II Literacy, Language & Liberation

II. DECOLONIZING HEALTH LITERACY:

EMBRACING CULTURAL HUMILITY TO ENVISION POSSIBILITIES FOR ENACTING JUSTICE

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REFLECTION GUIDE

Grounding

II.

Read and reflect on this article by By Dr. Uché Blackstock.

1. What are your thoughts about the content of the article?
2. What feelings come up after reading this article ?
3. What beliefs come up as you engage in this article ?
4. Are there any actions you want to take after reading this article, personally? in the area of practice?

SLPs should be deeply concerned about the Black maternal health crisis because we are part of the healthcare system. Our mission is to make communication a human right, which includes ensuring that every voice, especially those of the most oppressed, are heard, believed, and acted on.

The Cultural Humility Framework

Tervalon and Murray-Garcia (1998) conceptualized cultural humility to incorporate:

- lifelong commitment to self-evaluation
- redressing power imbalances
- developing mutually beneficial advocacy partnerships
- holding institutions accountable for justice

MYTHS & TRUTHS ABOUT HEALTH LITERACY

Myth 1: Health literacy is just about making materials "simpler."
Truth: Clear language matters — but it's only one piece.
Health literacy is about whether people can understand, trust, and use health information in real-life contexts.
If a healthcare system does not listen to patients, respect their pain, or create safe conditions for decision-making, no amount of simplified materials can fix that.
A brochure can be written at a 4th-grade level, but if a patient's concerns are dismissed, communication has already failed and there is a missed opportunity for building trust.

Myth 2: Health literacy problems come from patients lacking education.
Truth: Disparities persist even among highly educated patients — especially Black women.
Black women with college degrees have higher maternal mortality rates than white women without a high school diploma.
This tells us the issue is not education or "literacy skills" . It's racism, bias, power dynamics, and lack of equitable communication.
The problem isn't what patients know — it's how the system treats them.

Myth 3: "It's not about race — everyone struggles with medical jargon."
Truth: Medical jargon affects everyone, but health outcomes are not equal.
Black women are three times more likely to die of pregnancy-related complications than white women.
This is not explained by literacy or vocabulary. It is explained by structural racism, implicit bias, and institutional practices rooted in white supremacy culture (such as dismissing pain, delaying care and refusing a "sense of urgency" to some, or privileging staff "objectivity" over patient experience).
When whole groups consistently receive worse care, that is not an individual issue — it's a systemic one.

Myth 4: Health literacy is the patient's responsibility.
Truth: Health literacy is a shared responsibility, and the system carries most of it.
Patients cannot make informed decisions if:

- **their pain is doubted,**
- **their questions are brushed off,**
- **or their voices are not taken seriously.**

To foster organizational health literacy, healthcare systems must create environments where questions are welcomed, concerns are validated, and communication is equitable.
We can't expect patients to fully engage in a system that doesn't fully engage with them.

MYTHS & TRUTHS ABOUT HEALTH LITERACY

Myth 5: If we simplify materials enough, we automatically reduce inequities.
Truth: Inequities are not reading-level problems.
A system can have plain-language handouts and still:

- **ignore a Black woman in active labor,**
- **delay her care,**
- **or fail to respond to her pain.**

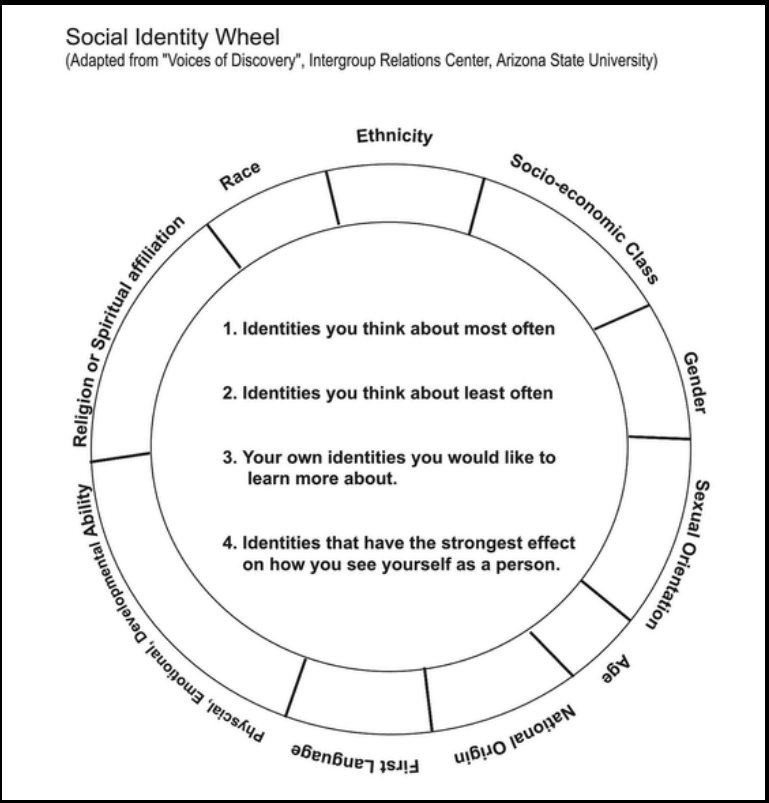
These are failures of trust, bias, institutional culture, and accountability, not vocabulary.
Health literacy without equity is incomplete and ineffective.

Myth 6: Talking about racism or white supremacy culture "isn't relevant" to health literacy.
Truth: Racism and white supremacy culture directly shape how information is delivered, received, and acted on.
White supremacy culture characteristics, such as power hoarding, one right way, paternalism, and belief in staff "objectivity" over patient experience, and deeply perpetuated racial biases create barriers to fair communication and safe care.
If the system doesn't value every voice, it cannot expect every patient to benefit equally.

Myth 7: This is about blaming individual providers.
Truth: This is about examining systems, not blaming people.
Most healthcare workers enter the field to help people.
But we all work inside systems that produce predictable patterns, including the pattern of Black women being ignored when in pain.
Our work is not to assign guilt — it's to build accountability, compassion, and equity into everyday practice.
We inherit the system, but we also have the power to transform it.

Key Takeaway
Improving health literacy is not just about clearer brochures! It's about building a healthcare system that is literate, a system that listens, respects, and provides equitable care for every patient. That requires courage, cultural humility, and a commitment to justice.

CULTURAL HUMILITY REFLECTION



Critical Self-Reflection:

1. **How do my own experiences, identities, and assumptions shape the way I interpret patient communication, pain, or urgency?**
2. **When have I unintentionally dismissed or minimized a patient's concern? What contributed to that moment?**
3. **What emotions come up for me when conversations about racism, inequity, or systemic harm arise in clinical settings?**
4. **How do I respond when I am corrected, challenged, or made aware of a blind spot? (Think about common discomfort responses: denial, minimization and blame)**
5. **Whose voices do I tend to trust most easily? Whose voices do I tend to question? Why?**
6. **What is one action I can take today to practice listening more deeply and with fewer assumptions?**
7. **At an institutional level, where do I see patterns of dismissal, delay, or disbelief and what accountability structures exist to address them? What is one action I can take to change a practice or policy at the institutional level?**

Thank you for your time, attention, and intention to stay engaged and lean in throughout this conversation and reflection.

Thank you for your bravery.

We look forward to staying in community with you.

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Take care,
Megan & Dani

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