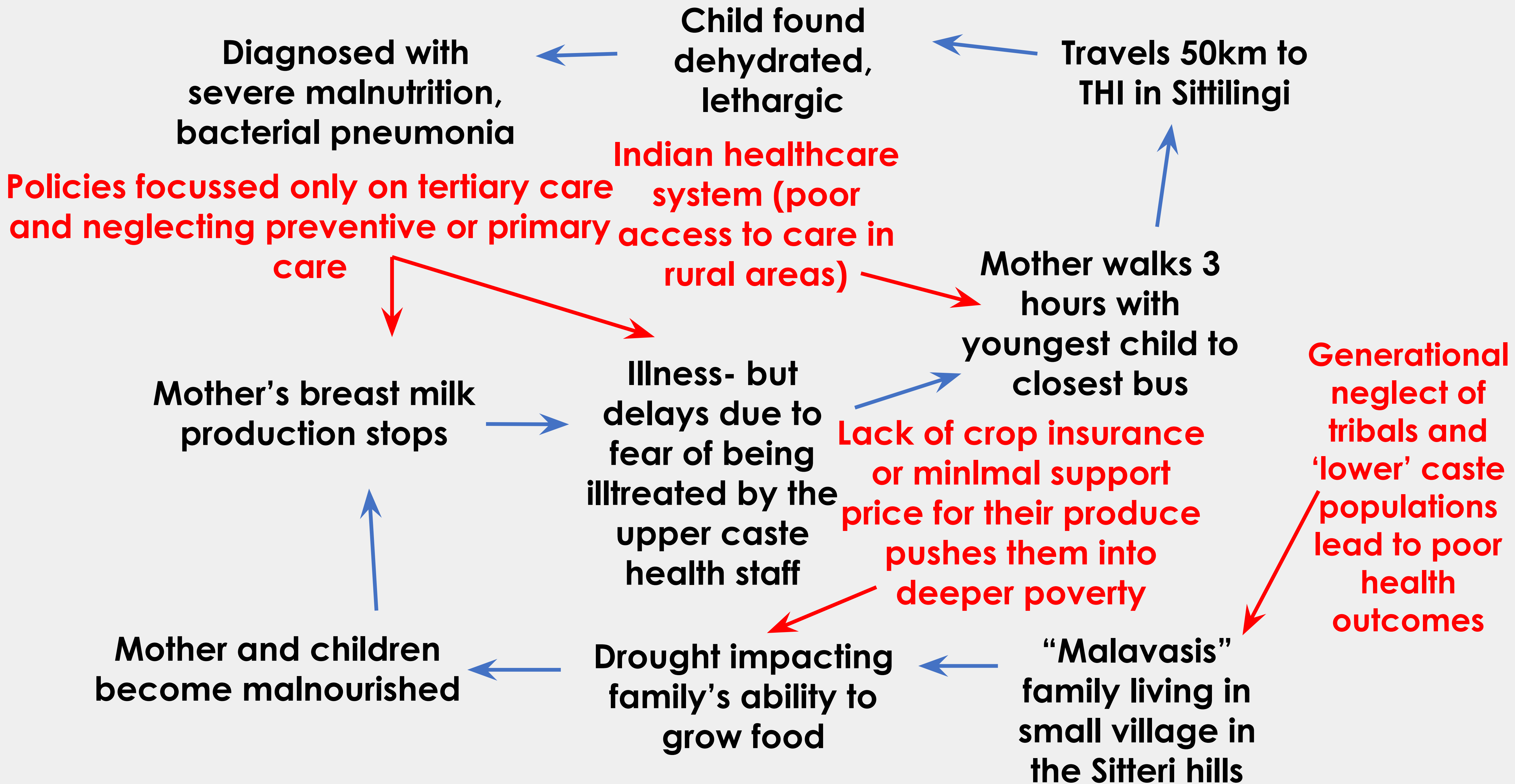
Case: Tribal Health Initiative



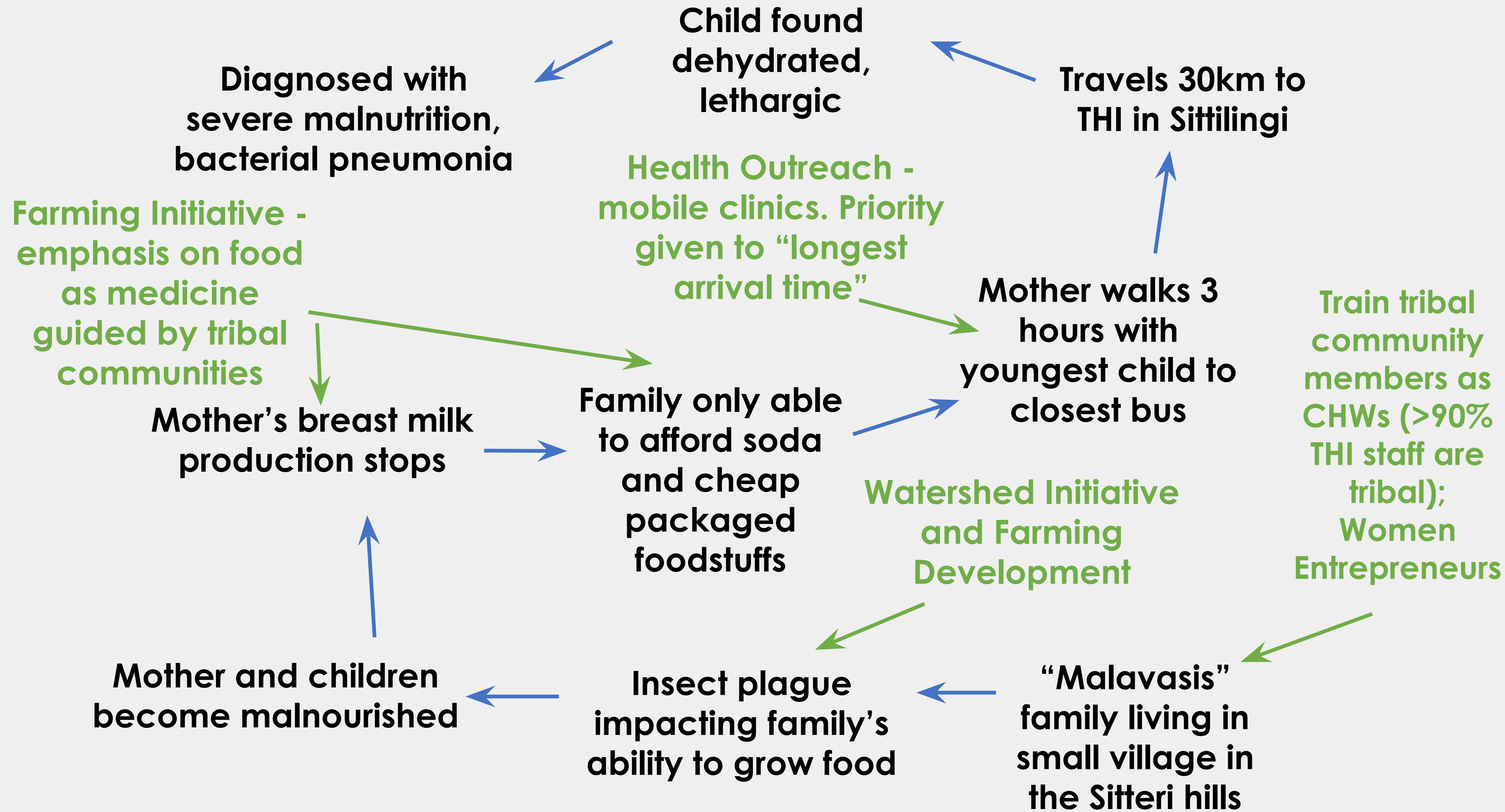
Diagnosed with severe malnutrition, bacterial pneumonia
Child found dehydrated, lethargic
Travels 30km to THI in Sittilingi
Initial Assessment
Mother's breast milk production stops
Family only able to afford soda and cheap packaged foodstuffs
Mother walks 3 hours with youngest child to closest bus
Mother and children become malnourished
Insect plague impacting family's ability to grow food
"Malavasis" family living in small village in the Sitteri hills

What social, economic, and political factors have contributed to this case?

If you don't know, who would you ask or how could you find out?


Child found dehydrated, lethargic
Diagnosed with severe malnutrition, bacterial pneumonia
Travels 50km to THI in Sittilingi
Indian healthcare system (poor access to care in rural areas)
Policies focussed only on tertiary care and neglecting preventive or primary care
Mother walks 3 hours with youngest child to closest bus
Generational neglect of tribals and 'lower' caste populations lead to poor health outcomes
Illness- but delays due to fear of being illtreated by the upper caste health staff
Mother's breast milk production stops
Lack of crop insurance or minlmal support price for their produce pushes them into deeper poverty
Mother and children become malnourished
Drought impacting family's ability to grow food
"Malavasis" family living in small village in the Sitteri hills

What interventions have already been put in place to address these challenges and/or dismantle structural violence in this case?



Child found dehydrated, lethargic
Diagnosed with severe malnutrition, bacterial pneumonia
Travels 30km to THI in Sittilingi
Health Outreach - mobile clinics. Priority given to "longest arrival time"
Farming Initiative - emphasis on food as medicine guided by tribal communities
Mother walks 3 hours with youngest child to closest bus
Train tribal community members as CHWs (>90% THI staff are tribal); Women Entrepreneurs
Mother's breast milk production stops
Family only able to afford soda and cheap packaged foodstuffs
Watershed Initiative and Farming Development
Mother and children become malnourished
Insect plague impacting family's ability to grow food
"Malavasis" family living in small village in the Sitteri hills

What interventions could you IMAGINE happening to further improve the situation in this case?

Domains of Intervention

- **Intrapersonal**: addressing your own biases and implicit frameworks
- **Interpersonal**: how you interact with patients or colleagues
- **Institutional**: clinic, hospital, school or non-profit organization
- **Community**: neighborhood or local efforts outside your workplace
- **Research**: e.g. community-based participatory research
- **Policy**: involvement at local, state, federal or international levels

Why should health care practitioners about social structures?

- How we think about individuals and their communities matters
  - Matters for how we do our jobs
  - Increases empathy, decreases burnout and moral injury
- We have contact with the harms experienced by structurally vulnerable communities
- Powerful position for advocacy – when we speak from professional experience we are less likely to be seen as "partisan"

“Don’t ask what the world needs. Ask what makes you come alive and go do it. Because what the world needs are people who have come alive.”

- Howard Thurman

Thank you!

www.structcomp.org
www.structuralcompetency.org

Email structuralcompetency@gmail.com with questions

Post-training survey: https://tinyurl.com/SCWGPostSurvey