THE DESIGN, IMPLEMENTATION AND EVALUATION OF A STATEWIDE CULTURAL COMPETENCY TRAINING FOR NORTH CAROLINA DISEASE INTERVENTION SPECIALISTS

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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the School of Social Work.

Chapel Hill
2009

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ABSTRACT

MARCIE M. FISHER-BORNE: The Design, Implementation and Evaluation of a Statewide Cultural Competency Training for North Carolina Disease Intervention Specialists
(Under the direction of Dr. Kathleen Rounds, Chair)

Black males have the highest HIV incidence and AIDS mortality rates in the United States despite two decades of advances in AIDS research and care (Kaiser Family Foundation, 2006). In North Carolina, African Americans represent 24% of the population yet account for 66% of AIDS cases. In 2003, among males ages 13 to 24 who were newly diagnosed with HIV, more than 70% were Black (NC Department and Health and Human Services [DHHS], 2003). At least half of all new HIV cases in the United States occur among people under the age of 25 with a substantial proportion of these infections occurring among young men who have sex with men (MSM) (Centers for Disease Control and Prevention [CDC], 2007).

Current HIV research reveals an urgent need to address macro-environmental factors such as social barriers (e.g., poverty, racism, and homophobia) that contribute to health inequalities for HIV-infected populations (Beatty, Wheeler, & Gaiter, 2004; Brown, Trujillo &Macintyre, 2003). Promoting cultural competency among health professionals is one strategy to address these disparities (US DHHS, 2000).

This dissertation evaluates the outcomes of a cultural competency training for North Carolina Disease Intervention Specialists (DIS). In North Carolina, DIS are “first responders” after HIV diagnosis and play a vital role in connecting HIV-infected persons to

care. The study sample includes DIS (n=54) who attended a two-day training to increase their effectiveness in interacting with clients who are gay, bisexual, and transgender (GBT). The specific outcome measures evaluate changes in providers' knowledge, awareness, attitudes, and skills related to working with GBT clients with a focus on clients of color. Overall, the majority of DIS showed an increase in knowledge related to GBT issues and population, yet demonstrated no change related to attitudes, awareness and skills in working with GBT clients. Implications for research and practice are discussed.

To Chantelle for being there since the beginning and

to Miley,

for providing a major incentive to see this to the end.

ACKNOWLEDGEMENTS

I hope it is as Salmon Rushdie says, and that "answers are easier to come by, and less reliable than questions." This dissertation process has raised far more questions than answers. I am left wondering if a more respectful, person-affirming approach to health is possible. Can the deep and institutionally sanctioned intolerance for and denial of LGBT people change in my lifetime? How do I actively challenge (or contribute to) the process of change? It is as important for me to acknowledge these questions as it is for me to acknowledge the people who have helped me sit with them.

First, I would like to express a deep gratitude to the POINT Foundation. Without the financial, emotional, and mentoring support you have provided over the last 5 years, I would not be here. Thanks also to the Royster Society of Fellows for making my last year of writing possible. I would like to thank Justin Smith, Project STYLE Coordinator. Justin served as a co-facilitator and collaborator for this dissertation study. Without him this training would have not been possible. I want to also acknowledge Sarah Zlotnik, whose copious field notes during the training intervention were invaluable. Thanks to Lisa Hightow-Weidman for her amazing leadership with Project STYLE and commitment to quality HIV care.

I want to thank Todd Vanhoy at the North Carolina HIV/STD Prevention and Care Branch for recognizing the need for this training as well as Andrea Hanner, Staff Development Specialist, who went above and beyond with logistical and emotional support to make the training happen.

Thanks also go to my committee who supported me in taking a chance on this pilot intervention. Thanks especially to my chair, Dr. Kathleen Rounds who provided ongoing support and direction throughout this study. Thanks to Dr. Natasha Bowen for her guidance

related to the methods and results section of this dissertation. Thanks to Dr. Amelia Roberts-Lewis for providing critical input relevant to the cultural competency social work literature. Thanks to Dr. Geni Eng in HBHE, who helped to shape the conceptual framework related to this study. Finally, thanks to Dr. Peter Leone, whose work in medicine and HIV remind me that research must (and can) have "real world" application.

Thanks also to Yonghong Nie and Kathy Zimmer for invaluable statistical assistance. I am deeply grateful for the editorial eye of Jennie Vaughn, whose capacity for detail is awe-inspiring. Special thanks to my friends and colleagues at the School of Social Work. In particular, I want to acknowledge Traci Wike, who was the first social worker I met at UNC and still one of my favorites. I also want to express deep gratitude to Mat Despard, whose commitment to community practice and extraordinarily grounded teaching ability have kept me grounded during my research and provided an unexplainable degree of sanity during my time here. Related to my sanity, I am indebted to Jeanne Stanley, dissertation coach extraordinaire, whose frank (yet gentle) guidance helped me get to my defense in one piece.

Finally, to the young HIV-positive gay, bisexual, and transgender men in North Carolina, it is my sincere hope that my research and service continue to support you and help to create a world where there is more love and possibility for all of us.

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CLAS	Culturally and Linguistically Appropriate Services
CSWE	Council on Social Work Education
DHHS	U.S. Department of Health and Human Services
DIS	Disease Intervention Specialist
GAP	Gay Affirmative Practice Scale
GBT	Gay, Bisexual, and Transgender
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration
IAH	Index of Attitudes Towards Homosexuality
IOM	Institute of Medicine
LGBT	Lesbian, Gay, Bisexual, and Transgender
MSM	Men who have sex with men
NASTAD	National Association of State AIDS Directors
NASW	National Association for Social Work
NCCC	National Center for Cultural Competency
NCCC	National Center for Environmental Health
NC DHHS	North Carolina Department of Health and Human Services
OMH	Office of Minority Health
PCCS	Patient Cultural Competency Scale
SGLHR	Support for Lesbian and Gay Human Rights Scale
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STYLE	Strength Through Youth Living Empowered, Project
UNC	University of North Carolina at Chapel Hill

CHAPTER I

PROBLEM STATEMENT

Black males continue to have the highest HIV incidence and AIDS mortality rates in the U.S. despite two decades of advances in AIDS research and care (Kaiser Family Foundation, 2006). In the United States, young Black men (ages 13 to 25 years) who have sex with men (MSM) carry a disproportionate burden of HIV infection (Centers for Disease Control and Prevention [CDC], 2007). Current HIV research has revealed an urgent need to address macro-environmental factors such as stigma, discrimination, and other social barriers (e.g., poverty, racism, and homophobia) that contribute to health inequalities for HIV-infected populations (Beatty, Wheeler, & Gaiter, 2004; Brown, Trujillo & Macintyre, 2003). A key strategy in addressing these health disparities is promoting cultural competency among health professionals. Cultural competency training for health professionals encompasses an ongoing process of increasing self-awareness, information, and skills related to race, gender, gender identity, sexual orientation, age, and socioeconomic status (Brach & Fraser, 2000; Campinha-Bacote, 1999; Office of Minority Health [OMH], 2001b).

The following dissertation study takes initial steps toward exploring a cultural competency intervention related to HIV health care provision and is the result of a three-year collaboration with researchers from the University of North Carolina (UNC) Schools of Medicine and Public Health and the HIV/STD Prevention and Care Branch within the North Carolina Department of Health and Human Services (NC DHHS). The study sample included all Disease Intervention Specialists (DIS) in North Carolina (n=54) who attended a

mandatory two-day cultural competency training. The training concentrated on increasing the effectiveness of these health care providers' interactions with clients who are men who have sex with men (MSM) or gay, bisexual, and transgender (GBT) identified clients, with a focus on Black men. The combined term MSM/GBT is used within this dissertation as many MSM do not self-identify as gay, bisexual, or transgender, yet social stigma related to non-heterosexual identity (e.g., GBT identity) is an issue the intervention addresses. The specific outcome measures focused on changes in providers' knowledge, awareness, and skills related to working with MSM/GBT clients of color. Several factors made North Carolina an ideal setting to pilot this intervention: (a) the Southeastern region of the United States has the nation's highest incidence of HIV infection and sexually transmitted infections (STIs) among Black men; (b) this is the only region of the country where HIV infection rates have not stabilized or declined (CDC, 2007); (c) evidence has established an ongoing outbreak of HIV infection in North Carolina among young Black MSM; and (d) there was a demonstrated need and opportunity for university collaboration with the NC DHHS HIV/STD Division.

Study Research Aims

The aims of this study are three-fold and are detailed below:

1. Characterize young Black MSM/GBT clients' needs and perceptions regarding sexual health and HIV prevention and care.
2. Design and implement a culturally competent training tailored to Disease Intervention Specialists.
3. Evaluate the outcomes of training in improving provider cultural competency regarding interactions with MSM/GBT clients of color.

Aim I. Characterize young Black MSM/GBT clients' needs and perceptions regarding sexual health and HIV prevention and care.

In order to understand clients' needs and perceptions, four sources of data were utilized: (a) focus groups with Black MSM/GBT individuals, (b) a Photovoice project with

college-age Black men, (c) ongoing meetings with an expert advisory group comprised of researchers and representatives of community-based organizations that serve MSM/GBT clients, and (d) a review of literature related to HIV prevention efforts with young HIV-infected MSM and cultural competency theory and training. The information gathered informed the development of curriculum for the cultural competency training targeted to DIS in North Carolina.

Aim II. Design and implement a cultural competency training tailored to Disease Intervention Specialists.

Findings from primary and secondary data related to Aim I as well as ongoing input from the North Carolina DHHS HIV/STD Prevention and Care Branch informed the development of a 16-hour cultural competency training (8 hours of instruction over 2 consecutive days) targeted to DIS in North Carolina. The two-day training was offered in April 2007 (for the eastern North Carolina region) and May 2007 (for the western North Carolina region). The objective of the training was to improve quality of care delivered by DIS to MSM/GBT clients. In addition to the qualitative data described in Aim I, the training was informed by an open-ended needs assessment conducted with all North Carolina DIS in fall 2006.

Aim III. Evaluate the outcomes of training in improving provider cultural competency regarding interactions with MSM/GBT clients.

Pretest and posttest measures were conducted to assess changes in each provider's cultural competency-related knowledge, awareness, attitudes and skills in working with MSM/GBT clients. Surveys were administered at three time points: before the training (T1); immediately after training (T2); and 12 weeks post-training (T3). To supplement the findings

from the survey analysis, data from the North Carolina STD Management Information System (MIS) was also used in the evaluation. Specifically, the NC DHHS STD Division provided data related to the number of HIV-related interviews that DIS conducted with MSM individuals and the number of partners notified during the two months prior to the training intervention (February-March 2007), during the training intervention (April-May 2007), and in the two months following the training intervention (June-July 2007).

Organization of Paper

The following dissertation describes a pilot intervention to explore the utility of cultural competency training in addressing HIV health disparities among GBT people of color in North Carolina. Chapter II provides an overview of the challenges related to current HIV research, defines terminology related to cultural competency, and describes how cultural competency training for health care providers is a needed component of health disparities research. Chapter III explores and critiques existing frameworks and theoretical models related to cultural competency in health care and attempts to identify and define additional cultural frameworks that may be more germane to HIV prevention interventions specific to MSM/GBT populations. Chapter IV explores current cultural competency research including interventions, strategies, and approaches to cultural competency training and education. Methodological challenges are discussed. Chapter V details the study background and outlines the theoretical and conceptual framework for the pilot intervention. Chapter VI describes the research design, methods, and data analysis procedures for the study. Chapter VII presents an overview and summary of the major findings from this research. Finally, Chapter VIII discusses implications for future research and practice. Limitations of the study are also presented.

CHAPTER II

HIV, MSM, AND CULTURAL COMPETENCY

Statement of Problem

Every year more than 55,000 U.S. residents are infected with HIV, and at least half of these cases are among adolescents or young adults under 25 years old (CDC, 2008; Office of National AIDS Policy [ONAP], 2000). Young MSM are at particularly high risk for HIV infection (CDC, 2007; Kaiser, 2006; Valleroy et al., 2000). The CDC's (2005) Young Men's Survey estimated an HIV incidence of 14.7% per year among Black MSM in their twenties, compared with an incidence of 2.5% per year among White MSM of the same age (CDC, 2005; Valleroy et al., 2000). In North Carolina, the incidence rate among young Black men is equally alarming, as evidenced by the 2,022 new HIV infections reported in 2006 (NC DHHS, 2008). Although only 21% of North Carolinians are Black, this racial group accounted for more than 70% of the state's AIDS cases in 2006, and among males ages 13 to 24 years who were newly diagnosed with HIV, more than 70% were Black (NC DHHS, 2007).

HIV prevention efforts intended to reach young men of color have primarily focused on individual behavior. However, researchers have suggested that future investigations should consider both the interpersonal and systemic determinants that impact risk and resiliency related to HIV and sexual health (Mays, Cochran, & Zamudio, 2004; Millett, Malebranche, Mason, & Spikes, 2005; Millett & Peterson, 2007; Wheeler, 2005).

Furthermore, *Healthy People 2010* identified the elimination of health disparities related to gender, race or ethnicity, and sexual orientation as a major public health goal (US DHHS, 2000). Thus, addressing the interrelationship of race, sexuality, class, and other cultural factors is crucial to new intervention approaches. For example, frameworks for understanding sexuality issues such as "coming out" (i.e., disclosing sexual orientation) for White males are not necessarily transferable to gay and bisexual men of color (Kennamer, Honnold, Bradford, & Hendricks, 2000; Malebranche, 2003; Stokes & Peterson, 1998). The complex interactions of racial, ethnic, and sexual identities among clients may impact treatment and referral decisions by health care providers (Majumardar, Brown, Roberts, & Carpio, 2004; Shulman et al., 1999; Wheeler, 2005). Identifying and understanding the interactions of clients and providers as they relate to health disparities for Black MSM/GBT clients is important to ensure effective HIV prevention efforts (Wheeler, 2005) as "care of gay and bisexual males can be influenced by providers' attitudes toward homosexuals" (p. 105).

Cultural competency education and training have been proven effective in increasing the capacity of health care providers to serve an increasingly diverse U.S. population. Price et al. (2005) conducted a systematic review of the literature that examined cultural competency training as a tool for improving health among racial and ethnic minority clients and found trainings to be helpful in improving providers' knowledge, attitudes, and behavior. Although there is an evidence base to support cultural competency training as an avenue to increase providers' confidence and skill in working with clients from diverse populations, questions remain regarding the effectiveness of these efforts on client outcomes and in reducing health disparities.

Understanding Cultural Competency

In considering cultural competency, it is important to first clearly define concepts and provide an explanation of related terms. Unfortunately, definitions and conceptual frameworks of cultural competency vary widely depending on discipline and worldview. The absence of standardized definitions and frameworks creates challenges for both practice and research (OMH, 2001b). A review of the literature yields numerous frameworks, definitions, and theoretical strategies for cultural competency. For example, the Health Resources and Services Administration (HRSA) provides eight definitions of cultural competency (HRSA, n.d.) and the National Center for Cultural Competency (NCCC) provides 16 definitions (NCCC, n.d.). A review of mental health literature from 1985 to 2004 related to cultural competency also yielded multiple definitions, although the reviewers found the definitions had a common aim of increasing the capacity to serve minority populations (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007).

Framing Culture

The first step in defining cultural competency is identifying what is meant by "culture." Much of the health care literature concurs with Cross, Bazron, Isaacs, and Dennis (1989), who defined culture as the "integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups" (p. 3). In addition, culture can be understood as a "system of meaning" (Dunn, 2002, p. 106) which is fluid, multilayered, and "inseparable from economic, political, religious, psychological, and biological conditions" (Kleinman, 2006, p. 1674). The dynamic nature of culture makes it impractical to attempt to completely characterize individuals based on a particular group identity (Dunn, 2002).

Cultural Competency

Cross et al. (1989) have provided the most widely cited definition of cultural competency as "a set of attitudes, skills, behaviors, and policies enabling individuals and organizations to establish effective interpersonal and working relationships that supersede cultural differences" (p. 3). This definition has been adapted by HRSA, the NCCC, and the Council for Social Work Education (CSWE).

Cultural competency is viewed as an ongoing process of increasing self-awareness, information, and skills, without a finite endpoint. Cultural competency moves beyond *cultural awareness* (i.e., knowledge about a particular group) and *cultural sensitivity* (i.e., knowledge as well as some level of direct experience with a particular group different than one's own) to include a commitment to effective responses and engagement strategies related to cultural diversity (Brach & Fraser, 2000; Campinha-Bacote, 1999). However, cultural competency is not simply a technical skill, a communication technique, or something that can be learned overnight (Kleinman, 2006). Rather, cultural competency "requires a fundamental change in the way people think about, understand, and interact with the world around them" (Dunn, 2002, p.107). Cultural competency, though often used to address racial and ethnic disparities, also includes issues related to socioeconomic status, religion, age, ability, gender, gender identity, and sexual orientation (Abrums & Leppa, 2001).

Cultural Humility

The term and concept of *cultural humility* describes a lifelong process that a provider enters into with clients, communities, colleagues, and him or herself. This process requires the provider to negotiate the inherent power imbalances between those in positions of authority (i.e., providers) and those with little or no power (i.e., clients). Cultural humility

advocates client-focused interviewing and care (Tervalon & Murray-Garcia, 1998, p. 118). The concept will be discussed in detail later in this paper.

Shifts in terminology may reflect differing discipline values and perspectives as well as paradigm shifts as the idea of cultural competency continues to evolve as a concept and practice (Fong & Furuto, 2001). Characteristics of the varying cultural competency terminology are summarized in Table 1.

History of the Development of Cultural Competency

In order to understand current frameworks related to cultural competency it is necessary to first understand the history and evolution of culturally specific work. This section discusses early contributions to the conceptualization of cultural competency in medicine, nursing, psychology, and social work.

Medicine

The etiology of cultural competency as it is understood in medicine can be traced to medical anthropology and the work of Arthur Kleinman. Kleinman argued for a client-centered rather than a disease-based approach to health and developed an *Explanatory Model of Health and Illness* to recognize and validate clients' conceptions, explanations, and expectations of their experience of illness based on cultural beliefs and encounters (1981). Though providers may identify illness from a purely biomedical perspective, individuals' experiences of health and disease are more complex. The exploration of this complexity and the role culture plays from both a provider and client perspective has provided the medical field with a foundation for understanding cultural competency.

Nursing

Since the early 1900s, the field of nursing has explored cultural aspects of health. In

Table 1
Definitions and Perspectives of Frequently Used Terms

	Defining characteristics	**Perspective on culture**	**Challenges/critiques**
Cultural sensitivity	Recognizes differences in others Assumes the problem is cultural difference Solves problem by learning details of the cultural difference in order to be sensitive to them	Framework to help understand differences Promotes tolerance	Can lead to stereotyping Complexity of layers of identity not acknowledged Role of power and systemic discrimination not acknowledged
Cultural competency	Assumes the problem is a lack of knowledge, awareness and skills to work across lines of difference Individuals and organizations develop the values, knowledge and skills to work across lines of difference	Acknowledges the layers of cultural identity Challenges stereotypes Difference is seen in the context of systemic discrimination Increases potential for institutional accountability	Requires personal commitment and development Depends on a climate that proactively fosters working across differences Could be interpreted as "cookbook" approach and lead to stereotyping
Cultural humility (Tervelon & Murray-Garcia, 1998)	Process involves seeking to understand clients, communities, colleagues, and ourselves Requires humility and recognition of power imbalances that exist in client-provider relationships and in society	Acknowledges the layers of cultural identity Recognizes that working with cultural differences is a lifelong and ongoing process Emphasizes not only understanding the "other" but understanding ourselves as well	Emerging concept, not empirically tested

1917, the Committee on Curriculum of the National League for Nursing published a curriculum guide that included content on social inequalities (DeSantis & Lipson, 2007). In the 1950s, Madeline Leininger pioneered the field of transcultural nursing and provided the foundational concepts of cultural competency in the field of nursing. The term *cultural competency* is currently used interchangeably with *cross-cultural* or *transcultural nursing*. Leininger (1991) asserted that understanding the learned, shared and transmitted values, beliefs, norms, and life experiences of a particular group would help nurses provide culturally specific and congruent care.

In 1983, the National League for Nursing developed criteria for nursing education curricula that addressed ethnic, racial, and cultural diversity (DeSantis & Lipson, 2007). In 1992, the American Academy of Nursing's Expert Panel on Culturally Competent Care first defined culturally competent care as that which is "sensitive to issues related to culture, race, gender, and sexual orientation" (American Academy of Nursing, p. 278) and offered 10 recommendations for health care. In 2007 the panel reconvened, citing an increased need to focus on cultural competency as a way to eliminate health disparities and, in an effort to "advance clarity and understanding of the concept," offered new recommendations related to identifying an effective model of culturally competent care and furthering related research in the nursing profession (Giger et al., 2007, p. 96).

Psychology

While awareness of culture in the field of psychology can be traced back decades and includes the work of prominent scholars such as Carl Jung and Erik Erikson (Eunyoung, 2004), the body of work by Derald Sue and colleagues has set the standard for cultural competency in the field of mental health on an individual provider level (Sue et al., 1982;

Sue, Arredondo, & McDavis, 1992; Sue, 2001). Sue et al. (1982) developed multicultural counseling guidelines that are now considered standard cultural competency guidelines by six divisions of the American Counseling Association and two divisions of the American Psychological Association (Eunyoung, 2004). General concepts of cultural competency focus on cross-cultural language skills, awareness of diversity, and providing effective care across lines of difference (Sue, 2001). These competencies are explained in greater detail later in this paper.

Social Work

The work of Sue et al. (1982) formed the foundation for early cultural competency models in social work (Yan & Wong, 2005). Terms related to culture and social work practice began to emerge in the literature in the early 1980s (Fong & Furuto, 2001). These terms included *ethnic sensitive* social work practice, *cultural awareness, cross-cultural social work, ethnic competency* (Devore & Schlesinger, 1981; Green, 1995) and a *process-stage approach with people of color* (Lum, 1986). According to Green, ethnic competency represents a provider's awareness of his or her limitations, being open to cultural differences, adopting a client-centered approach, and utilizing cultural resources. Lum (1999) introduced the term *culturally competent practice* to social work and provided a foundation for social workers to understand and evaluate multicultural counseling competencies with people of color.

Social worker Terry Cross and colleagues (1989) provided pioneering work in the field of cultural competency by expanding the discussion to include an institutional framework for assessing effective services for minority populations. Cross et al. argued that the same skills needed on an individual and clinical level were necessary on a macro level

which included the evaluation of an agency's policies, procedures, and practices to assess their cultural compatibility with the populations they serve (Fong & Furuto, 2001).

Inclusion of Sexual Orientation in Culturally Competent Care

It is important to note that the vast majority of cultural competency literature across the health and mental health fields focuses primarily on race or ethnicity. The Civil Rights Act of 1964 (Title VI) provided protection against discrimination based on race, color, national origin, sex, age, or disability and is often cited as a means to enforce state and local policies related to cultural competency. This statute, however, does not include sexual orientation or gender identity and currently there are no federal laws that protect gay, lesbian, bisexual, or transgender persons from discrimination (Harcourt, 2006).

Lesbian, gay, bisexual, or transgender persons (LGBT) have only recently been defined as a cultural group and seen as a population that experiences health disparities (Turner, Wilson, & Shirah, 2006). One major challenge in defining health disparities within the LGBT population involves the diversity of racial/ethnic and socioeconomic groups represented within that population. Despite this, a growing body of literature documents unique challenges faced by LGBT populations across a range of health issues (Harcourt, 2006).

In 1999, the Gay, Lesbian, Bisexual, and Transgender Health Access Project created the first community standards of practice and care related to LGBT clients in an effort to improve access to care for LGBT people and to assist health care providers and institutions to create more welcoming environments (GLBT Health Access Project, 1999). *Healthy People 2010* (US DHHS, 2000), the national health agenda, includes sexual orientation in 29 of the 467 health objectives. In 2001, HRSA contracted with the Gay and Lesbian Medical

Association to develop a companion document on LGBT health issues and disparities to supplement the *Healthy People 2010* agenda with specific goals related to lesbian, gay, and bisexual health. While this was a historic moment in terms of federal recognition of health issues for non-heterosexual persons, data related to these goals and objectives are not currently tracked and these objectives fail to include transgender populations (Harcourt, 2006).

Cultural Competency and Health Disparities

In its seminal report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine (2003) examined over 175 studies to assess the extent of racial and ethnic health care disparities and make recommendations for future interventions. Among its conclusions, the report found that disparities in health care occur in the context of "broader historic and contemporary social and economic inequality" (p. 6) and that "bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities" (p. 9). This understanding is in accordance with research that has documented poor communication between client and provider (Collins et al., 2002) and discrimination on the part of health care providers (Geiger, 2001; Schulman et al., 1999; van Ryan & Burke, 2000) as some of the causal factors related to racial/ethnic health inequalities. The Institute of Medicine report cited cultural competency training with health professionals as a specific avenue for improving quality of care for diverse populations and eliminating health disparities.

Federal Guidelines on Cultural Competency

Cultural competency is now regarded as a national standard of care. In 2000, the federal Office of Minority Health (OMH) created the National Standards on Culturally and

Linguistically Appropriate Services (CLAS Standards) to address health care inequalities. The CLAS standards provide 14 criteria to ensure clinical health care practices are culturally and linguistically accessible (see Appendix A). The rationale behind the creation of the CLAS Standards was to unify disparate efforts in conceptualizing and implementing cultural competency (OMH, 2002a). The standards are organized in three themes: culturally competent care, language access services, and organizational supports for cultural competency. *Culturally competent care* refers to the client-provider relationship and primarily focuses on providers' knowledge, awareness, and skills in working with minority populations (see Table 2). Standards under this theme are addressed through the development of cultural competency frameworks, curricula, and provider training.

Table 2
CLAS Standards for Culturally Competent Care

CLAS THEME: Culturally Competent Care
1. Health care organizations should ensure that clients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Note. From "National Standards on Cultural and Linguistically Appropriate Services (CLAS) in Health Care," Office on Minority Health, *Federal Register, 65,* p. 247.

Professional Mandates

Numerous accreditation bodies in medicine, public health, nursing education, and social work consider cultural competency a standard of care within their educational objectives (Accreditation Council on Graduate Medical Education, 1999; American Public Health Association, 1998; OMH, 2002a). In 1992, the Council on Social Work Education

(CSWE) added a mandate for cultural diversity to be included in core course content. The National Association of Social Workers' (NASW) *Code of Ethics* (2000) includes a standard for *Cultural Competence and Social Diversity* which states that social workers should "understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability" (NASW, 2000). In 2001, NASW established standards for culturally competent social work practice to provide specific guidelines for practitioners when working with diverse populations (NASW, 2001).

Health Disparities, HIV, and the Role of Health Care Providers

Prevalence and incidence rates of HIV among Black MSM in the United States mirror those of developing countries (CDC, 2004; Millett & Peterson, 2007; Valleroy et al., 2000), and Black MSM account for the majority of new and existing HIV cases in the U.S. (Kaiser, 2006). Though the literature offers a multitude of explanations for disparities in HIV rates related to individual behavior (Mays et al., 2004), little research exists that explores the sociocultural predictors of HIV risk (Malebranche, 2003; Millett, Peterson, Wolitski, & Stall, 2006; Ford, Whetten, Hall, Kaufman, & Thrasher, 2007) such as socioeconomic status, and cultural and social forces such as racism and homophobia (Vinh-Thomas, Bunch, & Card, 2003).

Few HIV interventions targeting MSM are inclusive and address men of color as part of the intended audience (Card, Benner, Feinstein, & Shields, 2001; Johnson et al., 2002). Many Black MSM experience discrimination and threats of violence related to their identity as Black within the White gay community and as MSM within the Black community (Stokes & Peterson, 1998), leading some Black MSM to compartmentalize their sexual and racial

identities to avoid compounding stigmas (Mays et al., 2004; Millet & Peterson, 2007; Stokes & Peterson, 1998).

Accounting for the interplay of race, sexuality, class and other cultural factors is crucial to new intervention approaches (Kennamer, 2000; Stokes & Peterson, 1998). This should not only translate into innovative and inclusive individual-level interventions with clients, but also into macro-level interventions that assess the role of structural discrimination and stigma on individual health outcomes. For example, evidence suggests that negative attitudes of health care providers may inhibit Black MSM from seeking health care (Malebranche et al., 2004). Health care providers play a pivotal role in connecting individuals to treatment and prevention resources (Wheeler, 2005). Strengthening the quality of relationship between provider and client is imperative to the work of cultural competency. In 2006, the National Alliance of State and Territorial AIDS Directors (NASTAD) developed a set of recommendations for supporting Black MSM populations. The monograph calls for the delivery of cultural competency training with health department staff and health care service providers as one specific step in improving support and care for Black MSM (NASTAD, 2006).

CHAPTER III

CONCEPTUAL FRAMEWORKS FOR CULTURAL COMPETENCY

An overview of cultural competency, as reflected in the history section of this paper, reveals a concept originating out of practice rather than theory. The literature offers models and frameworks for cultural competency instead of a theory, per se. Although there is no consensus on a specific framework for cultural competency, many of the existing conceptual models related to cultural competency depict the concept as an ongoing process of learning that includes knowledge acquisition, personal awareness, and skill development (Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1997; Cross et al., 1989; Tervalon & Murray-Garcia, 1998). Most models describe cultural competency in levels or stages that build consecutively upon each other.

In order to identify conceptual frameworks and models related to cultural competency, a computerized literature search was conducted using the following databases: PubMed, PsychInfo, Social Work Abstracts, Social Services Abstracts and Sociological Abstracts. The following terms were initially included and combined as search terms: *cultural humility, cultural competency, LGBT, gay and lesbian, health care provider, cultural awareness, cultural sensitivity, multicultural, multiculturalism, diversity, theory, frameworks, models, training,* and *conceptual model*. To narrow the concept analysis, the key phrase *cultural competency* combined with the search terms *model, framework* or *theory* was used. This search yielded over 850 references through PubMed and almost 400 references through

PsychINFO. To classify every conceptual model for cultural competency is beyond the scope of this dissertation, so to develop a more refined understanding of seminal models in specific disciplines, literature searches were separated by field.

Searches of the social work, psychology, nursing, public health and medical literature were performed with the search term *cultural competency* and focused on the authors and/or frameworks that were most often cited in those fields. This section focuses on five specific cultural competency frameworks selected based on their common reference in the literature, their ability to represent conceptual approaches in differing disciplines (e.g., social work, public health, or medicine), and their ability to be measured and replicated. See Table 3 for a summary of these models.

Campinha-Bacote Model

The *Process of Cultural Competence in the Delivery of Health Care Services Model* was developed in 1998 by Josepha Campinha-Bacote. The model, commonly referred to as the Campinha-Bacote model, originated in the field of nursing and is now used widely in the health care field (Xu, Shelton, Polifroni, & Anderson, 2006). A key characteristic of the Campinha-Bacote model involves viewing cultural competency as a process or continuum and not an endpoint. Most importantly, the model acknowledges that just as many variations exist within a cultural group as among cultural groups (Campinha-Bacote, 1995, 1999, 2002, 2003). The model includes five interdependent constructs that comprise cultural competency (Campinha-Bacote, 2002, pp. 182-183):

1. **Cultural awareness** is defined as the deliberate, cognitive process in which health care providers become appreciative of and sensitive to the values, beliefs, lifeways, practices, and problem-solving strategies of clients' cultures. In

Table 3. *Summary of Major Cultural Competency Frameworks and Models*

Author	Stages/Constructs	Key Features	Field
Campinha-Bacote, 1999, 2002	Presents five interdependent constructs of cultural competency: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters	Individuals (and organizations) must show intrinsic desire to engage in the process Acknowledges plurality of culture Cultural competency is a process, not a destination; dynamic, not static All encounters are cultural encounters Emphasis on *becoming* not *being* culturally competent	Nursing, Health Care
Cross et al. 1989	Individual and institutional developmental continuum ranging from: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competency, cultural competency, to cultural proficiency	Culture as integrated pattern of human behavior includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group Competency manifested at every level of an organization including policy making, administrative, and practice	Social Work, Mental Health, Health Care
Culhane-Pera 1997	Five levels ranging from No insight to Integration of attention to culture in all areas of professional life. Targets provider knowledge, attitudes, and skills	Targets individual Used primarily in medicine Adapted from Bennett model (1993)	Medicine
Purnell & Paulanka, 2003	Model presents four constructs that make up stages of cultural competency: unconscious incompetency, conscious incompetency, conscious competency and unconscious competency	Acknowledges cultural variation Acknowledges provider's own cultural background Culture competency is a process, not an endpoint Provides constructs and concepts to guide culturally specific interview process with clients	Medicine, Nursing, Health Care
Sue et al. 1982, 1998, 2001	Stresses awareness of assumptions, values bias, understanding of worldview of client, communication skills, and culturally appropriate intervention strategies	Primarily individual-level indicators Model focuses on race Focuses on multicultural counseling skills Revised model includes organizational level change (2001)	Psychology, Mental Health

addition, providers must be willing to explore their own cultural identities and values, assumptions, and prejudices.

2. **Cultural knowledge** is defined as the process of seeking and obtaining a sound educational framework concerning various cultural groups and includes an understanding of social, economic, and political factors that shape individual experiences and opportunities.
3. **Cultural skill** is defined as the ability to collect relevant cultural data regarding clients' health histories and presenting problems in partnership with clients.
4. **Cultural encounters** occur when health care providers engage directly in cross-cultural interactions with clients from culturally diverse backgrounds.
5. **Cultural desire** includes motivation on the part of health care providers (and organizations) to engage in the process of cultural competency.

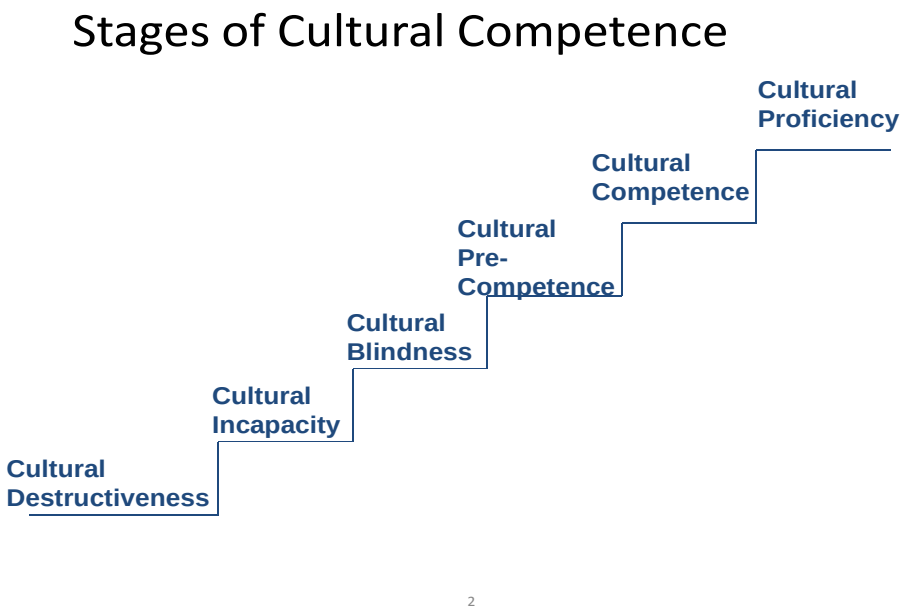
For Campinha-Bacote (2003), the most important component of cultural competency is cultural desire. In order to demonstrate cultural competency, individuals, agencies, and systems must show an intrinsic motivation that is cultural desire to engage in the process (1999, 2002).

Cross and Bazron Model

The *Cross and Bazron model of cultural competency* (Cross et al., 1989) was originally created by two social workers to guide mental health providers in offering culturally competent care for children of color. The authors offered one of the first definitions in the literature of cultural competency and provided a widely cited framework that includes agency and organizational accountability. The model offers an individual and institutional developmental continuum ranging from cultural destructiveness, cultural

incapacity, cultural blindness, cultural pre-competency, cultural competency, and finally, to cultural proficiency. Each stage of the model is depicted below in Figure 1 (Cross et al., 1989, p. 3).

Figure 1.Cross and Bazron Model of Cultural Competency



Note. From "Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed (p. 3), by T. L. Cross, B. J. Bazron, M. R. Isaacs and K. W. Dennis, 1989, Washington, DC: Georgetown University Center for Child Health and Mental Health Policy, CASSP Technical Assistance Center.

While the Cross and Bazron model has not been empirically tested, it is one of the most widely cited models for purposes of defining the concept of cultural competency (HRSA, n.d.; Fong & Furuto, 2001; NCCC, n.d.; Xu et al., 2006). This model is utilized by multiple professions including social work, nursing, public health, and medicine in health and mental health settings (NCCC, n.d.; Xu et al., 2006).

Culhane-Pera Model

The *Culhane-Pera model* (Culhane-Pera et al., 1997) was created specifically for medical education and was adapted from Bennett, who described cultural sensitivity in stages ranging from ethnocentrism to ethno-relativism (Bennett, 1993). The model focuses on individual-level changes and includes the following stages, described in Table 4:

Table 4
Culhane-Pera Model of Cultural Competency

Level One	No insight about the influence of culture on medical care
Level Two	Minimal emphasis on culture in medical setting
Level Three	Acceptance of the roles of cultural beliefs, values, and behaviors on health, disease, and treatment
Level Four	Incorporation of cultural awareness into daily medical practice
Level Five	Integration of attention to culture in all areas of professional life

Note. From "A Curriculum for Multicultural Education in Family Medicine" by K.A. Culhane-Pera et al., 1997, *Family Medicine, 29*, pp. 719-723.

Although the model is limited in depth, it has been utilized and measured in a number of medical education studies (Blue, Thiedke, Chessman, Kern, & Keller, 2005; Crandall et al., 2003) and emphasizes the application of skills and awareness across the continuum of medical education.

Purnell Model

The *Purnell model* developed by Purnell and Paulanka (2003) conceptualizes cultural competency along an upward continuum of learning and practice and was developed as a multi-disciplinary tool for health care providers. Like Campinha-Bacote, Purnell articulates cultural competency as a process. Other assumptions of the Purnell model (2005) include: (a) prejudices and biases can be minimized with cultural understanding; (b) core similarities are shared by all cultures; and (c) differences exist within, between, and among cultures.

The provider-centered model moves through the following stages: *unconscious incompetency*, *conscious incompetency*, *conscious competency*, and *unconscious competency* (Purnell, 2005, p. 11). While these stages are not clearly delineated, Purnell does offer an elaborate "metaparadigm" of culture describing 12 domains common to all cultures. Domains include: overview and heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, health care practices, and health care practitioners. Purnell further asserts that culture is composed of primary and secondary characteristics. Primary characteristics consist of nationality, race, color, gender, age, and religious affiliation; they are, Purnell asserts, largely unchangeable and shape one's cultural understandings from an early age. Secondary characteristics as defined by Purnell relate to "life's circumstances and experiences" (p. 14) as one grows and include socioeconomic status, education, occupation, military status, occupation, military status, political belief, urban vs. rural residence, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration. This model, which is used primarily within a framework for nursing, provides an explanatory model for health and illness across cultures, though it has been criticized for its complex graphic presentation (Xu et al., 2006).

Sue Framework

Although Sue and colleagues are cited frequently in the mental health and social work literature, their work is not often noted in the medical field. Despite this, Sue's work provides an important conceptualization of cultural competency at the individual provider level and has been widely tested (LaFromboise, Coleman, & Hernandez, 1991; Sodowsky, et al., 1994). This framework stresses awareness of assumptions and biases, an understanding of the

worldview of the client, and culturally appropriate intervention strategies (Sue et al.,1992). Sue et al. use the terms *cultural competency* and *multicultural counseling skills* interchangeably (Ridley, Baker, & Hill, 2001) and focus primarily on communication skills in a clinical encounter (Eunyong, 2004), although Sue expanded his framework to include recommendations and implications for organizational level cultural competency efforts in 2001.

Unlike other frameworks that tend to define culture broadly, Sue's work focuses specifically on race (Sue, 2001). Sue argued that focusing on group identities such as "ethnicity, social class, gender, and sexual orientation" serves to "dilute the importance of race" (p. 792). As such he explicitly focuses on five broad racial/ethnic categories: African American, Asian American, Latino American, Native American, and European American (p. 792). This perspective has been challenged as many people do not "always fit into one of the five race-based groups in Sue's model" (Ridley et al., 2001, p. 829) and is thus rendered useless for those who are biracial, multiracial, or for whom other identities are salient.

Critiques of Cultural Competency Frameworks and Models

There is a growing body of literature critiquing existing cultural competency frameworks and assumptions (Abrums & Leppa, 2001; Betancourt, 2004; Dean, 2001; Duffy, 2001; Dunn; 2002; Gregg, 2006; Kleinman, 2006; Tervalon & Murray-Garcia, 1998; Wear, 2003). This section explores some of the major criticisms of cultural competency frameworks including: (a) the focus on self-awareness (or lack thereof); (b) prioritizing racial/ethnic group identity above other "cultural" identities; and (c) attempting to "know" and become "competent" in understanding another culture.

Focus on Self-Awareness

While many of the models presented here focus on some level of self-awareness (Campinha-Bacote, 1999; Culhane-Pera et al., 1997; Sue et al., 1992), the breadth of this analysis tends to focus on being "open" and "comfortable" (Purnell, 2005) with others as opposed to being aware of power differentials (e.g., between health care provider and client). Many cultural competency frameworks fail to encourage self-awareness that examines or challenges the inherent power imbalance between provider and client (Tervalon & Murray-Garcia, 1998). For providers who are part of dominant mainstream culture (e.g., White, male, middle class), cultural competency must include recognition that among dominant culture's "deeply ingrained values are those that perpetuate separation and discrimination" (Dunn, 2002, p. 107). Sue et al. (1992) provide the only model that discusses the role ethnocentrism plays in provider care.

Aspects of cultural competency models may appear intuitive. For example, Campinha-Bacote's (2003) stage of *cultural desire* states that providers must *want* to understand differences. In reality, constructs such as cultural desire are complex and must include an analysis of why providers (particularly those who represent dominant culture) may not feel inclined to understand differences. Dunn (2002) argues that providers must acknowledge that social/cultural values that privilege certain groups (i.e., White people) may translate into personal values and behavior that are discriminatory and unconsciously exclusionary. Many models fail to account for the complex history and reality of present social inequalities.

Prioritizing Racial/Ethnic Group Identity

Some models appear to place higher value on racial or ethnic identities to the exclusion of other identities, particularly sexual orientation and gender. For example, the Purnell model (2005) labels sexual orientation and "gender issues" as "secondary" cultural characteristics attributed to "life's circumstances" (p. 14) as opposed to immutable primary characteristics. The separation of identities into individual and distinct categories with different "values" is problematic. Similarly, Sue's model (2001) asserts that racial identity has primacy over other socio-demographic characteristics due to providers' "greater discomfort" (p. 792) with race. These assertions do not allow an individual to define his or her own salient identities or account for intersections of identities such as race, gender, gender identity, and sexual orientation. In addition, this framework treats culture as a static construct and assumes that culture does not shift over time (Ridley et al., 2001).

Defining and Knowing "Other"

A major critique of cultural competency frameworks involves the goal of competence itself (Dean, 2001). Competence suggests that knowing broad descriptions of various group identities can translate into knowing the life experiences of an individual client. This "other" focus also assumes that the "locus of normalcy" is White, Western culture while the "other" is defined as "nonwhite, non-Western, non-heterosexual, non-English-speaking, and non-Christian" (Wear, 2003, p. 550). In this framework, the only barriers between provider and client are "understanding" and "awareness," not systemic inequalities (Duffy, 2001). Dominant groups "learn" about non-dominant groups to characterize behavior in the name of "understanding." The danger of this strategy is that it supposes "culture" is monolithic and knowable and may create stereotypical composites of various group identities (Betancourt,

2003, 2004; Dunn, 2002). The Campinha-Bacote model accounts for this possibility and cautions against stereotyping any individual or group, arguing that "clients, not a book, workshop, seminar nor website, are the true experts of their unique cultural values and practices" (2001, p. 49). At its worst, cultural competency may inadvertently define another "culture" using stereotypes (Purnell, 2002), conflate race with culture (Kleinman, 2006), and fail to identify the structural forces such as poverty and racism that underlie health disparities (Betancourt, Green, & Carrillo, 2002; Jacobs, Kohrman, Lemon, & Vickers, 2003).

Cultural Humility

Tervalon and Murray-Garcia (1998) offer an alternative lens to cultural competency. The authors suggest that a framework of *cultural humility* may be a more suitable framework as it takes into account the fluidity and subjectivity of culture. Tervalon and Murray-Garcia define cultural humility as a process of "commitment to an ongoing relationship with patients, communities, and colleagues" that requires "humility as individuals continually engage in self-reflection and self-critique" (1998, p. 118). As such, cultural humility is not defined by a discrete endpoint but as a commitment to active engagement in a lifelong process that individuals enter into with clients and with themselves (1998).

The cultural humility model addresses many of the critiques leveled against cultural competency models. For example, the cultural humility model explicitly acknowledges power differentials between provider and client and asserts that problems do not often arise "from a lack of knowledge but rather the need for a change in practitioners' self-awareness and attitudes toward diverse clients" (Tervalon & Murray-Garcia, 1998, p. 118). Instead of engaging providers in a descriptive process of "the other," this model advocates for self-reflection on "unintentional" patterns of "racism, classism, and homophobia" (p. 119).

Cultural humility stresses a client-centered approach that is ongoing. The authors argue that equating competency with completion of "a series of training sessions" is "inadequate and potentially harmful" (Tervalon & Murray-Garcia, 1998, p. 119). Instead, an ongoing effort to be in relationship with the client (coupled with self-awareness) is stressed. The major contribution of cultural humility to the conversation on cultural competency is its recognition of power relationships and the role of provider awareness as well as its emphasis on understanding and knowing each individual client on his or her own terms. There are limitations to the cultural humility model, however. Although the model has been in existence since 1998, it is not well developed. In addition, cultural humility as a construct is somewhat vague and difficult to operationalize.

Promising Frameworks

In spite of its current limitations, the cultural humility framework provides a deeper foundation to begin the work of eliminating health care disparities than do other cultural competency models. The cultural humility model seeks to cultivate self-awareness on the part of providers and acknowledges the ways in which cultural values and structural forces shape client experiences and opportunities. As such, the model offers a theoretical base that accounts for structural inequalities and the complexities of culture that is absent from most of the existing cultural competency models.

While cultural humility provides a theoretical re-visioning of traditional cultural education efforts, it is less developed than current models for educational interventions. For example, the literature contains only one published evaluation of an educational curriculum based on this model (Juarez et al., 2006). With this in mind, it may be useful to integrate existing cultural competency models with the cultural humility paradigm. Some of the

concepts behind cultural humility are present in existing cultural competency models. Most notably, the Campinha-Bacote model (2002) stresses *becoming* vs. *being* culturally competent. The strength of this existing framework might be useful to integrate into the cultural humility paradigm as the Campinha-Bacote model has been tested with validated measures (Brathwaite & Majumdar, 2006). Re-visioning in this fashion would include an awareness of cultural competency as a process of learning about others as well as the inclusion of provider self-reflection and focus on social discrimination, a major strength of the cultural humility model. Application of the Campinha-Bacote model to this dissertation study is discussed in greater detail in Chapter 5.

CHAPTER IV

EVALUATING CURRENT CULTURAL COMPETENCY EDUCATION INTERVENTIONS

Interest in cultural competency in health and mental health care settings has led to active evaluations of educational interventions focusing primarily on providers' cultural competency. Cultural competency training and education includes a variety of activities aimed to increase the capacity of individuals and agencies to meet the needs of a diverse population (OMH, 2001b). To date, the vast majority of the literature on cultural competency training is descriptive in nature (OMH, 2002b). Outside the body of descriptive research, much of the cultural competency literature centers on evaluating provider outcomes from cultural competency training, with a focus on knowledge, awareness, and skill acquisition. Few studies have moved from analyzing training effects on providers to evaluating how changes in provider attitudes and behavior affect clients.

In order to evaluate cultural competency training interventions, a systematic literature review by Price and colleagues (Price, Beach, Gary, Robinson, Gozu, Palacio, et al., 2005) was reviewed which analyzed cultural competency trainings for health care providers from 1980 to 2003. Reviewed also were promising research studies focusing on cultural competency trainings described by a DHHS review on cultural competency research (US DHHS, 2004). Finally, this information was supplemented with a computerized literature review utilizing the search terms previously described in this paper (e.g., *cultural competency, cultural humility, diversity training,* etc.).

This chapter will first examine the overall findings of Price et al. related to cultural competency provider training. Next it will review six cultural competency training interventions related to provider/client interactions. Interventions were selected based on their ability to meet one of the five domains of study quality identified by Price et al. These domains include: (a) representativeness of targeted providers (i.e., the study's setting and sample are described in enough detail to allow such a determination to be made); (b) inclusion of a complete description of the intervention; (c) use of comparison groups; (d) objective evaluation strategies (e.g., direct observation, validated scales); and (e) reporting of analytic approach. In addition to the five studies that meet one or more of these criteria for study quality, an additional intervention focusing specifically on sexual orientation (Scout, Bradford, & Fields, 2001) is included. This discussion excludes programs that have not been empirically tested. See Appendix B for a summary of the interventions discussed.

Review of Cultural Competency Educational Interventions

Beach and colleagues (Beach, Price, Gary, Robinson, Gozu, Palacio, et al., 2005) conducted a systematic review of the literature related to cultural competency training as a tool for improving health among racial and ethnic minority clients. In their examination of 34 training-related studies, the authors identified 19 studies that evaluated effects on provider knowledge. Of the 19, 17 of the studies demonstrated significant improvement in provider knowledge of diverse populations. The authors also identified 25 studies that evaluated provider attitudes and skills. Of the 25, 21 showed an improvement in provider interactions with racial and ethnic minorities (Beach et al., 2005). In terms of knowledge acquisition, the authors noted no "obvious pattern" related to the type of knowledge that was most impacted by training (p. 366). The most common measure utilized to assess providers' attitudes was

the Cultural Self-efficacy Scale (Bernal & Froman, 1987), though 75% of the studies cited failed to augment this self-assessment with objective assessments of changes in learner attitudes such as an external observer (Beach et al., 2005). In studies that evaluated changes in providers' skills, there was an observed increase in providers' ability to conduct behavioral analyses and a reported increase in social interactions with peers from different racial backgrounds. Similar to findings related to attitudinal shifts, the literature related to culturally competent skill acquisition is largely based on self report (Beach et al., 2005).

Quality Domain One: Representativeness of Targeted Providers

Crandall, George, Marion, and Davis (2003) evaluated a one-year cultural competency training for second-year medical students at Wake Forest University School of Medicine to explore the theoretical frameworks available for cultural competency training. The authors administered a pretest and posttest to study participants (n = 12) which included the Multicultural Assessment Questionnaire (Culhane-Pera et al, 1997). Two communication theories informed the design and implementation of the curricula. These theories were Howell's levels of "communication competency" (Howell, 1982) and Bennett's model of "intercultural sensitivity" (Bennett, 1993), which describes six stages of development related to cultural awareness. Results from the study indicated the course was successful in improving students' knowledge, attitudes, and skills related to cultural competency ($p < .003$). Although a principal limitation of this study is the small sample size, it adequately describes the setting and population from which providers were drawn and targets health care providers. In addition, the study is based on an existing cultural competency framework. In much of the published literature, evaluation of cultural competency training fails to include established theoretical models (Beach et al., 2005; Koehn & Swick, 2006).

Quality Domain Two: Description of Intervention

Few studies adequately describe interventions in sufficient detail to allow for replication (Price et al., 2005). Williams (2005) completed a social work-specific study that offers a thorough description of a cultural competency training intervention as well as an evaluation of intervention outcomes. This is particularly important as the majority of the social work literature on diversity and cultural competency is almost exclusively conceptual in nature (Gelman, 2004). Williams's study evaluated a series of cultural competency workshops for social workers practicing in a mental health care setting (n = 46) and utilized a pretest-posttest design with a nonequivalent comparison group. Williams provided an in-depth description of the curriculum including an outline of learning objectives and activities for each of the training modules. The training focused on developing skills related to assessment and intervention planning with racial and/or ethnic minorities. A needs assessment was utilized to inform the curriculum development. In addition, adult education principles and evidence-based clinical training practices were used. The intervention group received four 3-hour training sessions, while the comparison group received information about print resources and community meetings related to diversity. The Multicultural Counseling Inventory (Sodowsky et al., 1994) was used to measure awareness, knowledge, skills, and relationships. The author conducted a pilot of the study instrument with four social work faculty members.

Study results indicated no difference between the intervention and comparison groups, though it found significant difference within the group that received the intervention. Differences related to the awareness subscale within the intervention group were observed with participants who were racial minorities and with participants who had attained a

master's or higher level degree (e.g., an MSW). Limitations included a small sample size which meant the study lacked adequate power to detect differences between groups. Despite this limitation, the description of the training intervention was detailed and comprehensive and fills a gap in existing cultural competency literature.

Quality Domain Three: Use of Comparison Groups

Few studies on cultural competency training utilize a comparison group (Price et al., 2005). Thom, Tirado, Woon, and McBride (2006) provide an example of a randomized control trial with primary care physicians (n = 53) conducted at four medical practice sites. Patients of the participating physicians were also recruited. These patients (n = 429), all of whom were receiving treatment for diabetes or hypertension, were asked to rate their physicians using the Physician Cultural Competency Scale (PRPCC). Ratings were made at baseline and at 3 months and 6 months following the intervention. At two of the practice sites, physicians received 4.5 hours of cultural competency training in three sessions as well as written feedback on the interpretation of their aggregate PRPCC scores from their clients. Physicians at the two remaining sites received written feedback only and were considered the comparison group.

The primary outcome measured was change in patients' PRPCC scores 6 months following the training which assessed physician behaviors identified as critical for cultural competency. Results indicated no measurable impact of the training on client outcomes at three or six months following the intervention as evidenced by the PRPCC survey as well as secondary outcome measurements which included changes in patients' weight, systolic blood pressure, and hemoglobin. The findings of this study are unique as it measures client outcomes over of period of six months. Authors cite the brevity of the training as a possible

study limitation (Thom et al., 2006, p. 7) and rationale for lack of change in patient reporting. There is a dearth of studies that demonstrate rigor in outcome assessment strategies (Price et al., 2005).

Quality Domain Four: Outcome Assessment

Studies that assess cultural competency interventions through the use of objective evaluation strategies (e.g., validated survey measures) are rare (Price et al., 2005). Braithwaite and Majumdar (2006) conducted a mixed methods, one-group repeated measures study of public health nurses (n = 76) using their Cultural Knowledge Scale, a valid and reliable 25-item Likert-type scale test. The study involved a five-week cultural competency training (2-hour sessions) and a booster session one month after the intervention. Data were collected at four time points: at baseline, 2 months later (immediately before intervention) and at 1 week and 3 months post-intervention. Findings from the study indicated an increase in cultural knowledge ($p < .01$), and qualitative measures supported these results. While the one-group design is a limitation, the use of the double pretest design minimized testing effects by repeating the same measure and provided the opportunity for outcome observation over time.

Quality Domain Five: Reporting Analytic Approach

Few studies adequately report their analytic strategy and outcomes; reporting of missing data and reasons for non-inclusion of participants is rarely included (Price et al., 2005). Majumdar, Browne, Roberts, and Carpio (2004) provided the first randomized control trial of the effectiveness of cultural competency training on health care providers (nurses and home health care workers). The authors studied 114 health care providers and 133 clients to determine the effectiveness of 36 hours of cultural sensitivity training on the attitudes and

knowledge of health care providers and to determine health outcomes for clients over 18 months (p. 161). Only patients receiving care from health care providers in both sections of the trial were included. In addition, patients with a documented history of cognitive impairments were excluded (p. 162).

Providers completed the Cultural Awareness Questionnaire (Majumdar, Brown, Roberts, 1992) and six additional instruments which were combined to assess cultural competency and administered at baseline, at 3 months, and at 6 months. The experimental group (n = 54) received 36 hours of cultural sensitivity training three months after the initial data collection phase. Twelve months into the intervention, the control group received the training program (n = 54). Patient surveys were completed at baseline and at 3 months, 6 months, and 12 months. Patient measures included the Multidimensional Measure of Functional Capacity, the Client Satisfaction Questionnaire, the Physical and Mental Health Assessment Questionnaire, and the Health and Social Service Utilization Questionnaire (Majumdar et al., 2004). The study found that at 6 and 12 months post-training, there was a significant increase in the open-mindedness, communication skills and cultural awareness of health care providers in the experimental group. While changes in providers were self-reported, client's ratings of providers in the control and experimental groups were not significantly different. Authors attribute this to the primarily European and British origins of clients in the study which matched the racial/ethnic identities of providers. Limitations of this study include client attrition during the course of the study due to illness and death, a client population within the study that was not racially or ethnically diverse, and a patient reporting measure that focused on client satisfaction and not providers' cultural competence.

Cultural Competency Training on Sexual Orientation

There is a paucity of studies that offer outcome measures related to LGBT-specific cultural competency education and training. As discussed previously, this may be due to a lack of understanding or belief that sexual minorities comprise a "cultural group." While a number of cultural competency definitions include sexual orientation, the majority of intervention studies reported in the literature focus exclusively on race and/or ethnicity. One exception within the public health literature is the work of Scout, Bradford, and Fields (2001), who measured provider attitudes and behaviors focusing specifically on cultural competency as it relates to awareness of homophobia and heterosexism in improving provider care to lesbians and women who partner with women in the United States. Scout et al. created and implemented a half-day training for health care providers around the United States. The training included participant learning aids and modules on culturally competent care, common language, lesbian health issues, and contracts for change. This training focused specifically on providing care to lesbian and bisexual women and did not include issues for gay and bisexual male clients. Participants (n = 278) completed a pretest, a posttest immediately following the training, and a final posttest 3 months after the training. The survey instrument was created by the authors and evaluated knowledge, attitudes, and behaviors at baseline, immediately following the training, and at the 3-month posttest ($p<.001$). The survey was not based on existing scales and did not integrate issues and barriers related to sexual minority clients who are also racial and ethnic minorities. The authors found that participants sustained change related to knowledge and comfort in working with lesbian and bisexual women and comfort in providing harm reduction counseling to non-heterosexual women. Knowledge related to community services and

resources specific to lesbian and bisexual women was not sustained at the 3-month follow-up. Though the study lacked a control group, the authors made some provision for this limitation by administering multiple posttests (immediately post-training and at 3 months). In addition, the study is worthwhile as it is one of the few cultural competency studies directly addressing heterosexism and homophobia among health care providers.

Evaluating Cultural Competency: Methodological Challenges

The following section addresses existing methodological challenges related to evaluating cultural competency. Specifically, challenges related to measuring cultural competency, the lack of validated and standardized cultural competency instruments, and problems with training design are discussed.

Measuring Cultural Competency

A majority of the critiques of cultural competency center on the broad challenges of measuring a complex, fluid, and often vague concept. As seen in the history section of this paper, definitions of and approaches to cultural competency vary by discipline. While many of the models theoretically view cultural competency as an ongoing process (Campinha-Bacote, 1999), the language of cultural competency and the upward trajectory of the conceptual models imply an endpoint and mastery. If there is no endpoint and culture is indeed multi-faceted and fluid (Duffy, 2001; Kleinman, 2006), it is challenging to ever truly evaluate and measure competency (Dean, 2001).

Assessment Tools

Assessment tools and instruments used to evaluate provider training interventions vary widely and often are not empirically validated (Beach et al., 2005; US DHHS, 2001; Price et al., 2005). In the early 1990s, researchers began to develop psychometric measures related to

cultural competency (Ponterotto, Sanchez, & Magrids, 1991) based on a self-reported knowledge-awareness-skills model identified by the American Psychological Association (APA, 1982). Typically these measures evaluate awareness of personal beliefs and assumptions related to other cultural groups (typically people of color), knowledge about a given cultural population (typically people of color), and skills in cross-cultural communication (Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005). While most instruments follow this trajectory, no agreed-upon measures exist for evaluating cultural competency (US DHHS, 2001), and tested and validated measures of cultural competency are limited (Boyle & Springer, 2001).

According to a recent systematic review of the last 20 years of literature related to quantitative measures of cultural competency, only 2 of the 54 identified psychometric measures addressed cultural variation beyond race or class (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Even in accounting for race and ethnicity, the majority of these measures treat racial and ethnicity identities as a proxy for culture, creating an oversimplification of the term and offering little critique of institutional structures that perpetuate discrimination and favor dominant or privileged groups (Kumas-Tan et al., 2007). Another instrumentation challenge involves the lack of patient/client input in the development of psychometric tools (Geron, 2002; Kumas-Tan et al., 2007; Stanhope et al., 2005), which are often tested on White, college-educated populations and assume the provider/training participant is culture-neutral (Kumas-Tan et al., 2007).

A paucity of studies measuring client outcomes is another major methodological challenge. In their systematic review of the literature from 1980 to 2003, Beach et al. (2005) found only three studies that evaluated client outcomes. One possible explanation for this gap

is that most interventions to date have targeted students and not health professionals (Price et al., 2005). Other possible explanations include the devaluation of cultural competency as a "soft science" within the medical field (Kripalani, Bussey-Jones, Katz, & Genao, 2006), and the limited resources of agencies conducting research (Beach et al., 2005).

Training Design

A review of the literature indicates that the methodology of provider education and training varies greatly. Many study designs demonstrate an overall lack of rigor (Beach et al., 2005). Most studies rely on providers' self-reporting of changes in knowledge, attitudes, and skills, which is highly subjective (Betancourt, 2003; Brach & Fraser, 2000; Kumas-Tan et al., 2007). Few studies measure changes in behavior based on external observation such as external observer audits, client reporting, or standardized measures (OMH, 2002b). While studies indicate that educational training has a positive effect on providers, it is difficult to determine which types of training interventions are most effective due to the range of training techniques and curricula utilized (Beach et al., 2005, p. 366; Stanhope et al., 2005). In addition to a lack of uniformity in the design of culture competency trainings, Gregg and Saha (2006) argue there is a general "mismatch between the motivation behind the *design* of cross-cultural education" and the "motivation behind their current *application*" (p. 542). For example, if the goal of cultural competency provider education in health care is to reduce health disparities, then understanding the source of disparities needs to be an integral component of provider training and reduction of disparities should ultimately be measured as an outcome of trainings designed to reduce them. This would entail a more nuanced approach to discussions of culture(s) and involve including specific content related to privilege, power, social stigma, and discrimination (Kumas-Tan et al., 2007).

In summary, a review of the literature reveals a broad-based effort to understand, evaluate, and critique current cultural competency training interventions. There are clear challenges including a lack of uniformity in the methods used to evaluate cultural competency in the training of health professionals. Despite this, the aforementioned studies and guidelines suggest a growing effort to create more rigorous and accurate evaluation strategies to assess cultural competence.

Research can benefit from increased patient input, an expansion of what is traditionally defined as cultural identity, and an inclusion of information and assessment of social conditions related to (among other things) race, sexuality, gender, and class. The pilot study in this dissertation attempts to address some of these gaps.

CHAPTER V

STUDY BACKGROUND AND CONCEPTUAL FRAMEWORK

Description of Intervention

This dissertation study employed a mixed-methodology approach (Trochim, 2001) to examine, describe, and test a cultural competency intervention for Disease Intervention Specialists (DIS) in North Carolina. The study had three successive aims or phases; results from each aim informed the design of the next phase. The first aim of the study entailed reviewing preliminary studies and analyzing primary qualitative data to characterize young Black MSM/GBT clients' needs and perceptions regarding HIV prevention and care. The preliminary studies associated with Aim I are detailed below along with a description of the study environment and population. Subsequent aims related to the pilot study are discussed in detail in the methods section of this dissertation.

Description of Study Environment

The intervention designed for this dissertation took place in North Carolina. Several factors made North Carolina an ideal setting to pilot this intervention: (a) the U.S. southeast region has the highest incidence of HIV infection and STIs among Black men; (b) this region is the only region of the country where HIV infection rates have not stabilized or declined (CDC, 2004); and (c) evidence has established an ongoing outbreak of HIV infection in North Carolina among young Black MSM. Tthe training intervention was initiated in response to demonstrated community need and at the request of the NC DHHS and HIV/STI

Prevention and Care Branch. Administrative staff from the HIV/STI Prevention and Care Branch had raised concerns about the inadequacy of contact with MSM-identified clients as well as ongoing observations of intolerance among their staff when working with LGBT-identified people.

Description of Study Population

Disease Intervention Specialists (DIS) in North Carolina are responsible for conducting field investigations of communicable diseases, primarily HIV and syphilis, by locating and counseling individuals who are exposed to or have a positive test for HIV. DIS are also responsible for connecting individuals to care by providing referrals to physicians, local health departments, and mental health services (NC DHHS HIV/STD Prevention and Care Branch, n.d.). There are seven regional offices for DIS who partner with local health departments to identify and prevent the spread of HIV. Issues related to DIS sample recruitment and retention are discussed in greater detail in the methods section of this paper.

Research Team

The pilot intervention was conducted under the auspices of Project STYLE (Strength Through Youth Living Empowered) with whom the author served as a research associate. Project STYLE is an HIV/AIDS prevention, outreach, and care program which serves young MSM of color in North Carolina. The project team is comprised of Drs. Lisa Hightow-Weidman and Peter Leone, co-principal investigators; Justin Smith, project coordinator; two research associates; two outreach coordinators; and a social work intern. In addition, an expert advisory group was established in January 2006 to inform effective approaches for training development and delivery related to serving the Black MSM population. The advisory group, Project STYLE staff, NC DHHS administrators, DIS, and local HIV

community-based agency representatives, provided ongoing consultation during the development process of the training. The advisory group reviewed the study methodology, identified process and outcome objectives, and informed the curriculum content and approaches that would be most effective in communicating the needs and issues of GBT individuals.

Preliminary Studies

Project STYLE has conducted an extensive series of investigations under the direction of Principal Investigators (PIs) Drs. Hightow-Weidman and Leone. In one study, these PIs documented the first recognized outbreak of HIV infection among college students in the southeastern U.S., the majority of whom were Black MSM (Hightow et al., 2003). As part of the investigation of this outbreak, Project STYLE has worked closely with Centers for Disease Control and Prevention (CDC) investigators and the NC DHHS to identify factors associated with HIV infection among Black MSM.

In addition, the team has conducted qualitative studies to collect data regarding Black MSM's ideas about HIV prevention strategies, experiences with health care providers, and sexuality. These studies include: (a) focus groups to inform the development of a social marketing campaign tailored to improve outreach, HIV prevention, and engagement in care for young Black MSM college students (Fisher-Borne, Zlotnik, Stapleton, Smith, & Hightow-Weidman, in press), and (b) a pilot Photovoice project with young Black men to identify their perceptions of the factors driving the HIV epidemic (Fisher-Borne, 2008). Findings are discussed below.

CDC Epidemiological Case Control Study

In collaboration with the CDC and the NC DHHS, Drs. Hightow-Weidman and Leone conducted a case-control study comparing HIV-infected Black MSM college students (cases) with HIV-negative Black MSM of the same age group (controls) to identify variables associated with HIV seroconversion. In-depth interviews were conducted with 53 Black MSM (18 cases and 35 controls). Controls were stratified into college and non-college students. Examination of HIV risk factors produced several findings that are relevant to the proposed intervention: (a) college students most frequently chose sex partners who were Black and 30 years old or younger; b) college student respondents were less likely to identify as gay (44% and 58%, respectively) compared to non-college controls (80%); (c) cases and college controls were less likely to be open about their sexual orientation (0% and 16%, respectively) compared to non-college controls (33%); and (d) all respondents communicated a history of depression, alienation, and violence (Hightow et al., 2003, 2004, 2005). The results of this study suggested that stigma and alienation related to sexual orientation may fuel the HIV outbreak among young Black MSM (Brown et al., 2002). The process of this study as well as the findings were instrumental in strengthening the relationship between the NC DHHS HIV/STD Prevention and Care Branch and the Project STYLE team and laid the groundwork for this dissertation study.

Focus Groups

An early goal of Project STYLE was to develop a social marketing campaign to increase HIV testing and linkages to care for Black MSM college students in North Carolina. This goal was accomplished in part by conducting focus groups with Black MSM students (N=16) attending college at three universities in the Raleigh-Durham area in fall 2005. The

researcher was responsible for conducting one focus group and participating in the data analysis and theme identification of subsequent focus group sessions. Most important among the themes that emerged were those regarding homophobia: (a) most participants perceived homophobia in the Black community as an explanatory reason for the high rates of HIV infection among Black men because (b) homophobia in the Black community encourages unprotected sex and high-risk sexual behavior and (c) feelings such as embarrassment, fear of judgment, and lack of self-worth created barriers to seeking HIV testing and related healthcare services (Fisher-Borne et al., in press).

Photovoice Pilot Study

To engage young Black men in self-inquiry of the issues and needs they had identified around HIV prevention, the researcher implemented a project using Photovoice, a qualitative community-based participatory research method (Wang & Burris, 1997). Photovoice is designed to reach, inform, and organize community members to enable them to prioritize their strengths and concerns and identify strategies for creating change by using photography. The objective of this pilot project was to generate constructs to inform the development of the proposed training curriculum. Four Black male students (ages 20 to 25 years) at UNC-Chapel Hill participated. Themes that emerged from this project included: (a) the difficulty of combating a social perception of Black men as predators, (b) daily challenges related to institutional racism, (c) experiences of homophobia in the Black community, and (d) the risks involved with "breaking free" from societal and cultural expectations.

Intervention Logic Model

The aforementioned studies demonstrate that the Project STYLE team possessed sufficient content, expertise, and capacity to provide a cultural competency training intervention with specific content related to young, Black MSM for DIS in North Carolina. Figure 2 depicts the logic model for the dissertation study, which is described in greater detail in Chapter 6. Factors that were examined as possible contributors to individual behavior change include a provider's race/ethnicity, age, educational status, and years of employment. Organizational-level moderators, such as organizational readiness and policies to support ongoing training efforts, may also support or inhibit the training design.

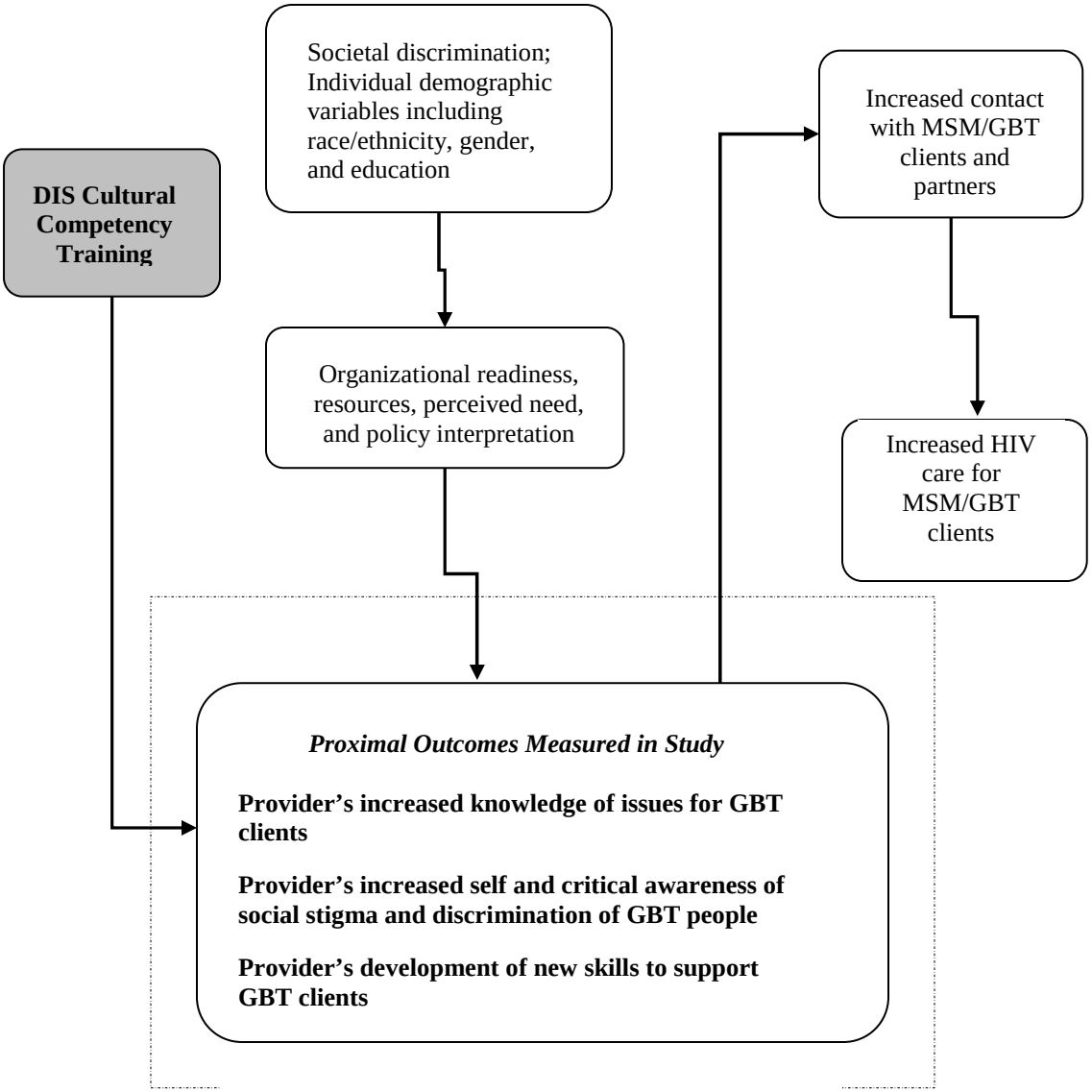
As indicated in the model, evaluating proximal outcomes is the primary concern of this study. Distal outcomes of the intervention (see Figure 2) include a demonstrated increase in contact with GBT clients as well as partners. According to the model, the training process would ultimately result in increased care for GBT clients, though this is not tested in the pilot intervention.

Study Conceptual Model and Theoretical Framework

This dissertation is primarily informed by two theoretical and conceptual frameworks. First, the training is informed by the theory of cultural humility (see Chapter 3), which stresses a client-centered approach and an ongoing commitment to self-reflection and self-critique (Tervalon & Murray-Garcia, 1998). Cultural humility adds a recognition of power imbalance and social discrimination which is missing in other models. As such, the training intervention and subsequent evaluation will include recognition of power dynamics and focus on social forces such as racism and homophobia.

While cultural humility as a theoretical framework has been in existence since 1998, there is not a well developed model for intervention design. Given this, the previously outlined *Process of Cultural Competence in the Delivery of Health Care Services Model* developed in 1998 by Josepha Campinha-Bacote is also utilized to inform this study. This model was selected to guide the intervention based on its frequent use across health and mental health disciplines and because of its conceptual clarity and perspective on culture.

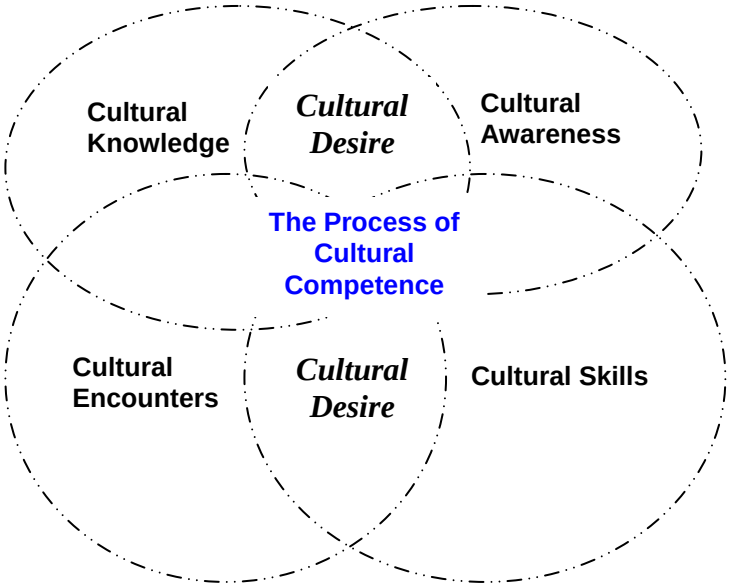
Figure 2. Intervention Model for DIS Cultural Competency Training



As described earlier, a key characteristic of the Campinha-Bacote model is that cultural competency is viewed as a process or continuum and not an endpoint. The Campinha-Bacote model acknowledges that just as many variations exist *within* a cultural group as *among* cultural groups (Campinha-Bacote, 1995, 1999, 2001, 2002, 2003), includes

elements of social critique, and is most in line with the cultural humility perspective. The model is depicted in Figure 3.

Figure 3. Campinha-Bacote Model, The Process of Cultural Competency in the Delivery of Healthcare Services



Note. From "A Model and Instrument for Addressing Cultural Competency in Health Care, by J. Campinha-Bacote, 1998, *Journal of Nursing Education, 38(5),* pp. 203-207.

As demonstrated in the conceptual model, the constructs of cultural knowledge, cultural awareness, cultural encounters, cultural skills, and cultural desire are inter-dependent and must be addressed collectively in order to fully engage in the process of cultural competency (Campinha-Bacote, 2002). This model also offers clear developmental levels to help structure an educational intervention (Brathwaite, 2003). In the present study, these developmental levels were used to both inform the training design and categorize the

various subscales within the intervention assessment, which are described more fully in the methods section of this paper. The conceptual model will also be utilized to interpret the results of the study and discuss its empirical utility.

CHAPTER VI

RESEARCH DESIGN AND METHODS

This chapter outlines the study methods for: (a) Aim I, a qualitative study exploring Black MSM/GBT clients' needs and perceptions regarding HIV prevention and care; (b), Aim II, the design and implementation of a cultural competency training for North Carolina DIS, and (c), Aim III, a one-group pretest-posttest-follow-up study to determine if there were changes in DIS knowledge, awareness, and skills in working with MSM/GBT populations.

AIM I: Characterize Young Black MSM/GBT Clients' Needs and Perceptions Regarding HIV Prevention and Care

To identify issues related to attitudes and normative beliefs of young Black MSM and these men's experiences related to HIV prevention and care, findings from the preliminary studies described in Chapter 5 were reviewed. To supplement these findings and address issues specific to DIS, a protocol for qualitative focus group sessions with young Black MSM was developed. Working in collaboration with the advisory board and Project STYLE staff, the author designed a focus group guide to foster a structured, focused discussion that included specific questions related to interacting with DIS. (See Appendix C.) In spring 2007, three focus groups were conducted in the Raleigh-Durham area with Black MSM young adults (ages 18 to 25 years). The University of North Carolina Medical Institutional Review Board (IRB) approved the study.

Sample

Recruitment efforts were initiated to obtain 6 to 10 young BMSM adult participants for each of three focus groups (N=18 to 30) held in the Triangle area in March 2007. Recruitment efforts included outreach to individuals through local GBT bars and clubs, GBT community listserves, and local HIV support groups facilitated by Project STYLE staff. Persons interested in participation were screened via a telephone interview to ensure they met the criteria for eligibility (i.e., identify as Black, identify as male, are between the ages of 18 and 25 years, and report having had sex with a man in the past 12 months). Those deemed eligible were enrolled as participants in one of the focus group sessions. Before each focus group session began, participants received a consent form with information about the purpose and procedures of the focus group and how to withdraw from the study.

Data Collection

To elicit open answers to sensitive topics and foster a deeper exploration of the unique situation of being both Black and MSM/GBT, the focus groups were facilitated by project staff members who had extensive work experience with young Black MSM. The note taker was also culturally and demographically similar to the sample population. A semi-structured interview guide was used to facilitate the discussion; topics included online HIV prevention messaging, experiences with healthcare providers, and specific questions related to interactions with DIS. Follow-up open-ended questions were used to clarify respondents' statements. To encourage participation, focus groups were held in the evenings, and a $30 gift card was offered to each participant.

Data Analysis and Coding

Audiotapes of the focus group sessions were transcribed verbatim by a research

assistant. Field notes provided additional contextual details for the transcripts. Transcripts were read and coded independently by the author using the qualitative analysis software package ATLAS.ti to assist with analysis. Data queries were run to aid in identifying themes. The analysis was conducted in two stages: (1) extraction of predetermined themes specific to DIS encounters; and (2) open coding to identify emergent themes from the focus group discussion. This dual coding method provided information about the subjects' individual insights about their encounters with DIS and also allowed exploration of participant-initiated issues beyond DIS encounters. The first phase involved extracting verbatim participant comments from directed questions related to DIS encounters; these comments were later used in the role-play portion of the DIS training intervention. The second phase entailed line-by-line open coding to discover concepts and themes (Strauss & Corbin, 1998); each concept was recorded and sorted into categories to inform the training content. This coding was checked by the project team for consistency and accuracy as well as relevancy to the study.

AIM II: Design and Implement a Cultural Competency Training Tailored to Disease Intervention Specialists

The training curriculum was designed in conjunction with NC DHHS, Disease Intervention Specialists, the intervention's expert advisory group which includes leadership from community-based organizations that serve HIV-infected MSM clients, and was informed by regional field visits and focus group data with young, HIV-infected MSM of color. Meetings related to the development of the training intervention began in February 2006. The advisory group met three times throughout the year-long curriculum development process to enhance the intervention's content and relevance. In addition to the larger group advisory board meeting, the HIV/STD Care Branch training director provided ongoing

curriculum consultation and coordinated a day-long field visit for the author to accompany a DIS on visits with two HIV-positive clients to guide the curriculum development process.

Based on this collaborative partnership the training intervention was designed to (a) enhance self-awareness of attitudes toward MSM/GBT and personal biases; (b) increase healthcare provider knowledge of the unique needs and experiences of MSM/GBT men of color (e.g., experiences of discrimination, social stigma, oppression); and (c) improve healthcare providers' client interaction skills (Crandall et al., 2003; Majumdar et al., 2004; Price et al., 2005; Scout et al., 2001). A manualized curriculum was developed to meet the local needs of DIS and then disseminated in a two-day (16 hour) mandatory professional training. A more detailed description of factors that contributed to training content and instructional strategies is outlined below.

Training Design Process

Black MSM/LGBT input. The themes identified from the qualitative analyses of focus group data and data collected in the preliminary qualitative studies were used to shape the training curriculum. For example, focus group participants repeatedly mentioned growing up with messages about their "immorality" and about "going to hell." This information and subsequent discussions with Black MSM staff and advisory board members led to the inclusion of the film *All God's Children* in the training. This film explores the relationship of lesbian and gay African Americans to their faith communities and includes a statement of affirmation from established African American religious leaders. While the author found this decision potentially inflammatory, there was sufficient support from the advisory board and from the qualitative data to warrant the film's inclusion. The information gathered in focus groups with Black MSM was also useful in shaping the role play and interviewing sections of

the training and informed the decision to include a panel of HIV-positive MSM during the second day of the training.

Disease Intervention Specialists input. Based on ongoing meetings and conversations with DIS administrators and staff, a DIS needs assessment was developed in fall 2006 to identify training needs related to interactions with MSM/GBT clients (N=50). The assessment included seven open-ended questions and was approved by DIS supervisors and the Project STYLE team before dissemination. Needs assessment results indicated that most DIS faced challenges in communicating with MSM/GBT clients (particularly white, middle-class clients). DIS also said they wanted to learn how to better establish trust MSM/GBT clients and more skillfully elicit information related to sexual partners. These results were used to refine the curriculum content concerning client interviews, LGBT-related terminology, and the design of case studies. Needs assessment results are included in Appendix D.

DIS supervisors' input. The training was originally conceptualized by DIS supervisors as a four-hour training, but it soon became apparent that a longer training was needed. After numerous meetings and phone conversations concerning the specific training needs of DIS, a two-day training (eight hours each day) was developed. DIS supervisors also provided the author with materials related to new staff training, DIS-specific terminology, and work expectations. Early in the curriculum development process, the Training Director for the HIV/STD Prevention and Care Branch organized a day-long field visit with three clients, a DIS and the author to ensure that the author and the Project STYLE team had an adequate understanding of the client interview process.

Conceptual Framework

Along with a literature review of cultural competency curricula, the previously described Campinha-Bacote model of cultural competence in health care delivery provided a conceptual framework for course content development and survey structure. Each section of the training addressed the interdependent constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. In addition, there was a strong emphasis on adult education principles including peer-supported learning (Crandall, 2003) and exercises that utilized providers' personal expertise and experience to set the context for the discussion (Williams, 2005). The training outline is included in Appendix E.

In March 2007, the expert advisory board provided a final review of qualitative findings and made recommendations regarding the salient themes and issues most relevant to the proposed intervention development. DIS administrative staff and the Project STYLE team finalized the curriculum including a resource manual for each participant that contained summaries of training content, handouts related to terminology, case scenarios, and LGBT-specific local and statewide resources.

AIM III: Evaluate the Outcomes of Training in Improving Providers' Cultural Competency Regarding Interactions with MSM/GBT Clients of Color

This pilot study measured outcomes of a cultural competency training curriculum focusing on needs and issues for MSM/GBT clients of color. Outcomes were measured by evaluating changes in providers' knowledge, awareness, and skills at three time points: before the training (T1); immediately after training (T2); and 12 weeks post-training (T3). The training was offered in two regions of the state and was facilitated by the author, along with the Project STYLE project coordinator, over two consecutive days (16 hours of training).

Study Design

This study originated from a request by NC DHHS to deliver a cultural competency training with a specific focus on working with MSM/GBT clients to Disease Intervention Specialists; it has been approved by the Medical Institutional Review Board at the University of North Carolina at Chapel Hill. The study utilized a one-group pretest-posttest-follow-up design and was conducted with Disease Intervention Specialists in North Carolina (n=54). A one-group design was employed because the entire group of providers was required to attend the training, which eliminated the possibility of a control group. At the beginning of the training, participants were asked to participate in a survey related to their perceptions and experiences working with MSM/GBT clients. Participants signed a consent form stating that they understood the purpose of the study, what it entailed, and that they could terminate involvement at any time during the project activities. Pretest, posttest, and follow-up measures were administered to assess training outcomes related to provider's knowledge, attitudes, and improvement in skills when working with MSM/GBT clients.

Sample

The sample included 57 of 59 Disease Intervention Specialists in North Carolina at baseline. All DIS were required to attend the training as part of their professional development training. Two were missing due to medical reasons at the beginning of the training and were therefore excluded from the study. Although the training was mandatory, the trainers clearly stated to the DIS that completing the study survey were not required. Further, research staff made sure the DIS understood that their participation in the survey (or lack thereof) would not be communicated to their supervisors or administrative staff.

Recruitment was not a study limitation as all Disease Intervention Specialists were required to attend the training. There was the possibility of attrition at T3 due to staff loss. However, because this study took place over a 3-month period, loss of a significant number of participants was unlikely. To encourage participation at T3, a $10 gift card was offered to all who completed the final survey.

Procedures

At baseline, all participants were assigned an automatically generated personal identification number (PIN) which was the only identifying information recorded on the baseline assessment and subsequent posttest surveys. The PIN file was kept in a locked cabinet separate from the completed surveys; only STYLE research staff were able to associate specific responses with a participant's name. This information was collected to ensure participants received the follow-up survey at T3. Table 5 presents measures utilized in the survey. Participants who agreed to complete the baseline survey were asked at T2 (immediately post-intervention) if they would agree to be contacted in 12 weeks to complete a final survey about training outcomes. Participants who agreed were asked to provide contact information. Follow-up surveys were administered by project staff in each of the HIV/STD county offices around North Carolina to ensure confidentiality. Participants were given the opportunity to complete the surveys privately in their offices if they did not want to complete the survey in the designated conference space.

Database management. Only Project STYLE team members had access to participant information. Data from the surveys were entered manually into a dedicated SPSS database housed at UNC. Data entry was conducted using the application of standardized error-trapping and data-cleaning procedures including double entry of data. The database with no

identifiers will be kept for subsequent analyses under the UNC Medical IRB protocol. Access to the database was password protected and restricted to Project STYLE staff.

Measures

As reviewed in Chapter 3, no existing validated measurement tool explores cultural competency as it relates to the combined issues of sexual orientation, gender identity and race. As such, a survey instrument was developed in collaboration with the advisory team and Project STYLE staff to broadly characterize DIS' knowledge, awareness, and skills in working with LGBT clients. In order to construct this scale, an item pool was compiled from surveys, scales, and questionnaires used in existing cultural competency educational interventions. Items from three existing scales were included and are discussed below. Additional items relevant to DIS were created to account for issues specific to this study's population. The survey was initially piloted with the training advisory group and the Project STYLE team in March 2007 to assess content validity. An overview of measures in the survey is included in Table 5.

The survey consists of three subscales including: a 12-item knowledge subscale (measuring knowledge about issues specific to LGBT individuals and social discrimination); a 16-item attitudes/awareness subscale (measuring attitudes and assumptions about LGBT people); and a 12-item skills and abilities subscale (measuring skills related to working with LGBT people). The responses are given using a Likert-type scale ranging from 1 (*no knowledge*) to 5 (*very knowledgeable*) in the knowledge subscale and from 1 (*strongly agree*)

Table 5
Variables and Measures Used in Intervention Survey

Variable Name	Measures	Description
Baseline variables of interest	Demographic items	Race/ethnicity, age, gender, educational status, years of employment, sexual orientation
Knowledge (12 items)	Modified Gay Affirmative Practice [GAP] Scale (Crisp, 2006)	Measures to assess clinicians' knowledge about gay and lesbian clients and issues
	Quantitative items developed by author/advisory team	Measures to assess basic knowledge related to sexual orientation and gender identity; measures to assess understanding of societal stereotypes and discrimination for LGBT clients of color
Attitudes / awareness (16 items)	Index of Attitudes Towards Homosexuality [IAH] (Herek, 2000)	Measures to assess beliefs and behaviors toward gay and lesbian individuals
	Support for Lesbian and Gay Human Rights Scale [SLGHR] (Ellis, Kitzinger, & Wilkinson, 2002)	Measures to assess support for human rights for lesbian and gay individuals
	Quantitative items developed by researcher/advisory team	Measures to assess comfort working with transgender clients, bisexual male clients, and provider comfort in addressing discrimination
Skills and abilities (11 items)	Quantitative items developed by researcher/advisory team Qualitative items	Measures to assess providers' confidence in interacting with diverse populations and interviewing skills

to 5 (*strongly disagree*) in the attitudes and skills subscales. See Appendix F for the study's survey.

Knowledge subscale. The selection of items used in the knowledge subscale was based on (a) the Campinha-Bacote conceptual framework, (b) an ongoing collaborative process with advisory board team which identified knowledge needed to be effective with GBT/MSM clients of color, and (c) a modification of select items from the Gay Affirmative Practice Scale [GAP] (Crisp, 2006). The GAP Scale is designed to assess practitioners'

beliefs and behaviors in practice with gay and lesbian individuals. This scale has been validated with mental health clinicians and demonstrated high internal consistency, with reported alpha coefficients ranging from .93 to .95 (Crisp, 2006).

Attitudes/awareness subscale. Items from the Index of Attitudes Toward Homosexuality [IAH] (Herek, 2000) were included in the attitudes and awareness subscale. The IAH attempts to identify "sexual prejudice," defined as "negative attitudes toward an individual because of her or his sexual orientation" (Herek, 2000, p. 19). The IAH provides a standardized way to measure sexual prejudice and to determine levels of acceptance or rejection of gay or lesbian persons. This index is among the most widely used standardized measures for evaluating beliefs and behaviors toward gay and lesbian persons. Studies have demonstrated both the validity and reliability of the IAH, with reported alpha coefficients ranging from .90 to .95 (Hudson & Ricketts, 1980; Pain, 1995) with the standard error of measurement at -4.75 (Malley & Tasker, 2004).

While the IAH has been demonstrated to be psychometrically sound, it lacks specific measures for bisexual or transgender populations and does not address issues related to sexual orientation for people of color. For the study, four IAH items were selected to capture data regarding general attitudes towards LGBT persons. In addition, three modified IAH items were added to elicit information specific to client interaction. A summary of these items and modifications is included in Table 6. Supplementary questions were created regarding participants' perceptions related to working with MSM/GBT men of color as well as working specifically with transgender populations.

In addition to validated items from the IAH, two items from the Support for Lesbian

Table 6.
Items from Validated Measures Utilized and Modified in Intervention Survey

Measures Utilized to Assess Knowledge	
Original GAP Scale Items	**Modified GAP Scale Items Added to Knowledge Subscale**
• Practitioners should be knowledgeable about gay/lesbian resources	• Resources for *transgender* clients • Resources for gay and *bisexual male* clients
• Practitioners should be knowledgeable about issues unique to gay/lesbian couples	• Issues unique to gay and *bisexual men* • Issues unique to *transgender persons* • Issues unique to *lesbians* • Issues unique to *LGBT people of color*
Measures Utilized to Assess Attitudes and Awareness	
IAH Items Included in Attitudes Subscale	**Modified IAH Statements Added to Attitudes Subscale**
• I would feel comfortable working closely with a gay or bisexual male coworker. • I would feel comfortable working closely with a lesbian coworker. • It would disturb me to find out that my doctor was gay, lesbian, or bisexual. • I would feel comfortable if I learned that my child's teacher was gay, lesbian, or bisexual.	• I would feel comfortable working with gay and/or bisexual male *clients*. • I am comfortable working with lesbian *clients*. • I am comfortable working with *transgender clients*.
SLGHR Survey Items Included in Attitudes Subscale	
• A person's sexual orientation/identity should not block that persons' access to basic rights and freedoms. • Lesbian and gay couples should have all the same parenting rights as heterosexuals do (i.e., adoption, fostering and access to fertility services).	

and Gay Human Rights Scale (SLGHR; (Ellis, Kitzinger, & Wilkinson, 2002) were included to uncover potential bias related to gay and lesbian rights. The SLGHR scale was created by Ellis and colleagues to assess the level of support for lesbian and gay human rights among graduate psychology students in the United Kingdom. The study found that while participants (n=226) reported a high level of generalized support for "basic rights and freedoms" (p. 131), they indicated a lower degree of support for specific rights (i.e., parenting rights for lesbian and gay couples). As these two specific questions seemed to

reveal an inconsistency in values, they were included in the attitudes and awareness subscale (see Table 6).

Skills subscale. Questions related to skills were phrased to capture the presence of specific skills relevant to DIS staff such as confidence in client interviewing, ability to address negative stereotypes, and ability to elicit partner information from clients. These items were developed and approved by the advisory group.

Training fidelity measure. An observer from the Project STYLE team monitored both trainings and provided written evaluation regarding instructors' fidelity to the training model to enhance internal reliability and validity (Bellg et al., 2004). Bellg et al. suggest that "monitoring and optimizing treatment fidelity over a series of studies may increase effect sizes and reduce the number of subjects required in later studies" (p. 444). In addition to a standardized fidelity measure, comprehensive field notes were taken by a designated Project STYLE team member.

The evaluation of training fidelity was based on a model developed by the Treatment Fidelity Workgroup of the National Institutes of Health Behavior Change Consortium (Bellg et al., 2004) and presented in Table 7. The Project STYLE observer utilized an expert observer rating tool modified from a National Science Foundation (1997) fidelity assessment tool to evaluate issues such as session content, pace of training, strategies, materials and activities employed, and trainers' approach. Field notes and data collected through the fidelity measure were utilized to modify the second training and also inform the discussion and implications section of this dissertation. The training fidelity measure is included in Appendix G.

STD MIS data. To supplement the findings from the survey analysis, data from the

Table 7
Treatment Fidelity Strategies for Monitoring and Improving Provider Training

Goal	Description	Strategies
Standardize training	Ensure that training is conducted similarly by different providers	Providers train together; use standardized training manuals/materials; have training take into account the different experience levels of providers; use structured practices and role plays; observe intervention implementation with pilot participants; design training to account for diverse implementation styles
Ensure provider skill acquisition	Train providers to well-defined performance criteria	Observe intervention implementation with pilot participants, score provider adherence according to an a priori checklist; conduct provider-identified problem solving and debriefing; provide written pretest and posttest for training
Minimize "drift" in provider skills	Ensure that provider skills do not decay over time (e.g., show that provider skills demonstrated halfway through the intervention period are not significantly different than skills immediately after initial training)	Conduct observations or recording encounters and review (score providers on their adherence using a priori checklist); conduct weekly supervision or periodic meetings with providers; allow providers easy access to project staff for questions about the intervention; have providers complete self-report questionnaire
Accommodate provider differences	Ensure adequate level of training in providers with differing skill level, experience, or professional background.	Monitor differential dropout rates; evaluate differential effectiveness by professional experience; use provider-centered training according to needs, background, or clinical experience

Note. From "Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from NIH Behavior Change Consortium," by A.J. Bellg et al., 2004, *Health Psychology*, *23*, pp. 443-45.

North Carolina STD Management Information System (MIS) was obtained. Specifically, the NC DHHS HIV/STD Division provided Project STYLE with information about the number of HIV-related interviews that DIS conducted with MSM individuals and the number of partners notified during the two months prior to the training intervention (February-March 2007), during the training intervention (April-May 2007), and during the two months following the training intervention (June-July 2007). If the training was successful, we would expect these data to indicate an increase in the numbers of MSM clients contacted as well as partners identified. The data provided by the division were aggregated based on individual

and region. This information allowed for a connection of survey data and individual PIN numbers from the training intervention to the STD MIS data.

Data Analysis

Descriptive analyses were conducted to describe participant characteristics. Repeated Measures ANOVA was used to explore whether the intervention was associated with change in knowledge, attitudes, and skills in working with GBT/MSM immediately following the training (T2), and whether change was sustained, enhanced, or attenuated over time. This analysis method allowed for the exploration of variation over time (change score) as well as change between individuals. All analyses were performed using SPSS for Windows 16.0.

Individual measures were combined into knowledge, attitudes, and skills composites at each time point. Scale scores were created as an average of constituent items. Cronbach's alpha was computed to measure the reliability of composite scores for knowledge, attitudes, and skills at each time point (T1, T2, T3). If composites failed to demonstrate reliability above .80 (Devellis, 2003), items with low item-correlation were deleted to potentially improve internal consistency. Items were deleted from a subscale if they had 50% or more missing cases. Variation in scale scores related to gender, age, race, education, and years of employment were explored. In addition, the content of each subscale with most and least favorable responses was examined to determine strengths and weaknesses within the training content.

CHAPTER VII

RESULTS

This chapter examines the findings related to Aims I and III of the study. Aim I intended to explore Black MSM/GBT clients' needs and perceptions related to HIV prevention and care in order to inform the intervention design. The primary data collected for this aim is discussed below. Aim II involved the design phase of the training curriculum and was described in Chapter 6. Aim III of the study evaluated changes in DIS cultural competency regarding interactions with MSM/GBT clients of color. Data related to Aim III are also detailed in this chapter.

Aim I. Characterize young Black MSM/GBT clients' needs and perceptions regarding sexual health and HIV prevention and care.

A total of 14 participants attended three focus groups designed to uncover concerns specific to Black MSM/GBT men's experience of HIV prevention and care efforts. All focus group participants were Black men between the ages of 18 and 25 years old who reported having had sex with a man in the past 12 months. Additional demographic information was not collected due to confidentiality concerns. Of the three focus groups conducted, only one group included men who were HIV-positive (n = 4). Of the four participants in this focus group, only two had direct experience with North Carolina DIS. All focus groups were asked broad questions related to encounters with health care providers, and qualitative analysis of the data revealed three salient themes emerged as instrumental in shaping the intervention's curriculum: 1) the need for inclusive language and terminology in connecting to MSM/GBT

clients, 2) the importance of privacy related to HIV disclosure and testing, and 3) the importance of a respectful and transparent approach to the DIS interview process.

Inclusive Language and Terminology

In all three focus group, participants were asked to share experiences related to their interactions with health care providers. Among the strategies generated to improve provider/client connections, the use of inclusive language and the importance of understanding basic LGBT-related terminology emerged as paramount. For example, one participant said he felt comfortable when providers' language was intentionally open:

> I like it when [healthcare providers] say, "Do you have *girlfriend or boyfriend?"* when they give you both options, so you know they are open or receptive to it. Then you just tell them which one it is.

Many participants recommended educational opportunities for health care providers that specifically addressed appropriate language with LGBT people:

> I think a lot of health care providers should be educated about what kind of dialogue to use when helping LGBT people. . . .[Health care providers] should give you the information and materials you need and not just say, "OK, if you're having sex with a man, you're going to get HIV."

In addition to stressing the importance of using gender-neutral terms and communicating a non-judgmental attitude through word choice, participants said that health care providers need to be familiar with terms commonly used in Black gay culture. One participant shared a specific encounter with a DIS that reflected a lack of familiarity with this culture:

> The LGBT community may observe *houses* [drag ball culture] and you go to another city and they don't give a damn about a *house.* That's always important. My DIS seemed real taken back when I used certain terminology. He was like, "What? What are you talking about?" It's important to understand the people you are dealing with to better understand, bond, and relate and get a connection so a person is more comfortable expressing themselves and letting loose.

Privacy Related to HIV Testing and Disclosure

Participants in all groups emphasized the importance of privacy and confidentiality in interactions with health care providers. Participants provided suggestions on how to improve HIV testing and care to reduce the fear and embarrassment related to HIV. Specifically, they suggested providers should be more aware about not only what they say but how the physical space may affect a client's comfort level:

> The environment makes a whole lot of difference. Like when I go to the doctor, I guess it's this big issue about privacy. But people never think about privacy and confidentiality, as far as walking into a doctor, or like when you go to the window to say, I am here to get tested. And then people may look at you a certain way. The staff act like they don't want to be there, that kind of discourages me from going [to get an HIV test].

Participants who had contact with DIS were particularly concerned about the issue of confidentiality related to their HIV status and expressed a sense of frustration about the DIS interview process:

> It's kind of an invasion of privacy and to someone who just found out [they were HIV-positive] and then you have the person who is chasing you around town, leaving notes on your door, on your car, who wants to re-address this issue and treat you like... I mean the individual who came to me did not disrespect me, he did not, you know talk down to me. We had a pleasant conversation, we talked, but at the same time it was a little bit too invasive.

The Need for a Respectful and Transparent DIS Interview Process

A major purpose of this focus group was to gather information specific to encounters with DIS by young Black GBT/MSM. Both of the participants who had interviewed with a DIS spoke about aversion and confusion related to the interview process:

> Thinking back I hate that experience [DIS interview]—like, why do I have to sign these papers and all this stuff. He was talking about, like a judgment of my character and I was thinking, is this constitutionally right?

Yet when the same participant was asked if he felt that the DIS was affirming of his sexuality, he indicated that he felt respected on a personal level but confused as to why the interview was happening. He went on to clarify:

> At that time it was a lot of fear, I was real numb, and I was trying to keep my head up at the time and I was dealing with other things. It wasn't totally negative but I question the validity and the necessity of it [DIS interview].

Another participant expressed similar confusion about the DIS interview, believing it was "mandatory" in order to receive medical care. He shared: "My experience with DIS was my first experience in North Carolina and I had to sign this form [public health control measures related to partner notification]. It was like I couldn't get treated until I signed this form—health wise." Both men communicated the need for increased clarity about their client rights and what they were required to disclose related to their sexual history.

AIM III: Evaluate the Outcomes of Training in Improving Providers' Cultural Competency Regarding Interactions with MSM/GBT Clients of Color

The results of the data for Aim III are organized according to the variables of interest including: 1) DIS demographic information, 2) change related to knowledge level, 3) change related to attitudes and awareness, 4) change related to skill level, and 5) self-report on the effect of the training intervention. Qualitative information collected in the survey is also discussed.

Characteristics of participants

Out of a total of 59 DIS, 57 attended the full training and 54 completed all phases of the study (pretest, intervention, and posttest). The sample was composed of 30 females (56%) and 24 males (44%). A majority of participants were between the ages of 24 and 39. 63 % of DIS identified as people of color. Overwhelmingly, DIS identified as heterosexual though

7% identified as lesbian and 10% of the sample indicated no response related to sexual orientation. Most DIS reported a college degree (74%) or a graduate degree (19%). Length of employment as a DIS was distributed evenly among participants with 18 (34%) reporting less than a year of employment, 17 (32%) reporting between 1 and 6 years of employment, and 18 (34%) reporting 7 or more years of DIS experience. Demographic information about the DIS is illustrated in Table 8.

Table 8
Demographics of Disease Intervention Specialists

	Number	Percent
Gender		
Female	30	56%
Male	24	44%
Race		
White	20	37%
Black	31	57%
American Indian	1	2%
Other	2	4%
Age		
24-29 years	12	22%
30-39 years	21	39%
40-49 years	14	26%
50-59 years	7	13%
Sexual Orientation		
Heterosexual	45	83%
Lesbian	4	7%
No response	5	10%
Education		
High school	2	4%
Some college	2	4%
College graduate	40	74%
Graduate degree	10	18%
Length of Time Working as DIS		
< 1 year	18	34%
1-6 years	17	32%
≥ 7 years	18	34%

Reliabilities and Treatment of Missing Values

Items Assessing Knowledge

For the set of 12 items addressing knowledge related to LGBT clients, response options ranged from "No Knowledge" (coded as 1) to "Very Knowledgeable" (coded as 5). Excluded from analysis were the responses of 11 participants who completed six or fewer items in this subscale. Therefore, the results for this item set reflect the responses of 43 participants. In addition, two items were missing from the final survey administered 3 months after the training due to a printing error. These are statements related to knowledge concerning "issues for lesbians" and "societal discrimination that impacts LGBT clients of color." An internal consistency reliability analysis was conducted for the knowledge subscale using Cronbach's alpha. A high level of congruence or consistency of the items comprising this subscale was observed at each time point (T1 $\alpha = .93$; T2 $\alpha = .93$; T3 $\alpha = .86$).

Items Assessing Attitudes and Awareness

For the set of 16 items addressing attitudes and awareness concerning LGBT issues, response options ranged from "Strongly Agree" (coded as 1) to "Strongly Disagree" (coded as 5). Ten participant responses were excluded from this analysis based on their completion of eight or fewer items in this subscale. Therefore, the results for this item set reflect the responses of 44 participants. In addition, one question was missing from the final attitudes and awareness subscale administered 3 months after the training due to a printing error. This statement related to comfort in "working closely with a lesbian co-worker." A reliability analysis was conducted for the attitudes and awareness subscale using Cronbach's alpha. An acceptable level of congruence or consistency of the items comprising this subscale was observed at T1 and T3 (T1 $\alpha = .86$; T2 $\alpha = .51$; T3 $\alpha = .77$).

Items Assessing Skills

For this item set, participants rated 11 items assessing skills in working with LGBT clients on a response scale ranging from "Strongly Agree" (coded as one) to "Strongly Disagree" (coded as five). Excluded from analysis were the responses from 10 participants who were missing the subscale from their survey due to a printing error. Eight other participants were excluded who completed 6 or fewer items in this subscale. Therefore, the results for this subscale reflect the responses of 36 participants. In addition, six questions were changed on the final skills subscale administered 3 months after the training due to a printing error. These changes can be seen the final survey included in Appendix F. A reliability analysis was conducted for the skills subscale using Cronbach's alpha. An acceptable level of congruence or consistency of the items comprising the skills subscale was observed at each time point (T1 $\alpha = .80$; T2 $\alpha = .71$; T3 $\alpha = .88$). A summary of missing values is detailed in Table 9.

Table 9
Missing Values

	% Missing Data
T1 vs. T2 (post-training vs. baseline)	
Knowledge	8%
Attitudes	6%
Skills	14%
T2 vs. T3 (3 months after training vs. post-training)	
Knowledge	15%
Attitudes	14%
Skills	13%
T1 vs. T3 (3-month after training vs. baseline)	
Knowledge	10%
Attitudes	12%
Skills	19%

Summary of Major Findings

Individual measures were combined into knowledge, attitudes, and skills composite scores at each time point. These subscales include: a 12-item knowledge subscale (measuring knowledge of issues specific to LGBT individuals); a 16-item attitudes and awareness subscale (measuring attitudes and assumptions about LGBT people); and an 11-item skills subscale (measuring skills related to working with LGBT people). Due to the small sample size, separate Wilcoxon signed rank tests were conducted on changes in knowledge, attitude, and skills between time points. The results of Wilcoxon signed rank test were consistent with the findings from the Repeated Measures ANOVA (RM-ANOVA). Test results are summarized in Table 10.

Table 10
P-values and Mean Scores for DIS Knowledge, Attitudes/Awareness, and Skills Related to Work with LGBT Clients

	Mean Score			P value for Score Differences (Wilcoxin Signed Rank Test)		
	T1	T2	T3	T1 vs. T2	T1 vs. T3	T2 vs. T3
Knowledge	3.11	3.67	3.58	**<0.0001*** (<0.0001)	**0.001*** (0.0002)	0.19 (0.44)
Attitudes	2.11	2.04	2.04	0.36 (0.53)	0.53 (0.26)	0.74 (0.70)
Skills	2.17	2.12	2.06	0.71 (0.77)	0.34 (0.44)	0.91 (0.47)

**p< .05.*

A statistically significant difference was found between the knowledge subscale mean score at T1 (M=3.11, SD=.84), and the mean score at T2 (M=3.67, SD=.67), ($p < 0.0001$). There was also a significant increase in the knowledge subscale mean score between T1 (M=3.11) and T3 (M=3.58, SD=.56), ($p = 0.001$) indicating that the course was effective in

increasing the participants' overall knowledge about LGBT clients and this knowledge was sustained at the 3-month follow-up. No significant changes in attitude/awareness and skills were observed between the three time points. Comparisons were made on pre- and post-training ratings for all items by age, gender, race, education, and years of employment as a DIS. No statistically significant differences were found based on these covariates.

Knowledge Subscale

In order to understand where participants gained the most significant information and to inform future training content, RM-ANOVA was used to test score differences between time points for each item in the knowledge subscale. These are illustrated in Figure 4 and the corresponding statements are outlined in Table 11. Higher scores (coded as 5) in knowledge indicate better knowledge. The results suggest that the participants were very knowledgeable about basic terminology such as "sexual orientation" and "gender identity," showing no significant change between the beginning of training and after the training intervention. On the remainder of items for the knowledge subscale, significant improvements in scores after the training were detected. In particular, questions related to knowledge in working with transgender clients showed improvement over time. Differences in individual question scores for each item in the survey between time points are detailed in Appendix H.

Attitudes/Awareness Subscale

For all 16 questions relevant to attitudes/awareness of LGBT issues, there were no significant changes in participants' scores as DIS reported relatively high levels of awareness and affirming attitudes at baseline. For example, participants expressed comfort in talking about same-sex sexual behavior with clients and in working with LGBT clients. However, when asked if they could provide effective services

Figure 4. Mean score on DIS response to individual questions relevant to knowledge

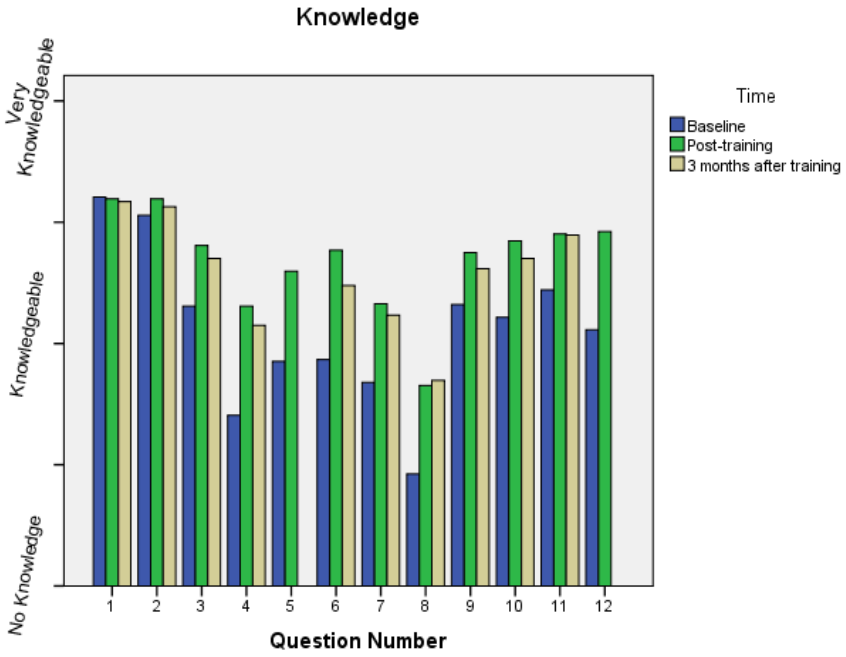
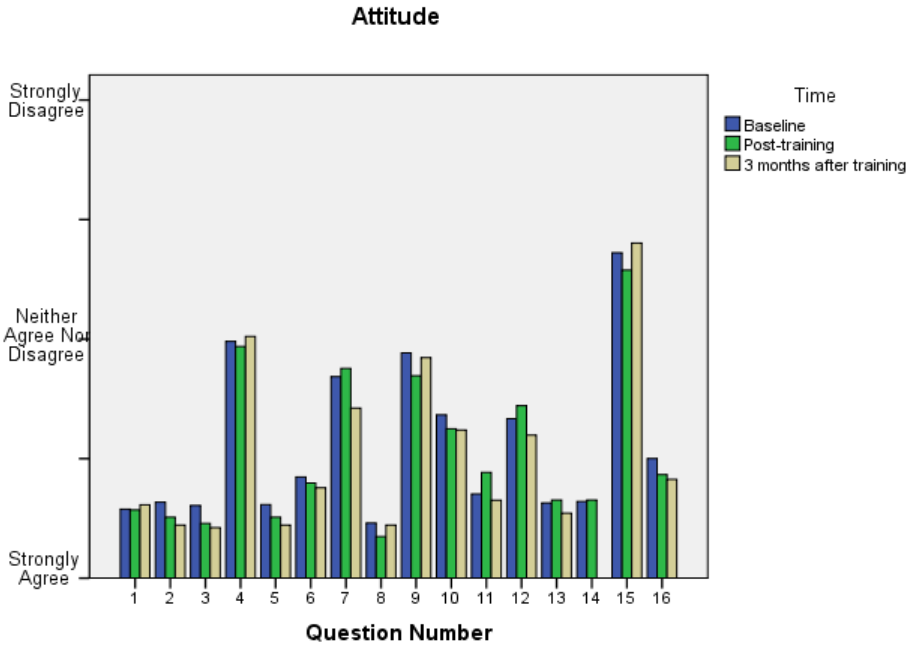


Table 11
Knowledge Subscale Statements

Knowledge Subscale Statements
Please indicate by circling the number that reflects the level of knowledge you have: 1. What "sexual orientation/identity" means 2. What "gender identity" means 3. Issues unique to gay and bisexual men 4. Issues unique to transgender persons 5. Issues unique to lesbians 6. Issues unique to LGBT people of color 7. Resources for gay and bisexual male clients 8. Resources for transgender clients 9. Societal stereotypes around sexual orientation and LGBT-identified people 10. Societal discrimination that impacts LGBT clients 11. Societal discrimination that impacts clients of color 12. Societal discrimination that impacts LGBT clients of color

for LGBT people and "still think that it is morally wrong to be LGBT," the majority of participants responded "neither agree nor disagree" at all time points. Figure 5 illustrates the differences in mean response scores for each item by time point. Table 12 outlines the statements associated with each item.

Figure 5. Mean score on DIS response to individual questions relevant to attitude/awareness



Skills Subscale

Of the 11 questions relevant to skills, only Questions 4 and 6 show significant improvement after the training intervention. Question 4 ("People in my work environment confront negative stereotypes related to race/ethnicity") shows significant change three months after training from baseline. However, scores for Question 4 are not significantly different between baseline compared to immediately after the training. Question 6 asks about

Table 12

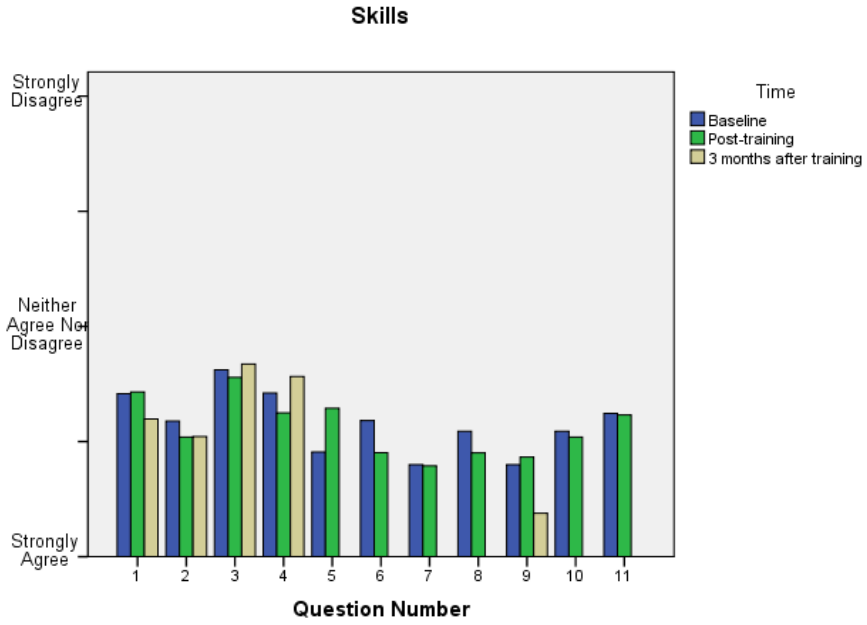
Attitudes/Awareness Subscale Statements

Attitudes and Awareness Subscale Statements
1. It is important to be aware of the sexual orientation/identity of your clients.
2. I am comfortable working with gay and/or bisexual male clients.
3. I am comfortable working with lesbian clients
4. Being gay, lesbian, bisexual, or transgender is a choice.
5. I am comfortable talking about same-sex sexual behavior with clients.
6. I am comfortable working with transgender clients.
7. Part of our work is to assist clients in dealing with societal discrimination related to their LGBT identity.
8. A person's sexual orientation/identity should not block that person's access to basic rights and freedoms.
9. You can provide effective services for LGBT people and still think that it is morally wrong to be LGBT.
10. Lesbian and gay couples should have all the same parenting rights as heterosexuals do (for example, adoption, fostering and access to fertility services).
11. Understanding the interaction of a client's race, gender, and sexual orientation/identity is important.
12. I would feel comfortable if I leaned that my child's teacher was gay, lesbian, or bisexual.
13. I would feel comfortable working closely with a gay or bisexual male coworker.
14. I would feel comfortable working closely with a lesbian coworker.
15. It would disturb me to find out that my doctor was gay, lesbian, or bisexual.
16. My work environment is a safe place for LGBT people.

confidence in interviewing skills with White gay and bisexual male clients and shows significant improvement between baseline and immediately following the training. The remainder of statements for the skills subscale show no significant improvement immediately after training or three months after training. As with the attitudes/awareness subscale, this is primarily due to DIS reports of high skill levels prior to the training. For example, DIS reported prior to the training intervention that they would address negative stereotypes related to a person's sexual orientation or race and that they had high confidence levels in their interviewing skills with clients regardless of sexual orientation or race. Figure 6

illustrates the differences in mean score on DIS responses relevant to skills and Table 13 outlines the statements associated with each item.

Figure 6. Mean score on DIS response to individual questions relevant to skills



Additional Findings

Training Delivery and Field Notes

In order to assess training fidelity and ensure that the training achieved its intended purpose, a staff person from Project STYLE observed and recorded content, activities, instructional resources, and participant comments for all training sessions. In general, the training content and delivery remained consistent for both DIS groups. Slight modifications in activities and set-up were made as a result of lessons learned following the initial DIS training group. During the first session the observer documented resistance from many DIS related to the content of the training. In field notes from the first training, the observer commented that "participants continued to express frustration with having to attend the training."

Table 13
Skills Subscale Statements

Skills Subscale Statements
1. If I heard negative stereotypes related to a person's sexual orientation, I would address those stereotypes. 2. If I heard negative stereotypes related to race/ethnicity, I would address those stereotypes. 3. People in my work environment confront negative stereotypes related to sexual orientation/identity. 4. People in my work environment confront negative stereotypes related to race/ethnicity. 5. I have confidence in my interviewing skills with white gay and bisexual male clients. 6. I am effective at getting white gay and bisexual male clients to identify partners. 7. I have confidence in my interviewing skills with gay and bisexual male clients of color. 8. I am effective at getting gay and bisexual male clients of color to identify partners. 9. I have confidence in my interviewing skills with lesbian clients. 10. I have confidence in my interviewing skills with transgender clients. 11. I am effective at getting transgender clients to identify partners.

For example, one participant asked in a hostile tone during the final wrap-up, "Who told you we have a problem?" This statement points to a defensive posture by some DIS who may have interpreted the training as punitive. The observer notes also revealed a deeper hostility toward LGBT people in general including sexualized responses around women who have sex with women and noted that "some participants continued to display homophobia in the training." After a short video discussing African American churches that affirm LGBT identities, one DIS remarked that the film was "pushing an agenda" and that he or she "knew what the Bible says." A number of DIS in the first training group commented that they believed LGBT people had a "lifestyle choice" and "could change." The observer also noted that participants expressed frustration when asked by the trainers to reframe words such as

"lifestyle" in association with LGBT identities and were unclear as to why they needed the training content.

To account for and attempt to understand the frustration and resistance expressed by the first training group, slight modifications to the opening activities were made in preparation for the second training. In an effort to clarify the purpose of the training, the HIV Prevention and Care Branch Training Director formally introduced the first session and the facilitators. During participant introductions, DIS were asked to share why they do the work they do beyond the incentive of a paycheck. Participants were also given an opportunity to express ambivalence or concern about attending the training. These modifications were added in an effort to acknowledge any discomfort as the training was mandatory for all DIS. In light of the resistance from participants regarding the necessity of the training, in the second session the trainers shared a case study written by a young HIV-positive Black gay male that illustrated his overwhelmingly negative experience with a DIS. The case study highlighted the problems and challenges encountered by young black MSM and was used as a discussion tool during the training. This narrative is included in Appendix I.

DIS Training Evaluation

Quantitative training evaluation. Overall, a majority of participants agreed or strongly agreed that the training helped contribute to their understanding of LGBT issues, was relevant to their work as a DIS, and provided strategies to more effectively work with LGBT clients. Interestingly participants also responded that the training had little effect on their attitudes towards LGBT clients. These results are illustrated in Table 14.

Table14
DIS Evaluation of Training

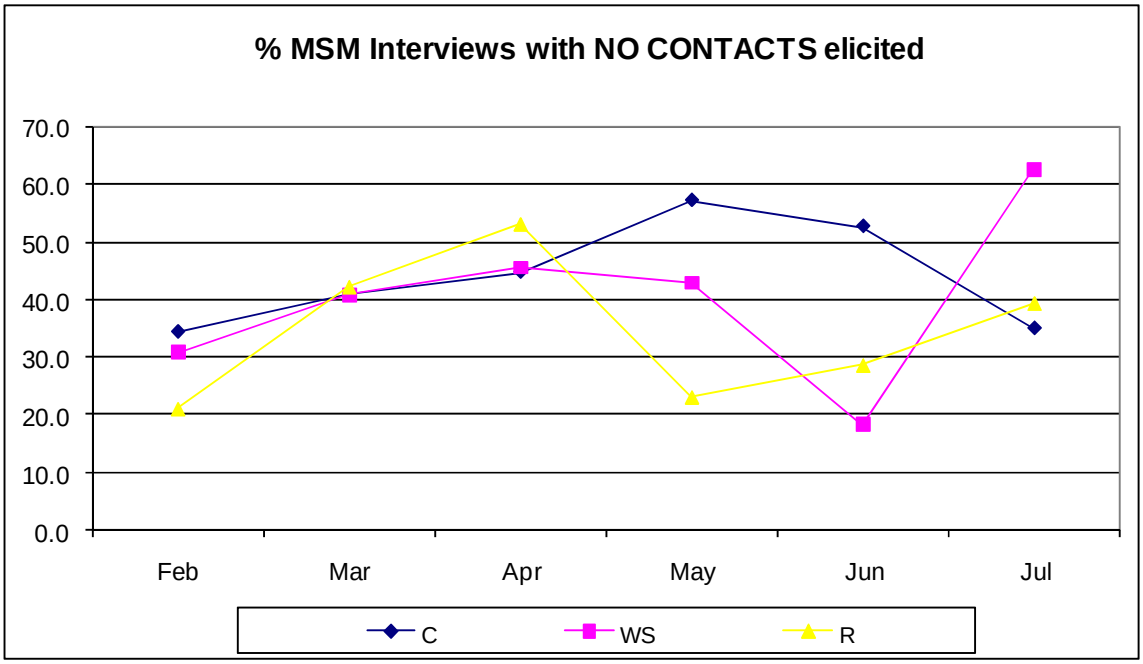
Survey Statement	Strongly Agree/ Agree	Neither Agree nor Disagree	Strongly Disagree/ Disagree
The training contributed to my understanding of LGBT issues.	78%	11%	11%
The training was relevant to my work experience.	85%	9%	6%
I learned strategies to better work with LGBT clients.	72%	15%	13%
The training changed my attitude toward LGBT clients.	23%	35%	42%

Qualitative training evaluation. Qualitative data from an open-ended question was content-analyzed to further explore participants' training experiences. Participants were asked, "If you were given the task to redesign the training, what would you change?" Overwhelmingly DIS recommended more time for dialogue with the panel of HIV-positive gay and bisexual individuals. They also recommended the addition of a transgender panelist and more content on transgender and lesbian issues. Overall, many DIS said there was nothing they would change. A few recommended that the training be more sensitive to "heterosexual views and values." One participant commented that they felt they were being "told and taught how to accept LGBT people." Another participant recommended removing content that addressed religious issues concerning LGBT identities.

STD MIS Data. The North Carolina HIV/STD Prevention and Care Branch provided analysis on DIS interview activity reports from February 2007 (two months before the training intervention), April and May 2007 (during the training intervention), and for June and July of 2007 (post-training). Data related to 1) total number of men interviewed 2) proportion of MSM interviews and 3) number of contacts elicited from MSM clients were

analyzed for each of the eight DIS regions. Of the eight DIS regions, only three had a large enough sample to explore statistical significance (Charlotte, Winston Salem, or Raleigh offices). If the training had an effect on the DIS interview process, a decrease in "no contact" interview would be expected over time. As Figures 7 illustrates, there is no apparent trend in the data related to percentage of "no contact" interviews in Charlotte, Winston Salem, or Raleigh. To explore the data further, a test of Significant Differences Between Proportions was conducted. Cohen's power table were utilized to compute harmonic means to determine the appropriate sample size in order to find the effect size for differences of proportions between the combined time points for Feb/March 2007 and June/July 2007 (1988). The test revealed insufficient power to detect change (see Table 15) and therefore no conclusions can be drawn related to training effects on providers' outcomes with clients.

Figure 7. Percentage of MSM interviews with no partner information elicited



Note: C=Charlotte, WS=Winston-Salem, R=Raleigh

Table15

Significant Differences Between Proportions in MSM Interviews Where Partner Information Was Obtained

	n'	ES	Hc	Observed Power
Charlotte	19	0.123	0.578	<.06
Winston Salem	19	0.082	0.636	<.06
Raleigh	20	0.123	0.62	<.06

Note: n'=harmonic mean of pre and post training sample sizes; ES=h (arcsine for difference in proportion); Hc=effect size necessary for .80 power at a2=.05

CHAPTER VIII

REVIEW OF KEY FINDINGS

This pilot dissertation study was a first attempt at developing and testing a cultural competency training focusing on health care providers' knowledge, attitudes, awareness, and skills related to working with MSM/GBT clients. The study sample consisted of North Carolina Disease Intervention Specialists (n=54), who serve as "first responders" for persons newly diagnosed with HIV and work one-on-one to connect them with care. The study was based on the conceptual framework of Campinha-Bacote which addresses cultural competency as an ongoing process requiring both self-assessment and a broader critique of socio-cultural factors that impact the population in question. Chapter 8 will discuss key findings by study aim, discuss study limitations, consider the findings related to the conceptual framework, and present suggestions for future practice and research.

Aim I. Characterize young Black MSM/GBT clients' needs and perceptions regarding sexual health and HIV prevention and care.

This phase of the study intended to provide insight into the experiences of young Black MSM/GBT clients to inform the development of a cultural competency training curriculum for DIS. Themes derived from the primary qualitative focus group data that were relevant in shaping the curricula included: 1) the need for inclusive language and terminology, 2) the importance of privacy related to HIV disclosure and testing, and 3) the importance of a respectful and transparent approach to the DIS interview process.

Participants in all focus groups spoke of the need for knowledge related to language about sexuality and LGBT identity. Given the invisibility of LGBT identity and a larger culture which often assumes heterosexuality, the importance of intentional dialogue around common terminology was not a surprising finding. The use of terminology that does not resonate with LGBT clients may impede health-seeking behaviors, particularly among Black MSM (Malebranche, 2003; Turner et al., 2006). While the focus group findings suggest the value of provider training that includes content on common vocabulary, care must be taken to acknowledge the fluidity and complexity of sexual identity (Sell & Silenzio, 2006; Silenzio, 2003) and the reality that many Black MSM do not identify with the labels of gay or bisexual (Malebranche, 2003; Wheeler, 2006). Beyond the need to establish common terminology, the focus groups revealed the more fundamental imperative of ensuring providers communicate in ways that do not equate sex with a man with being HIV positive. Black MSM have been "labeled as vectors" in the public health world and beyond and therefore interventions with Black MSM must be sensitive to avoid defining individuals based solely on their sexual behaviors (Wheeler, 2006, p. 15).

Focus group findings related to the need for privacy in HIV testing and status provide relevant information that may help DIS better serve MSM/GBT clients. Specifically, these findings underscore the need to account for the intimate nature of the DIS's request for information related to sexual partners and the spaces in which these requests are made. In order to motivate Black MSM who are HIV-positive to seek and maintain health care, attention must be paid to the setting of care (Wheeler, 2006) as well as how fear of stigma and discrimination may impact HIV disclosure (Brooks, Etzel, Hinojos, Henry, & Perez, 2005). The conclusions related to privacy issues for young Black MSM/GBT are consistent

with the preliminary focus group findings described in Chapter 6 which stressed the need for client confidentiality in HIV testing and care (Fisher-Borne et al., in press).

Finally, focus group feedback specific to the DIS interview process demonstrates the need for DIS to clarify their role as well as the rights of their clients related to state reporting and control measures. It is critical to change the behavior that caused clients to perceive the DIS interview process as punitive, overly invasive, or as a necessary prerequisite to clinical care. This assessment of DIS encounters provides an important perspective on the DIS relationship and underscores the importance of establishing a trusting and transparent dynamic between health care providers and clients (Martinez, 2005). Ensuring health care providers are seen as collaborators is particularly critical when working with Black MSM, who because of their race may feel additionally alienated from healthcare systems (Wheeler, 2005).

Limitations associated with Aim I. The data from the focus groups, though insightful, are of limited generalizability given the narrow selection criteria, small sample size, method of recruitment, and location. However, due to the stigma surrounding HIV and sexuality, the sample size of 11 participants is significant in incorporating young Black MSM voices into the development of this intervention.

Aim II: Design and implement a cultural competency training tailored to DIS

The overall goal of the training was to improve health care providers' knowledge, attitudes, awareness and skills in working with MSM/GBT clients. The participatory design and implementation phase of the cultural competency intervention study provides a unique contribution to the cultural competency intervention literature. Specifically, there were three

primary strategies associated with this study aim that demonstrate a distinctive approach to cultural competency training and education.

Collaborative approach to training development. A major strength of the curriculum development process was the collaborative partnership with the NC HIV/STD Prevention and Care Branch, DIS, Project STYLE staff, and leaders from community-based organizations that serve HIV-positive MSM clients. Initially, key issues important in the development of skills in working with GBT/MSM were discussed. Over the course of a year and a half, case studies, sample activities, data from a DIS training needs assessment, and information gathered during field visits with DIS were used to clarify and tailor the training content. In tandem with planning with the study's advisory group, the needs and perspectives of young Black MSM were critical to the training design. Too often, training curricula are developed with only cursory input from potential participants, much less the communities impacted by these interventions (Hancock & Minkler, 1999). Time for relationship building and understanding the priorities of the HIV/STD Prevention and Care Branch were key to the collaborative planning process.

Conceptual framework and approach that challenges privilege and social discrimination. Many existing cultural competency models focus primarily on "exposing" providers to different (i.e., non-dominant) cultural groups. These frameworks often fail to explore ways in which cultural values and structural forces shape not only client experiences and opportunities but also providers' capacity for care (Duffy, 2001; Tervalon & Murray-Garcia, 1998; Wear, 2003). In this respect, the study's curriculum offers a unique contribution to the literature with an explicit inclusion of content around privilege and understanding social forces that impact the lives of LGBT people. For example, one activity

allowed participants to explore ideas and assumptions about LGBT people and how these assumptions have a concrete impact on their clients' lives and on providers' ability to initiate and maintain care. From this activity DIS were able to explore how LGBT identity itself is not a health risk, but rather the risk comes from "living in a homophobic society" (Kelley et al., 2008, p. 252). By including specific content and processes to address social stigma and discrimination and doing so in the context of a well-developed conceptual framework, the intervention accounts for current critiques related to approaches that may reinforce harmful stereotypes and superficiality (Gregg & Saha, 2006; Kumas-Tan et al., 2007).

Cultural competency content specific to Black MSM/GBT. Of the few cultural competency education studies that intentionally include sexual orientation as part of the curriculum, none appear to include content on the unique needs and experiences of LGBT people of color (Martinez, 2005). As such, a final contribution related to the training curriculum involves the purposeful development and use of training materials, activities, and discussion prompts specific to understanding issues for this population. From addressing common misperceptions about HIV rates among Black MSM such as the notion of the "down low," to discussing the role religion plays in understanding GBT identity in the African American communities, the curriculum emphasized challenges and experiences linking sexuality and racial identity.

Limitations associated with Aim II. A number of challenges related to the training curriculum became apparent during the implementation phase of the study. Becker and colleagues describe challenges associated with developing successful community health partnerships. In particular, obstacles related to varied "priorities, assumptions, and values" were among the critical issues faced in the development of this training (Becker, Israel, &

Allen, 2005, p. 53). An assumption made by Project STYLE staff was that the DIS representatives participating in the advisory group were representative of the rest of the DIS population. During the training, however, it became apparent that many DIS were not supportive of the training or of cultural competency but instead viewed the training as punitive and unnecessary. Field visits by Project STYLE staff in each DIS region may have secured more buy-in from participants. In addition to the issue of buy-in, when the training failed to "fix things" (i.e. homophobic attitudes on the part of DIS) the administration seemed to view this as a deficit on the part of the facilitators and training and not necessarily a reflection of a larger organizational or societal problem.

Aim III. Evaluate the Outcomes of Training in Improving Providers' Cultural Competency Regarding Interactions with MSM/GBT Clients of Color

The present findings indicate that a short-term (16 hours) training aimed at improving DIS cultural competency with MSM/GBT clients did have a measurable impact on participants' knowledge of LGBT-related issues. Other studies have noted similar positive training effects related to cultural competency knowledge outcomes (Beach et al., 2005; Brathwaite & Majumdar, 2006; Culhane-Pera et al., 1997). Findings indicated that the level of reported knowledge increased immediately after the training and was sustained at 3 months. Statements related to knowledge of transgender clients, clients of color, and social discrimination these groups face showed particular improvement. This finding is promising given the overall goal of the intervention to address skills related to working with MSM/GBT clients.

Despite specifically targeted training sections addressing attitudes, awareness, and skills, the study failed to demonstrate any improvement among subjects for these measures.

The lack of a statistically significant effect of the training related to attitudes, awareness, and skills is not surprising. Participants reported relatively high levels of acceptance and skills in working with LGBT clients at the beginning of the training. Bennett (1993) provides one possible explanation for this finding suggesting that higher scores may be due to the tendency to overestimate competence when self-reporting cultural skills.

Though there was no demonstrated significance between pre- and post-training scores, the responses to the attitudes/awareness and skills subscales are revealing. For example, the majority of DIS neither agreed nor disagreed with the statement, "Being gay, lesbian, bisexual, or transgender is a choice." Similarly, the majority of DIS neither agreed nor disagreed with the statement, "People in my work environment confront negative stereotypes related to sexual orientation." The absence of change in these statements over time may be related to a desire to appear "neutral" on the issues or a recognition that certain responses are more socially desirable (Hyde & Ruth, 2002) than others. Field notes taken during the training indicate participants' concerns related to the anonymity of survey responses.

The issue of "choice" regarding sexuality warrants a deeper analysis. During the training, questions related to a biological explanation of homosexuality were frequent. Participants' challenged panelists about choosing "this lifestyle" and repeatedly asked the facilitators to explain "why" people were gay. These qualitative findings are interesting in light of a growing body of literature suggesting a positive correlation between heterosexuals' belief in the *choice* in being LGBT and levels of homophobia (Blackwell, 2008; Herek, 2000). Though survey data suggested open and affirming attitudes towards LGBT people, the qualitative findings reveal a more complicated reality and support previous research

indicating that negative attitudes toward LGBT people exist among health care providers (Burch, 2008; Stevens, 1998).

A number of activities were designed to challenge participants' negative attitudes specific to Black MSM/GBT clients. Qualitative data from the fidelity measure and field notes revealed many DIS had a conceptualization of the "down low" that was contrary to research data (CDC, 2007; Ford et al., 2007; Millett & Peterson, 2007). For example, in a values clarification activity that asked participants to respond to the statement, "Men on the 'down low' are a big problem in the Black community," an overwhelming majority of participants either agreed or strongly agreed with the statement. When HIV surveillance data that contradicted this view were shared with the participants, many were skeptical and determined to blame Black MSM for HIV among African American women. Multiple studies find Black men who have sex with men and women actually have fewer partners and report lower rates of anal intercourse than Black men who have sex exclusively with men (Diaz et al., 1993; Malebranche, 2003; Millett & Peterson, 2007). Therefore, the fact that DIS attribute rising HIV rates to "down low" men despite the lack of research to support this belief demonstrates an urgent need to confront negative messages and misinformation about Black MSM among health care providers.

Finally, the MIS/STD data provided by the state reinforced the survey results and provided no clear evidence that the training improved outcomes related to DIS client interactions. The MIS/STD data tracks the number of MSM contacts and partner information gathered by DIS in the interview process. Based on the data before, during, and after the training intervention period (February 2007-July 2007), there was no apparent effect on the participants' ability to identify MSM clients or elicit information about sexual partners in any

of the DIS regions. While these finding are disappointing, they are consistent with other studies that have found little evidence of provider behavior change based on cultural competency training (Thom et al., 2006).

Limitations associated with Aim III. There are several important limitations associated with this aim of the study. First, the overall efficacy of the intervention is moderate, given the statistical significance of only the knowledge subscale of the survey and the lack of demonstrable changes in providers' attitudes, awareness, and skills. Failure to obtain statistical significance may have resulted from a lack of statistical power for these subscales. Second, though it comprises 93% of the entire population of DIS in North Carolina, the overall study sample is relatively small (n=54). Though attrition accounted for only a 5% loss of survey data, printing error and participant error reduced the number of valid responses considerably. Additionally, related to the sample, there was sufficient power for the knowledge subscale but subscales related to attitudes/awareness and skills were low due to the high levels of DIS self-report of attitudes/awareness and skills at baseline.

Third, the survey instrument itself presents possible limitations. As the survey relied on provider self-report, social desirability poses a potential threat. The survey instrument was not psychometrically tested and therefore its reliability and validity are also unknown. The time intervals of 3 months between the administration of the baseline survey and the final follow-up were selected to minimize testing effects yet a longer time period between the intervention and post-test may have made the study more robust. Finally, this study was conducted in partnership with a state agency that required all DIS to participate in the training. While ideally the study design could have included a comparison group, resources, time constraints, and the already small DIS population (N=57) made this impossible.

Relationship of Results to Conceptual Framework

In the Campinha-Bacote model of cultural competency, cultural desire is defined as the motivation that makes providers *want* to "engage in the process of becoming culturally competent" vs. *having* to engage in the process (Campinha-Bacote, 2008, p. 142). Of the constructs identified within this conceptual framework, cultural desire is seen as a "foundational and pivotal construct of cultural competence" (Campinha-Bacote, 2008, p. 142). Within the context of this study it was impossible to determine the level of desire or willingness on the part of participants given the mandatory nature of the training. Further, if providers do not acknowledge the need for such training, positive behavioral change is not likely to be detected.

Another important finding related to the conceptual model involves the notion of cultural humility which Campinha-Bacote integrates into her construct of cultural desire. Cultural humility signifies a need on the part of providers for self-reflection, exploration of personal prejudices about minority groups, and a willingness to address power imbalances in the client/provider relationship. Qualitative data from the training field notes revealed a lack of willingness to engage on this level in the context of the training intervention. A number of participants commented they were only concerned with "sexual behavior" and that a person's sexual orientation was "private." Further field notes revealed a general belief among DIS that being objective and "professional" was the ultimate goal and required no level of self-scrutiny. In this light, a side effect of the content which asked providers to acknowledge, unpack, and critique social discrimination as it related to their own work may have been the resistance and anger some participants communicated in the training.

Practice Implications

This study was designed to extend previous research on cultural competency educational interventions by developing a cultural competency training intervention focusing on the needs and issues of MSM/GBT populations. Findings from the study have important implications for practice. Most importantly, the intervention highlights the need for a more systematic organization-wide approach in order to meet the needs of MSM/GBT clients. This will involve moving beyond one-time training opportunities and require a multi-pronged approach with provider education and training serving as one component of a larger structural approach.

There are a number of important recommendations related to organizational level efforts to ensure cultural competency among providers. Prior to hiring, potential providers should be screened more carefully for attitudes and beliefs that may make it difficult to adequately serve MSM clients. This may entail the creation of specific assessment tools to uncover hidden hostility or aversion to MSM/GBT clients. Forms and protocols used during client interviews should be continuously updated to ensure they reflect language that is appropriate with this population. For example, asking clients if they engage in “homosexual sex” is inappropriate. Ensuring that interview scripts and forms help providers utilize more accurate language is essential. Related to this, providers’ competence in the field with clients must be assessed through ongoing supervisory field visits that occur for new DIS as well as existing staff.

In addition, the HIV/STD Prevention and Care Branch specifically could incorporate ways for clients to offer feedback in a systematic way regarding their experiences with DIS. This is of particular importance with providers who demonstrate a low number of MSM

clients and challenges with eliciting partner information. Results from this study suggest that future cultural competency training efforts could target these issues directly. This would involve more direct and time intensive training for supervisors to help them address organizational issues in a more systematic way. For example, providing support to supervisors to help them coach their own staff around issues of cultural competency versus training DIS directly may have proved a more sustainable approach than having outside trainers (i.e., Project STYLE staff) deliver the training to DIS. Further, cultural competency content should be a mandatory part of orientation for new providers and embedded in staff training at all levels.

Larger questions related to the role of DIS also need to be addressed. Currently DIS primarily serve a surveillance or investigative role, have limited contact with clients, and are evaluated based on the number of client interviews instead of the quality of connection with clients. If the goal is to reduce HIV rates, a structural shift in the HIV/STD Care Branch's approach to prevention is imperative. Public Health prevention and intervention efforts must account for quality of care issues for clients. As "first responders" to HIV in North Carolina, DIS must have an increased role in linking clients to health care and be seen as collaborators in the process of care. The current role of DIS does not adequately include this critical component. Evaluation and reward structures on an agency level should mandate more comprehensive and client-centered approaches to HIV care.

In addition to the organizational context, the larger social and political environment must be taken into account when exploring cultural competence with LGBT populations. For example, while sodomy laws were deemed unconstitutional in 2003, they are still often used to criminalize homosexuality; sodomy remains a felony in North Carolina. LGBT individuals

are not protected under employee nondiscrimination laws and no state or federal guidelines exist to recognize same-gender relationships. In this context, even the most "culturally competent" approach still fails to remove the very real social, political, and financial barriers faced by the client population served by DIS.

Recommendations for Future Research

Critical reflection is not only the jurisdiction of practice but of research as well. Findings from this study raise concerns about the evaluation of cultural competency education and training interventions. A principal concern relates to measurement. Standardized measures create predetermined categories related to culture which may not be appropriate in all contexts. There is a need to create more flexible measures to allow room for individual definitions of cultural competency that do not homogenize groups or reinforce a monolithic view of culture. Also needed is a macro-level measurement tool. Though the literature offers measures specific to providers, there are few organizational-level measures related to cultural competency.

Conceptually, cultural competency must move from helping providers understand the cultures of "the other" to a critical exploration of power and privilege. According to the NASW Code of Ethics, the field of social work is geared toward prioritizing the needs of the most vulnerable and oppressed. This means accounting for the systemic forces that drive the health disparities we seek to address with our intervention strategies. Cultural humility is a promising construct to support this goal as it provides deeper personal accountability in the provider-client dynamic and accounts for structural inequalities. Future interventions should explore measurement and design issues relevant to cultural humility.

Although numerous studies have provided evidence that cultural competency trainings positively affect providers' knowledge, attitudes, and behaviors in interactions with racial or ethnic minorities (Beach et. al, 2005; Crandall et al., 2003; Majumdar et al., 2004; Smith, 2001), future studies should explicitly include sexual orientation, gender identity and the dual burden of racial and sexual minority status as they relate to health *outcomes* for minority clients. In addition to accounting for multiple layers of oppression within the context of provider education, research is needed to understand how this education relates to client outcomes. At present, empirical explanations demonstrate insufficient methodological rigor to support long-term conclusions regarding the efficacy of cultural competency on the health outcomes of patients (Beach et al., 2005; Price et al., 2005).

Conclusion

> Common indeed are the ethnographies in which poverty and inequality, the end result of a long process of impoverishment, are reduced to a form of cultural difference. We were sent to the field to look for different cultures. We saw oppression; it looked, well, *different* from our comfortable lives in the university; and so we called it "culture." We came, we saw, we misdiagnosed.
>
> Farmer, 1999, p. 7

The misdiagnosis of oppression and the failure to account for the broader social and political forces in the development of HIV interventions is no longer viable. As we seek to actively address the challenges of health disparities in the United States, we must realize that there is no singular solution to remedy the problem. Despite research challenges, cultural competency as it relates to client-provider interaction is one promising strategy to address barriers to care among marginalized populations. However, this strategy must be employed along with other structural approaches to HIV prevention which reduce HIV stigma, lessen homophobia, and address racism (Beatty et al., 2004; Fullilove, Green, & Fullilove, 2000).

This will mean challenging the basic definitions of culture and competency in order to appropriately address the historic, political, and economic context in which inequalities exist.

Appendix A

CLAS Standards

Culturally Competent Care

1. Health care organizations should ensure that clients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to clients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competency of language assistance provided to limited English proficient clients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client/ consumer).
7. Health care organizations must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competency

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competency-related measures into their internal audits, performance improvement programs, client satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual client's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing and implementing CLAS related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

US DHHS Office of Minority Affairs

Appendix B

Review of Studies of Cultural Competency Educational Interventions

Author(s)	Sample	Study Design	Measures	Findings
Crandall (2003)	Medical students (n = 12)	Single group pretest-posttest design Yearlong cultural competency course consisting of 20 three-hour sessions	Multicultural Assessment Questionnaire (MAQ)	Evidence that knowledge, skills, and attitudes were positively changed (p = .000)
Williams (2005)	Social workers in mental health care setting (n= 47)	Pretest-posttest nonequivalent comparison groups	Multicultural Counseling Inventory	No difference between groups; differences detected within intervention group from pretest to posttest measure
Thom, Tirado, Woon, & McBride (2006)	Primary care physicians (n = 53) from 4 practice sites Clients with diabetes and/or hypertension (n = 429)	Randomized control trial with two practice sites receiving "training + feedback" and 2 sites receiving "feedback only" (control) Physician intervention group (3 sessions, 12 hours total)	Client Reported Physician Cultural Competency (PRPCC) Scale at baseline, three months, and six months	No measurable impact of 4.5-hour training on client outcomes at three or six months
Braithwaite & Majumdar (2006)	Public health nurses (n = 76)	One-group repeated measure design Five-week cultural competency training with one-month booster session	Cultural Knowledge Scale	Increase in cultural knowledge ($p < .01$)
Majumdar, Browne, Roberts & Carpio (2004)	Healthcare providers, nurses and homecare workers (n = 114) Clients from 2 community agencies and 1 hospital (n = 133)	Randomized control trial	Providers: Cultural Awareness Questionnaire and Dogmatism Scale Clients: Off-Axis-Ratio (OAR) Multidimensional Measure of Functional Capacity, the Client Satisfaction Questionnaire, the Physical and Mental Health Assessment Questionnaire, and the Health and Social Service Utilization Questionnaire	Providers: Training resulted in increased cultural awareness Clients: Improvement in utilizing social resources and functional capacity (p =.003); no improvement related to "client satisfaction."
Scout, Bradford& Fields (2001)	Healthcare Providers (n = 278)	Single group pretest posttest design	Providers: Self-designed questionnaire testing knowledge, attitudes, and behavior related to working with lesbian clients	Outcome evaluations indicated significant changes in providers' knowledge, attitudes, and behaviors at 3-month post test ($p<.001$)

Appendix C

Focus Group Interview Guide

Purpose of the Project and of the Focus Group

Project STYLE (Strength Through Youth Living Empowered) focuses on black men's health issues on college campuses and is a collaboration between healthcare providers at UNC and within the larger community. One of the reasons for the project is a disproportionate number of STDs and HIV on college campuses and health disparities among African American men.

The purpose of this focus group is to get your perspectives on the ways that black men access and respond to information about sexual health and wellness

Informed consent and confidentiality

As you came in, each of you were given a copy of our information sheet outlining your rights as participants in university-sponsored research. It says, among other things, that you have a right to decline to participate, and if you decide to participate you still have the right to answer only those questions you wish to answer. Although we are interested in what you have to say, you must be the judge of what you are comfortable talking about so I want you to feel comfortable to say "pass" at any time.

The document tells you that we will be recording the session today on audiotape. We will not publish anything said here in a way that can be directly connected to the individual who said it. We will also ask you to respect each other's privacy, but we cannot guarantee the discretion of your fellow participants. There will be no negative consequences for not participating, and you will each get a $30 gift card from Target at the end of the session tonight for participating. Has everyone had a chance to read the form? Are there any questions about it?

(Primary Investigator): Also if you have any questions at any time about what's happening tonight, my name and my phone number is on the consent form. You can call at any time.

Group Norms

We want to acknowledge that some of the questions we will be asking may feel personal. Conversations about sexuality and sexual health can be difficult sometimes. Because we really want to know how to make talking about these issues easier on college campuses, we need to create a space where everyone feels safe to share. We ask that on the name cards provided you use only first names. We don't even care if you make up names as long as you talk. We really want to know what you think and have the space to say what you want to say. There are no "right" answers and no one has to agree. Just to make sure we are all on the same page for the conversation, we have included some ground rules for the conversation tonight.*(Read and post at the front of room).* Does anyone have anything they want to add or change about the ground rules?

Focus Group Questions

Theme: Hopes

1. Describe some of your hopes for the future in terms of:
   Family
   Relationships
   Work/Career

2. What are some things that can help you to achieve your goals in terms of:
   Family
   Relationships
   Work/Career

3. What are some of the barriers or things that make it difficult to achieve your goals in terms of:
   Family
   Relationships
   Work/Career

Theme: Sexual Health Information and Practices

1. What would you tell your son or a younger male relative about being sexually healthy? What would you want him to know? What information and resources would you want him to have?

2. What specific information would you want him to know about HIV/STIs?

3. What specific information would you want him to know about HIV testing?

4. What specific information would you want him to know about safer sex?

5. What kinds of risk reduction messages would resonate with you and your friends?

6. What would motivate you to use condoms more often?

7. What would motivate you to disclose your HIV status to your partners?* (HIV+ group only)

Theme: Experiences with DIS

1. Describe your experience with Disease Intervention Specialist and HIV notification. How did it go? *(Prompt: DIS are the individuals who meet with you to discuss state control measures and discuss partner notification.)* Was communication respectful? Sensitive?)
2. Did you understand why the DIS visited you? Was their purpose clear? Please explain.
3. Did you feel that DIS were affirming of your sexuality? Please describe.
4. What specific education and training would you recommend for DIS to better understand the needs of MSM? Why?
5. If you were to provide education and training to help DIS support MSM what would you include?
6. Is there anything else we should know related to your experience with the DIS?

Theme: Health Care Providers

1. What are the most effective ways for providers reach MSM/gay/bisexual people?
2. What are the most effective ways for providers to support MSM/gay/bisexual people?

Theme: Obtaining Health Information—Online

1. Where do you look to find information about sexual health? *(Probe: If internet comes up as a theme: What sites do you use?)*
2. What are some of the things that you like about these websites?
3. What would make you revisit a website on a regular basis?
4. What are some things that would make you NOT want to come back to a website on a regular basis?

Theme: Website-Specific Questions

1. What comes to mind when you look at this screen?
2. What do you like about this screen?
3. What would you change about this screen?

Closing

1. What else do we need to know about reaching black men who have sex with other men?

Appendix D

DIS Training Needs Assessment Results

(n=50)
Fall 2006

1. Describe your previous experience in working with Lesbian, Gay, Bisexual, or Transgender (LGBT) people.

- From 0-15 years experience
- "Live It"
- Have family members who are gay, died of AIDS

2. In your experience, what have been the major challenges in providing for people that identify as LGBT?

- Obtaining partner information (n=10)
- Trust issues (n=5)
    - Perceptions that we are sex police and there to judge them
    - Overcoming the idea they will be judged if truthful
    - Distrust of government
    - Population is more open when they feel they are not being judged
- Rude and non-compliant behaviors
    - Cavalier attitude that "I don't need your help—I'll do what I want to do—someone gave me this"
    - Friends have experience with DIS and new clients are already defensive
    - Very untruthful—saying and giving information that people feel you want to hear
- Confidentiality (n=5)
    - The fear of confidentiality being broken
- Not identifying as gay
- Not admitting sexual practices
- They feel attacked
- No good local LGBT resources (Greenville)
- Physical contact
    - Get physical with you—touching
- White MSM not familiar with the law, HIV knowledgeable and refuses disclosure of partners because they "don't have to talk to DIS"
- Working on facial expressions when LGBT describe sexual acts
- Working with transgender patient—ask questions about their lifestyle whether they are full on transgender or identifying as the opposite sex
- Gay people are hard to work with

3. How do you feel your professional community is currently providing for LGBT clients?

- Mixed review
    - Sometimes successful, sometimes not
    - Room for improvement
- 10%-85%
- Very if open and non-judgmental
- Successful except with LGBT clients whose doctors say they don't have to talk to DIS

- Success varies, at times LGBT clients are very hard to reach and don't want to be worked with
- Some DIS have a comfortability issue with dealing with LGBTNeed training
- Not many gay DIS
- Judgmental, uses authority to "flash badge" and get entry

4. Have there been any specific situations involving LGBT clients (or dealing with homophobia) that you have experienced that you would like to see addressed in the training?

- General insensitivity for LGBT persons—pervasive in society but detrimental to DIS work
- Professional, upper class MSM—once you say something right they open up
- Best words to convince a person that is unlike you (LGBT) that you do not judge them
- Basic fear of being in a room one on one with MSM. How to overcome and be non-judgmental
- How heterosexual people should approach homosexuals
- How homosexuals feel they should be approached
- Assertiveness that doesn't offend clients
- Getting people to understand that just because someone is gay doesn't mean they want to have sex with you
- Relaying the state policy before they shut the door in our face
- Staff show body language that they are nervous or judgmental
- Being afraid to ask questions about sexual behavior
- How to respond when someone comes on to you

5. How do your personal beliefs inform or impact your understanding of LGBT people?

- People are people
- I tell them they are people and not a lifestyle
- They choose what they want their lifestyles to be, I cannot judge
- Family member is MSM
- My personal beliefs sometimes conflict, but do not get in the way of my job
- Place no judgment—he who is w/o sin cast the first stone
- Lesbian myself, so no problems
- Speaking with them helps me understand LGBT people
- Address the problem before you can help the person
- My faith has taught me not to judge people—accept them as they are.
- To each their own
- My personal beliefs don't affect my understanding b/c everyone has the right to make their own decisions
- Open which means I can communicate and address concerns and needs of all clients I serve
- Very much so. Very religious. You should live and work with illness to the best of your ability because god doesn't make mistakes
- Very conservative and don't know many people like this
- I am very open about my support for LGBT population

6. Who are the most challenging clients/cases you interview and what resources would help you better support and interact with these individuals?

- MSM (n=15)
- Gay, white males who are educated and know they can refuse to talk
- MSM not "out" especially Black/Hispanic
- DL brothers (n=3)
  - Black and Hispanic
- White MSM (n=10)
  - Middle to upper class, not concerned with well-being of partners
- Young HIV +--feel invincible or the obstacles they face while trying to be "normal"
- People who have been diagnosed with HIV for many years and just been reported
- Gay white and black males who are educated and appear to believe that our services and help would be better suited for poor
- People with low SES
- Previous positive, CMV's
- Dual infected people who are constantly being named for new infection
- Understanding why they keep getting infected
- Married +'s with male and female partners
- Gay males who know about DIS

7. Anything else we should know?

- Bring Project STYLE to the East
- How do you address anything without faith? It is important for Black people. It is our foundation and where we have come from. It is what we stand on in hard situations. It is all we know
- More training initiatives should be put in place to be more sensitive to issues of sexuality.
- Politics and economics play major role.
- Better support from health directors
- What words, things, actions to avoid
- What specific experiences have HIV+ men had that created boundaries
- PMD need to be educated that DIS is there to helps
- What resources would be helpful
- More faith-based initiatives
- Web resources for contacting and sharing information
- Make it interactive and specific to DIS. Provide real experiences of how MSM is affected by a few uncompassionate DIS
- You must have a leveling exercise to attempt to place trainees in the situation of a disenfranchised population.
- Medical providers not telling about DIS
- DIS should be confronted and held accountable for not bringing religious beliefs into work.
- Best ways to approach white males and partner notification issues
- Should have panel with HIV+ men
- Clients involved with training

Appendix E

Disease Intervention Specialist Training
Tools for Working with Lesbian, Gay, Bisexual, and Transgender Clients
Dates: May 3-4 and May 10-11 2007
TRAINING OUTLINE

Training Day One:

TIME	*OBJECTIVE/ OUTCOME*	THEORY	CONTENT/ACTIVITY	FACILITATOR
7:30-8:30	**Arrival and space set-up**		Participants arrive, packets distributed, nametags, informal introductions	**Team**
8:30-9:00	**SURVEY**		Distribute survey, discuss informed consent and rationale for survey, **have all participants contribute question/issue to question box**	**Marcie**
9:00-9:45	**Setting the stage, reviewing norms and expectations, getting participant voices in the room, establishing training culture**	**Cultural Desire**	(5) Welcome and Introduction of facilitators	**Marcie** **Justin**
			(5) Goals/Training Approach/Assumptions/Agenda/Your needs *(reference assessment forms)* (5) Housekeeping • *Resources* • *Asking questions* • *Bathroom/breaks* (15) Group Go-around—Name/*Hopes/Hesitations* *What is it that brings you to this work? On a scale of 1-5, 5 being "ELATED" to be at the training, and 1 being, "I'd rather be anywhere else," how would you rank yourself?*	**Marcie**
		Cultural Desire	(10) Set Tone including encouraging honest dialogue— "First Thoughts" activity: <u>Diversity and Diversity Training</u> (10) *Office Clip* Norms/Group Process Agreements	**Justin**

TIME	OBJECTIVE/ OUTCOME	THEORY	CONTENT/ACTIVITY	Facilitator
9:45-10:30	**AWARENESS** • **Address underlying ideas about LGBT identity in a safe, non-threatening way** • **Get participants moving and talking about their personal ideas/experiences** • **Encourage thinking "outside the box" by hearing different points of view**	**Awareness—personal assumptions and values, social discrimin-ation**	Assumptions and Beliefs Activity: "Four Corners" (5) Form—individuals fill out and facilitators redistribute (7) Question one (7) Question two (7) Question three (15) Process—large group	**Justin**
10:30-10:45	**BREAK**			
10:45-11:30	**Addressing stereotypes, assumptions about LGBT people**	**Knowledge—socio-political forces that affect LGBT people**	**<u>"Cafe" Activity—(group by color dots)</u>** (5) Introduce Activity *(7) If you had to explain to someone THAT DID NOT anything about lesbian/gay/bisexual/transgender people using <u>ONLY messages from mainstream society and the media</u>, what would you say/describe* *(7) How might these ideas affect LGBT people (think about your work and personal environment)?* *(7) What does this reality mean for you and your work with LGBT clients? (supervising staff?* *(15) Process*	**Marcie**
11:30—11:45	**Addressing Heterosexual privilege**	**Awareness**	Buddy activity—practice interview Read List individually. Pick three questions and ask buddy.	
11:45-12:00	**Lunch Homework Explanation—"Disclosing Your Sexual Orientation"—** *Participants are asked to <u>brainstorm ways they communicate their sexual orientation/heterosexuality on a daily basis.</u> Based on this list, they are then invited to "abstain" from communicating any information that may reveal their orientation while at lunch.*			**Justin** (newsprint)

TIME	*OBJECTIVE/ OUTCOME*	THEORY	CONTENT/ACTIVITY	FACILITATOR
12:00-1:10	**Lunch**			
1:10—1:20	• **Opportunity for participants to process the "homework" and find out how it went** • **Address Heterosexism** • **Address new questions that have arisen**	**Awareness--Privilege**	Reflection on "homework" Have participants look at resource guide Address new questions that may have arisen in a.m. or over lunch. **(place in box for anonymity)**	**Justin and Marcie**
1:20-2:15	• **Awareness—personal experiences with belonging and difference**	**Awareness--Personal identities and experiences of discriminatio n**	5) Brainstorm—Groups/Identities we belong to: 10) Paired sharing (buddy) on STORY communities/belonging and group report back 5) *What stands out for you about the stories you heard?* *What were some of the identities you heard?* 5) Break into 4 groups (represented by at least two people) 10) *What are some things you want people to never say, think, or do to this group?* 15) Report Back/Group Process	**Marcie**
2:15-2:45	**Knowledge and Awareness** **Address language and ideas concerning LGBT people that exist in our culture** • **Address how this backdrop effects the LGBT population** • **Identify "in" and "out" language in reaching LGBT individuals** • **Distinguish "identity" and "orientation from "behavior"** • **Discuss the continuum of sexual orientation and gender**	**Knowledge**	*Why do we talk about language? How does this relate to your work as a DIS?* Brainstorm "In" and "Out" language Explain continuum of sexual orientation and gender identity	**Marcie**
2:45-2:55	**BREAK**			

TIME	*OBJECTIVE/ OUTCOME*	THEORY	CONTENT/ACTIVITY	FACILITATOR
2:55-3:40	**<u>Knowledge</u>** • **Introduce STYLE** • **Debunking DL** • **Address specific messages (or lack of) supportive of BMSM**	**Knowledge—Intersecting Identities**	STYLE project—What is it? Myths and Messages about "Down Low" (What is DL?) Myths and Messages about Black men: What we know about MSM population in North Carolina Unique issues for LGBT of color	**Justin**
3:40-3:45	**<u>ENERGIZER</u>-**Quick energizer here			
3:45-4:30	**<u>Practice Real Challenges/Scenarios</u>** • **Opportunity to utilize language and awareness activities from the day with real situations—set tone for role plays on day two**	**Skills**	(15) Small group case studies/scenarios (20) Report back to large group	**Justin and Marcie**
4:30-4:50	• **Address questions from the day that may not have been touched on yet**		Question box—review any questions that may have been identified/written through the day, ask if there are additional questions/issues that need to be addressed in the next day's training	**Marcie**
	• **What has been good about the day/What were some of the minuses** • **Trainers address how these will be dealt with in the following days training and review basic agenda**		Pluses and Minus	**Justin**
4:50-5:00	• **Wrap up key points, ask for additional comments or questions**		Closing and Homework: See Power Point—come prepared to discuss!	

Training Day Two:

TIME	*OBJECTIVE/ OUTCOME*	THEORY	CONTENT/ACTIVITY	FACILITATOR
8:30-9:00	**Regroup, and Warm-Up Activity**	**Knowledge--Gender**	(10) Regroup—review agenda and lessons learned from previous day's training (+'s and –'s) (20) Activity: Speed Dating/Cocktail Mingle on Homework 1) one lesson you learned about gender growing up 2) one thing you saw, heard, experienced related to the homework	**Marcie and Justin**
9:00-10:15	**KNOWLEDGE: Provide an opportunity for providers to hear the experiences of LGBT clients and ask questions**	**Knowledge and Awareness**	Panel of LGBT individuals: (30) Panelist stories (30) questions	**Marcie**
10:15-10:30	**Break**			
10:30-11:30	**Knowledge and Awareness: Faith/Sexuality/Black Community** **Opportunity for providers to discuss role of faith communities in supporting/not supporting LGBT people**	**Knowledge and Awareness—Intersecting Identities**	(10) Intro on topic (30) Film: All God's Children (30) Discussion (small groups)	**Justin**
11:30-12:10	**Interview Skills Practice—Review and Role plays**	**Skills**	Fishbowl Activity, Justin and I, then volunteer, and then in pairs (4 role plays)	**Marcie and Justin**
12:10-12:15	**Lunch Homework**	**Awareness and Skills**	Gender continued: Refrain from using gender pronouns (he/she) in your lunch conversations—might need to brainstorm how this can work	
12:15-1:20	**LUNCH BREAK**			

TIME	*OBJECTIVE/ OUTCOME*	THEORY	CONTENT/ACTIVITY	FACILITATOR
1:20-1:30	**Review Lunch Homework**			**Justin**
1:30-2:30	**Skills Section Continued:** **Role Plays**	**Skills**	Roving facilitator with difficult client scenario from before lunch: Group role plays (include resources)	**Justin**
2:30-3:15	**Next Steps/Action Plan:** **Begin individually** **Small groups by REGION** **Report out**	**Skills**	What change can you make in your practice? What systems/structures need to be examined? How will that work happen? Who needs to be a part of that conversation and the work? How do you keep the conversation/change happening?	**Marcie**
3:15-3:30	**Personal Assessment/ SURVEY**		(15) SURVEY	**Marcie**
3:30--4:00	**Closing and Evaluation** **And Resource Review**		(15) Resource Review—how to use, how to contact us at STYLE	**Marcie**
			(15) Process Evaluation and Go-around (commitments)	**Justin**
4:00	**Adjourn**			

Appendix F

TRAINING ASSESSMENT

HIV/STD DIVISION DISEASE INTERVENTION SPECIALISTS

BASELINE SURVEY

Conducted by

Project STYLE
Stylenc.org
Department of Infectious Disease
UNC-CH School of Medicine

ABOUT THIS SURVEY

This questionnaire is designed to explore the ideas, beliefs, and learning needs of health care providers regarding gay, lesbian, bisexual, and transgender (LGBT) clients. In addition, your feedback will help determine the effectiveness of this training.

Please answer all questions as honestly as possible. **This is NOT a test, and there are NO RIGHT OR WRONG ANSWERS.** The information you share will be kept confidential and will not be shared with anyone or connected to your DIS region. PLEASE DO NOT PUT YOUR NAME ON THIS QUESTIONNARE.

For the sake of brevity, LGBT is used as an abbreviation for lesbian, gay, bisexual, and transgender people in this survey.

If you have any questions, please contact Marcie Fisher-Borne at 919-962-6480 or our STYLE Project Coordinator, Justin Smith at 919-843-4722

Demographic Information

1. **Date of Birth**
   ____/____/_____
   month day year

2. **Gender**_____

3. **Race/Ethnicity** _____

4. **Sexual Orientation/Identity**_____

5. **Which of the following best describes the highest level of education completed?**

   High School Graduate..... ☐ 1

   Some College ..... ☐ 2

   College Graduate..... ☐ 3

   Graduate Degree ..... ☐ 4

   Please specify Graduate Degree:
   _____

6. How long have you worked as a DIS in North Carolina?

Less than 6 months ..... ☐ 1

7 months to one year ..... ☐ 2

2-3 years..... ☐ 3

4-6 years..... ☐ 4

7-10 years..... ☐ 5

More than 10 years (Please specify the number of years: ____)

7. Date of Training
____/____/_____
month day year

SECTION TWO

8. In your estimation, what is the percentage of lesbian, gay, bisexual or transgender clients that your agency has served in the past year?

0-1% ..... ☐ 1

2-15% ..... ☐ 2

16-50% ..... ☐ 3

51-80% ..... ☐ 4

9. Personally, what is the percentage of lesbian, gay, bisexual, or transgender clients (LGBT) you have served in the past month?

0-1% ..... ☐ 1

2-15% ..... ☐ 2

16-50% ..... ☐ 3

51-80% ..... ☐ 4

10. Have you received any specialized training related to working with LGBT people?

Yes..... ☐ 1 → **See Below**

No ..... ☐ 2

Please describe the training.

_____

11. Do you have <u>at least one</u> LGBT friend or family member you are close to?

Yes..... ☐ 1

No ..... ☐ 2

No LGBT friends or family..... ☐ 3

SECTION THREE

For this section, please indicate by circling the box/number that reflects the level of knowledge *you have for each statement.*

How would you rate your knowledge of:	**No Knowledge**		**Knowledgeable**		**Very Knowledgeable**
	1	**2**	**3**	**4**	**5**
What "sexual orientation/identity" means	**1**	**2**	**3**	**4**	**5**
What "gender identity" means	**1**	**2**	**3**	**4**	**5**
Issues unique to gay and bisexual men	**1**	**2**	**3**	**4**	**5**
Issues unique to transgender persons	**1**	**2**	**3**	**4**	**5**
Issues unique to lesbians	**1**	**2**	**3**	**4**	**5**
Issues unique to LGBT people of color	**1**	**2**	**3**	**4**	**5**
Resources for gay and bisexual male clients	**1**	**2**	**3**	**4**	**5**
Resources for transgender clients	**1**	**2**	**3**	**4**	**5**
Societal stereotypes around sexual orientation and LGBT-identified people	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts LGBT clients	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts clients of color	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts LGBT clients of color	**1**	**2**	**3**	**4**	**5**

SECTION FOUR

_____
_____

*For this section, please indicate by circling the box/number if you **Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree** with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
It is important to be aware of the sexual orientation/ identity of your clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with gay, and/or bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with lesbian clients.	**1**	**2**	**3**	**4**	**5**
Being gay, lesbian, bisexual, or transgender is a choice.	**1**	**2**	**3**	**4**	**5**
I am comfortable talking about same-sex sexual behavior with clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with transgender clients.	**1**	**2**	**3**	**4**	**5**
Part of our work is to assist clients in dealing with societal discrimination related to their LGBT identity.	**1**	**2**	**3**	**4**	**5**
A person's sexual orientation/ identity should not block that person's access to basic rights and freedoms.	**1**	**2**	**3**	**4**	**5**
You can provide effective services for LGBT people and still think that it is morally wrong to be LGBT.	**1**	**2**	**3**	**4**	**5**

Appendix F (continued)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
	1	2	3	4	5
Lesbian and gay couples should have all the same parenting rights as heterosexuals do (for example, adoption, fostering and access to fertility services).	1	2	3	4	5
Understanding the interaction of a client's race, gender, and sexual orientation/ identity is important.	1	2	3	4	5
I would feel comfortable if I learned that my child's teacher was gay, lesbian, or bisexual.	1	2	3	4	5
I would feel comfortable working closely with a gay or bisexual male coworker.	1	2	3	4	5
I would feel comfortable working closely with a lesbian coworker.	1	2	3	4	5
It would disturb me to find out that my doctor was gay, lesbian, or bisexual.	1	2	3	4	5
My work environment is a safe place for LGBT people.	1	2	3	4	5

SECTION FIVE

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to a person's sexual orientation, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to race/ethnicity, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to sexual orientation/identity.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to race/ethnicity.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with white gay and bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I am effective at getting white gay and bisexual male clients to identify partners.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with gay and bisexual male clients of color.	**1**	**2**	**3**	**4**	**5**
I am effective at getting gay and bisexual male clients of color to identify partners.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with lesbian clients.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with transgender clients.	**1**	**2**	**3**	**4**	**5**
I am effective at getting transgender clients to identify partners.	**1**	**2**	**3**	**4**	**5**

Is there any additional information you would like to share with us?

_____

_____

_____

_____

Thank you for taking the time to complete this survey.
We value your participation in this study!

Appendix F (continued)

TRAINING ASSESSMENT

HIV/STD DIVISION DISEASE INTERVENTION SPECIALISTS

POST-TRAINING SURVEY

Conducted by

Project STYLE
Stylenc.org
Department of Infectious Disease
UNC-CH School of Medicine

ABOUT THIS SURVEY

This questionnaire is designed to explore the ideas, beliefs, and learning needs of health care providers regarding gay, lesbian, bisexual, and transgender (LGBT) clients. In addition, your feedback will help determine the effectiveness of this training.

Please answer all questions as honestly as possible. **This is NOT a test, and there are NO RIGHT OR WRONG ANSWERS.** The information you share will be kept confidential and will not be shared with anyone or connected to your DIS region. PLEASE DO NOT PUT YOUR NAME ON THIS QUESTIONNARE.

For the sake of brevity, LGBT is used to denote lesbian, gay, bisexual, and transgender people in this survey.

If you have any questions, please contact Marcie Fisher-Borne at 919-962-6480 or our STYLE Project Coordinator, Justin Smith at 919-843-4722

SECTION ONE

For this section, please indicate by circling the box/number that reflects the level of knowledge *you have for each statement.*

How would you rate your knowledge of:	**No Knowledge**		**Knowledgeable**		**Very Knowledgeable**
	1	**2**	**3**	**4**	**5**
What "sexual orientation/identity" means	**1**	**2**	**3**	**4**	**5**
What "gender identity" means	**1**	**2**	**3**	**4**	**5**
Issues unique to gay and bisexual men	**1**	**2**	**3**	**4**	**5**
Issues unique to transgender persons	**1**	**2**	**3**	**4**	**5**
Issues unique to lesbians	**1**	**2**	**3**	**4**	**5**
Issues unique to LGBT people of color	**1**	**2**	**3**	**4**	**5**
Resources for gay and bisexual male clients	**1**	**2**	**3**	**4**	**5**
Resources for transgender clients	**1**	**2**	**3**	**4**	**5**
Societal stereotypes around sexual orientation and LGBT-identified people	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts LGBT clients	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts clients of color	**1**	**2**	**3**	**4**	**5**
Societal discrimination that impacts LGBT clients of color	**1**	**2**	**3**	**4**	**5**

SECTION TWO

_____
_____

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
It is important to be aware of the sexual orientation/identity of your clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with gay, and/or bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with lesbian clients.	**1**	**2**	**3**	**4**	**5**
Being gay, lesbian, bisexual, or transgender is a choice.	**1**	**2**	**3**	**4**	**5**
I am comfortable talking about same-sex sexual behavior with clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with transgender clients.	**1**	**2**	**3**	**4**	**5**
Part of our work is to assist clients in dealing with societal discrimination related to their LGBT identity.	**1**	**2**	**3**	**4**	**5**
A person's sexual orientation/ identity should not block that person's access to basic rights and freedoms.	**1**	**2**	**3**	**4**	**5**
You can provide effective services for LGBT people and still think that it is morally wrong to be LGBT.	**1**	**2**	**3**	**4**	**5**
Lesbian and gay couples should have all the same parenting rights as heterosexuals do (for example, adoption, fostering and access to fertility services).	**1**	**2**	**3**	**4**	**5**

Appendix F (continued)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
	1	2	3	4	5
Understanding the interaction of a client's race, gender, and sexual orientation/ identity is important.	1	2	3	4	5
I would feel comfortable if I learned that my child's teacher was gay, lesbian, or bisexual.	1	2	3	4	5
I would feel comfortable working closely with a gay or bisexual male coworker.	1	2	3	4	5
I would feel comfortable working closely with a lesbian coworker.	1	2	3	4	5
It would disturb me to find out that my doctor was gay, lesbian, or bisexual.	1	2	3	4	5
My work environment is a safe place for LGBT people.	1	2	3	4	5

SECTION THREE

_____
_____

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to a person's sexual orientation, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to race/ethnicity, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to sexual orientation/identity.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to race/ethnicity.	**1**	**2**	**3**	**4**	**5**
I am effective at getting white gay and bisexual male clients to identify partners.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with white gay and bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with gay and bisexual male clients of color.	**1**	**2**	**3**	**4**	**5**
I am effective at getting gay and bisexual male clients of color to identify partners.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with lesbian clients.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with transgender clients.	**1**	**2**	**3**	**4**	**5**
I am effective at getting transgender clients to identify partners.	**1**	**2**	**3**	**4**	**5**

SECTION FOUR

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
The training contributed to my understanding of LGBT issues.	**1**	**2**	**3**	**4**	**5**
I learned strategies to better work with LGBT clients.	**1**	**2**	**3**	**4**	**5**
The training was relevant to my work experience.	**1**	**2**	**3**	**4**	**5**
The training helped me feel more comfortable in approaching LGBT clients.	**1**	**2**	**3**	**4**	**5**
The training changed my attitude towards LGBT clients.	**1**	**2**	**3**	**4**	**5**
I plan to use much of the information presented in this training in my work life.	**1**	**2**	**3**	**4**	**5**

1. To what extent do you expect the training will make a <u>difference</u> in the way you do your job?

1	2	3	4	5
No Difference				Tremendous Difference

2. Do you think you will have the opportunity to utilize the information and skills shared in this training within the next two months? (If yes, please briefly describe when and how you might apply these skills. If no, please explain why you will not be able to utilize these training skills within the next two months.)

_____

_____

3. Please rate this training in terms of Trainer's <u>Expertise, Clarity, Cultural Appropriateness, Time Management, and Responsiveness</u> to your educational needs. Provide any additional feedback in the Comments section. Circle the appropriate numbers.

RATING SCALE: 1 = LOW 3 = MEDIUM 5 = HIGH

Trainer Name(s)	Expertise					Clarity					Culturally Appropriate					Time Management					Responsiveness				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Comments:																									

4. Which day of the training did you attend (please circle)?

Day One Day Two Day One and Day Two

5. If you were given the task of redesigning the training, what would you change?

_____
_____
_____

6. What further professional development training would you like to receive?

_____
_____
_____

7. Is there any additional information you would like to share with us?

_____
_____
_____

Thank you for taking the time to complete this survey.

TRAINING ASSESSMENT

HIV/STD DIVISION DISEASE INTERVENTION SPECIALISTS

FINAL SURVEY

Conducted by

Project STYLE
Stylenc.org
Department of Infectious Disease
UNC-CH School of Medicine

ABOUT THIS SURVEY

This questionnaire is designed to explore the ideas, beliefs, and learning needs of health care providers regarding gay, lesbian, bisexual, and transgender (LGBT) clients. In addition, your feedback will help determine the effectiveness of this training.

Please answer all questions as honestly as possible. **This is NOT a test, and there are NO RIGHT OR WRONG ANSWERS.** The information you share will be kept confidential and will not be shared with anyone or connected to your DIS region.

For the sake of brevity, LGBT is used to denote lesbian, gay, bisexual, and transgender people in this survey.

SECTION ONE

For this section, please indicate by circling the box/number that reflects the level of knowledge *you have for each statement.*

How would you rate your knowledge of:	No Knowledge		Knowledgeable		Very Knowledgeable
	1	2	3	4	5
What "sexual orientation/identity" means	1	2	3	4	5
What "gender identity" means	1	2	3	4	5
Issues unique to gay and bisexual men	1	2	3	4	5
Issues unique to transgender persons	1	2	3	4	5
Issues unique to LGBT people of color	1	2	3	4	5
Resources for gay and bisexual male clients	1	2	3	4	5
Resources for transgender clients	1	2	3	4	5
Societal stereotypes around sexual orientation and LGBT-identified people	1	2	3	4	5
Societal discrimination that impact LGBT clients	1	2	3	4	5
Societal discrimination that impact clients of color	1	2	3	4	5

SECTION TWO

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
It is important to be aware of the sexual orientation/identity of your clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with gay, and/or bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with lesbian clients.	**1**	**2**	**3**	**4**	**5**
Being gay, lesbian, bisexual, or transgender is a choice.	**1**	**2**	**3**	**4**	**5**
I am comfortable talking about same-sex sexual behavior with clients.	**1**	**2**	**3**	**4**	**5**
I am comfortable working with transgender clients.	**1**	**2**	**3**	**4**	**5**
Part of our work is to assist clients in dealing with societal discrimination related to their LGBT identity.	**1**	**2**	**3**	**4**	**5**
A person's sexual orientation/ identity should not block that person's access to basic rights and freedoms.	**1**	**2**	**3**	**4**	**5**
You can provide effective services for LGBT people and still think that it is morally wrong to be LGBT.	**1**	**2**	**3**	**4**	**5**

Appendix F (continued)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
	1	2	3	4	5
Lesbian and gay couples should have all the same parenting rights as heterosexuals do (for example, adoption, fostering and access to fertility services).	1	2	3	4	5
Understanding the interaction of a client's race, gender, and sexual orientation/ identity is important.	1	2	3	4	5
I would feel comfortable if I learned that my child's teacher was gay, lesbian, or bisexual.	1	2	3	4	5
I would feel comfortable working closely with a gay or bisexual male.	1	2	3	4	5
It would disturb me to find out that my doctor was gay, lesbian, or bisexual.	1	2	3	4	5
My work environment is a safe place for LGBT people.	1	2	3	4	5

SECTION THREE

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to a person's sexual orientation, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
If I heard negative stereotypes related to race/ethnicity, I would address those stereotypes.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to sexual orientation/ identity.	**1**	**2**	**3**	**4**	**5**
People in my work environment confront negative stereotypes related to race/ethnicity.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with gay and bisexual male clients.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with lesbian clients.	**1**	**2**	**3**	**4**	**5**
I have confidence in my interviewing skills with transgender clients.	**1**	**2**	**3**	**4**	**5**
I have specific tools and approaches for communicating effectively with lesbian, gay, and bisexual clients.	**1**	**2**	**3**	**4**	**5**
I have specific tools and approaches for communicating effectively with clients whose race/ethnicity is different than my own.	**1**	**2**	**3**	**4**	**5**

Appendix F (continued)

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
	1	2	3	4	5
I have specific tools and approaches for communicating effectively with transgender clients.	1	2	3	4	5
I have specific tools and approaches for working with gay, bisexual, and transgender men of color.	1	2	3	4	5

SECTION FOUR

For this section, please indicate by circling the box/number if you: ***Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree*** *with the statement.*

	Strongly Agree	**Agree**	**Neither Agree nor Disagree**	**Disagree**	**Strongly Disagree**
	1	**2**	**3**	**4**	**5**
The training contributed to my understanding of LGBT issues.	**1**	**2**	**3**	**4**	**5**
I learned strategies to better work with LGBT clients.	**1**	**2**	**3**	**4**	**5**
The training was relevant to my work experience.	**1**	**2**	**3**	**4**	**5**
The training helped me feel more comfortable in approaching LGBT clients.	**1**	**2**	**3**	**4**	**5**
The training changed my attitude towards LGBT clients.	**1**	**2**	**3**	**4**	**5**
I plan to use much of the information presented in this training in my work life.	**1**	**2**	**3**	**4**	**5**

1. To what extent did the DIS Cultural Competency Training make a <u>difference</u> in the way you do your job?

1 2 3 4 5

No Difference **Tremendous Difference**

2. Did you have the opportunity to utilize the information and skills shared in this training? (If yes, please briefly describe when and how you applied these skills and information. If no, please explain why you were not be able to utilize these training skills and information)

_____

_____

_____

3. Personally, what is the percentage of lesbian, gay, bisexual, or transgender clients you have served in the past month?

0-1% ..... ☐ 1

1-15% ..... ☐ 2

15-50% ..... ☐ 3

50-80% ..... ☐ 4

4. What further professional development training would you like to receive?

_____
_____
_____
_____
_____

5. Is there any additional information you would like to share with us?

_____
_____
_____
_____
_____

Thank you for taking the time to complete this survey. We value your participation in this study!

Appendix G

Training Session Fidelity Measure

Background Information

Observer
_____

Date of Observation
_____

Duration of Observation:

__ 1 hour __ half day

__ 2 hours __ whole day

Other, please specify
_____

Total Number of Attendees
_____

Name of Presenter(s)

_____
_____
_____

Section One: Context Background and Activities

This section provides a brief overview of the session being observed.

I. Session Context

In a few sentences, describe the session you observed. Include: (a) whether the observation covered a partial or complete session, (b) whether there were multiple break-out sessions, and (c) where this session fits in the project's sequence of training sessions for those in attendance.

_____
_____
_____
_____

II. Session Focus

Indicate the major intended purpose(s) **of this session, based on information provided by the project staff.**

_____

_____

_____

III. Training Session Activities

(Check all the activities— and related issues (such as resources)—you observed and describe them when relevant)

A. Indicate the major instructional resource(s) used in this training session.

___ Print materials

_____

___ Hands-on materials

_____

___ Technology/audio-visual resources

_____

___ Other instructional resources. (Please specify.)

_____

_____

B. Indicate the major way(s) in which participant activities were structured.

___ As a whole group

___ As small groups

___ As pairs

___ As individuals

(Describe)_____

_____

C. Indicate the major activities of facilitators and participants in this session. (Check to indicate applicability.)

___ Presentations by presenter/facilitator: **(describe focus)**

___ Presentations by participants: **(describe focus)**

___ Hands-on/investigative/field activities: **(describe)**

___ Problem-solving activities: **(describe)**

___ Reading/ written communication: **(describe)**

___ Assessed participants' knowledge and/or skills: **(describe approach)**

___ Provided opportunities for participant and group reflection: **(describe)**

___ Assessed participants' self awareness related to the issue: **(describe approach)**

___ Other activities: **(Please specify)**

D. Key Training Domains: Indicate how the training helped participants develop in these core areas. (Check to indicate applicability.)

___ Provided opportunities for participants to build *knowledge*: **(describe)**

___ Provided opportunities for participants to develop *awareness*: **(describe)**

___ Provided opportunities for participants to enhance *skills*: **(describe)**

E. Comments: Please provide any additional information you consider necessary to capture the activities or context of this training session. Include comments on any feature of the session that were salient but not captured elsewhere in the evaluation.

Section Two: Ratings

In Section One of this form, you documented what occurred in the session. In this section, you are asked to use that information—as well as any other pertinent observations you may have—to rate each of a number of key indicators from 1 (not at all) to 5 (to a great extent) in five different categories by circling the appropriate response.

Please note that any one session is not likely to provide evidence for every single indicator. Therefore:

- Use 6 (Don't know) when there is not enough evidence for you to make a judgment.
- Use 7 (N/A, meaning Not Applicable) when you consider the indicator inappropriate given the purpose and context of the session.
- Similarly, there may be entire rating categories that are not applicable to a particular session.

Note that you may list any additional indicators you consider important in capturing the essence of this session and rate these as well.

USING YOUR OBSERVATIONS AND OPINIONS

- Use your "Ratings of Key Indicators" (Part A) to inform your "Synthesis Ratings" (Part B).
- Indicate in "Supporting Evidence for Synthesis Ratings" (Part C) what factors were most influential in determining your synthesis ratings.
- Section Two concludes with ratings of the likely impact of the training session and a capsule description of it.

I. Design

A. Ratings of Key Indicators

	Not at all				To a great extent	Don't know	N/A
1. The strategies in this session were appropriate for accomplishing the training session's purposes	1	2	3	4	5	6	7
2. The session effectively built on participants' existing knowledge, experiences, and stated learning needs	1	2	3	4	5	6	7
3. The instructional strategies and activities used in this section reflected attention to participants' experience, preparedness, and learning styles	1	2	3	4	5	6	7
4. The session's design reflected careful planning and organization	1	2	3	4	5	6	7
5. The session's design encouraged a collaborative approach to learning	1	2	3	4	5	6	7
6. The session's design provided opportunities for participants to consider practical/personal application of resources, strategies, and techniques	1	2	3	4	5	6	7
7. Adequate time and structure were provided for reflection	1	2	3	4	5	6	7
8. Adequate time and structure were provided for participants to share experiences and insights	1	2	3	4	5	6	7
9. _____	1	2	3	4	5	6	7

B. Supporting Evidence for Rating

_____

_____

_____

II. Implementation

A. Ratings of Key Indicators

	Not at all				To a great extent	Don't know	N/A
1. The session effectively incorporated instructional strategies appropriate for training session purposes and the needs of adult learners	1	2	3	4	5	6	7
2. The session effectively modeled questioning strategies that are likely to enhance the development of conceptual understanding (e.g., emphasis on higher-order questions, appropriate use of "wait time," identifying perceptions and misconceptions)	1	2	3	4	5	6	7
3. The pace of the session was appropriate for training session purposes and the needs of adult learners	1	2	3	4	5	6	7
4. The session modeled effective assessment strategies	1	2	3	4	5	6	7
5. The presenter(s)' background, experience, and/or expertise enhanced the quality of the session	1	2	3	4	5	6	7
6. The presenter(s)' management style/strategies enhanced the quality of the session	1	2	3	4	5	6	7
7. Proactiveness of participants in addressing their training session needs	1	2	3	4	5	6	7
8. _____	1	2	3	4	5	6	7

B. Supporting Evidence for Rating

_____

_____

_____

III. Training Content

A. Ratings of Key Indicators

	Not at all				To a great extent	Don't know	N/A
1. Training content was appropriate for purposes of the training session and participants' backgrounds	1	2	3	4	5	6	7
2. The content was sound and appropriately presented/ explored	1	2	3	4	5	6	7
3. Facilitator displayed an understanding of concepts (e.g., in his/her dialogue with participants)	1	2	3	4	5	6	7
4. Appropriate connections were made to participants' work and to real world contexts (DIS work, HIV/AIDS, and to other disciplines)	1	2	3	4	5	6	7
5. Degree of closure or resolution of conceptual understanding was appropriate for session purposes and the needs of adult learners	1	2	3	4	5	6	7
6. _____	1	2	3	4	5	6	7

B. Supporting Evidence for Synthesis Rating

_____

_____

_____

_____

_____

IV. Culture/Equity

A. Ratings of Key Indicators

	Not at all				To a great extent	Don't know	N/A
1. Active involvement of all the participants was encouraged and valued	1	2	3	4	5	6	7
2. There was a climate of respect for participants' experiences, ideas, and contributions	1	2	3	4	5	6	7
3. Participants were encouraged to work together collaboratively	1	2	3	4	5	6	7
4. Interactions reflected collaborative working relationships between facilitator(s) and participants	1	2	3	4	5	6	7
5. The presenter'(s) language and behavior clearly demonstrated sensitivity to variations in participants':							
a. Experience and/or preparedness	1	2	3	4	5	6	7
b. Access to resources	1	2	3	4	5	6	7
c. Gender, gender identity, sexuality, race/ethnicity, and/or culture	1	2	3	4	5	6	7
6. Opportunities were taken to recognize and challenge stereotypes and biases that became evident during the training session	1	2	3	4	5	6	7
7. Participants were intellectually engaged with important ideas relevant to the focus of the session	1	2	3	4	5	6	7
8. Participants were encouraged to generate ideas, questions, conjectures, and propositions	1	2	3	4	5	6	7
9. Questions and risk-taking were valued	1	2	3	4	5	6	7
10. Constructive criticism, and the challenging of ideas were valued	1	2	3	4	5	6	7
11. _____	1	2	3	4	5	6	7

[1]Use 1, "Not at all," when you have considerable evidence of insensitivity or inequitable behavior; 3, when there are no examples either way; and 5, "To a great extent," when there is considerable evidence of proactive efforts to achieve equity.

B. Synthesis Rating

1	2	3	4	5
Culture of the session interferes with engagement of participants as members of a learning community				Culture of the session facilitates engagement of participants as members of a learning community

C. Supporting Evidence for Synthesis Rating

VI. Likely Impact on Participants' Capacity for Exemplary Instruction or Care

A. Ratings of Key Indicators

Consider the likely impact of this session on the participants' capacity to support MSM/GBT clients (or help staff support MSM/GBT clients). Circle the response that best describes your overall assessment of the *likely effect* of this session in each of the following areas.

___ Not applicable. (The session did not focus on building capacity for support and/or care of MSM/GBT clients)

	Not at all				To a great extent	Don't know	N/A
1. Participants' ability to identify and understand important issues for LGBT clients	1	2	3	4	5	6	7
2. Participants' understanding of the scope and depth of institutionalized heterosexism/homophobia	1	2	3	4	5	6	7
3. Participants' ability to identify self perceptions and social stereotypes around sexual orientation and LGBT-identified people	1	2	3	4	5	6	7
4. Participants' ability to identify specific tools, approaches and resources related to interviewing/serving LGBT clients	1	2	3	4	5	6	7
5. Participants' ability to provide culturally competent interviewing skills with LGBT clients	1	2	3	4	5	6	7
6. Participants' self-confidence in working with MSM/GBT clients	1	2	3	4	5	6	7
7. Participants' ability to identify barriers to care of LGBT clients within DIS services	1	2	3	4	5	6	7

B. Supporting Evidence for Synthesis Rating

VII. Overall Ratings of the Session

While the impact of a single training session may well be limited in scope, it is important to judge whether it is helping move participants in the desired direction. For ratings in the section below, consider all available information (i.e., your previous ratings of design, implementation, content, and culture/equity; related interviews, and your knowledge of the overall training session program) as you assess the likely impact of this session. Feel free to elaborate on ratings with comments in the space provided.

Appendix H

Difference in Individual Survey Question Scores Between Time Points

	Mean Score			P value for Score Differences (Wilcoxin Signed Rank Test)		
	T1*	T2*	T3*	T1 vs. T2	T1 vs. T3	T2 vs. T3
Knowledge						
Question 1	4.21	4.19	4.17	0.97 (0.96)	0.69 (1.00)	0.76 (0.77)
Question 2	4.06	4.19	4.13	0.35 (0.28)	0.66 (0.26)	0.32 (0.69)
Question 3	3.31	3.81	3.70	<0.0001 (<0.0001)	0.04 (0.01)	0.45 (0.86)
Question 4	2.41	3.31	3.15	<0.0001 (<0.0001)	0.0009 (0.0005)	0.18 (0.38)
Question 5	2.85	3.60	-	<0.0001 (<0.0001)	-	-
Question 6	2.87	3.77	3.48	<0.0001 (<0.0001)	0.002 (0.0008)	0.06 (0.09)
Question 7	2.68	3.33	3.23	<0.0001 (<0.0001)	0.002 (0.0009)	0.30 (0.30)
Question 8	1.92	2.65	2.70	<0.0001 (<0.0001)	<0.0001 (<0.0001)	0.89 (0.68)
Question 9	3.32	3.75	3.62	0.004 (0.003)	0.07 (0.03)	0.05 (0.12)
Question 10	3.22	3.85	3.70	<0.0001 (<0.0001)	0.01 (0.002)	0.11 (0.27)
Question 11	3.44	3.90	3.89	0.0006 (0.0004)	0.008 (0.002)	0.55 (0.88)
Question 12	3.11	3.92	-	<0.0001 (<0.0001)	-	-
Attitudes						
Question 1	1.58	1.57	1.61	1.00 (0.72)	0.75 (0.69)	0.97 (1.00)
Question 2	1.63	1.51	1.44	0.06 (0.12)	0.28 (0.11)	0.77 (0.66)
Question 3	1.61	1.46	1.42	0.08 (0.05)	0.39 (0.21)	0.91 (1.00)
Question 4	2.98	2.94	3.02	0.81 (0.86)	0.75 (0.86)	0.88 (0.91)
Question 5	1.62	1.51	1.44	0.12 (0.18)	0.36 (0.08)	0.87 (0.79)
Question 6	1.85	1.80	1.76	0.49 (0.69)	0.65 (0.40)	0.89 (0.58)
Question 7	2.69	2.76	2.42	0.83 (1.00)	0.07 (0.08)	0.08 (0.10)
Question 8	1.46	1.35	1.44	0.37 (0.18)	0.90 (0.58)	0.37 (0.48)
Question 9	2.88	2.69	2.84	0.57 (0.35)	0.91 (0.71)	0.62 (0.63)
Question 10	2.37	2.25	2.24	0.10 (0.06)	0.55 (0.51)	0.51 (1.00)
Question 11	1.70	1.88	1.65	0.13 (0.33)	0.88 (0.44)	0.08 (0.09)
Question 12	2.33	2.44	2.20	0.73 (0.54)	0.42 (0.43)	0.26 (0.13)
Question 13	1.63	1.65	1.54	0.78 (0.99)	0.62 (0.86)	0.49 (0.57)
Question 14	1.64	1.65	-	0.96 (0.99)	-	-
Question 15	3.72	3.58	3.80	0.46 (0.37)	0.87 (0.72)	0.40 (0.73)
Question 16	2.00	1.87	1.83	0.21 (0.36)	0.31 (0.60)	0.82 (1.00)
Skills						
Question 1	2.42	2.43	2.20	0.95 (1.00)	0.05 (0.04)	0.11 (0.06)
Question 2	2.18	2.04	2.04	0.35 (0.67)	0.24 (0.34)	0.84 (0.88)
Question 3	2.62	2.56	2.67	0.31 (0.33)	0.83 (0.79)	0.13 (0.35)
Question 4	2.42	2.25	2.57	0.15 (0.06)	0.50 (1.00)	0.01 (0.01)
Question 5	1.91	2.29	-	0.01 (0.003)	-	-
Question 6	2.18	1.90	-	0.03 (0.06)	-	-
Question 7	1.80	1.79	-	0.96 (1.00)	-	-
Question 8	2.09	1.90	-	0.13 (0.16)	-	-
Question 9	1.80	1.87	1.38	0.53 (0.42)	0.009 (0.01)	0.003
Question 10	2.09	2.04	-	0.79 (1.00)	-	(0.0002)
Question 11	2.24	2.23	-	0.56 (0.40)	-	-
						-

*Ti: baseline; T2: post-training; T3: three months after training intervention

Scale of all the following questions is from 1 to 5, where 1 indicates no knowledge, 3 indicates knowledgeable, and 5 indicates very knowledgeable.

Statements Relevant to Knowledge:

1. What "sexual orientation/identity" means
2. What "gender identity" means
3. Issues unique to gay and bisexual men
4. issues unique to transgender persons
5. issues unique to lesbians
6. issues unique to LGBT people of color
7. Resources for gay and bisexual male clients
8. Resources for transgender clients
9. Societal stereotypes around sexual orientation and LGBT-identified people
10. Societal discrimination that impacts LGBT clients
11. Societal discrimination that impacts clients of color
12. Societal discrimination that impacts LGBT clients of color

Scale of all the following questions is from 1 to 5, where 1 indicates strongly agree, 3 indicates neither agree nor disagree, and 5 indicates strongly disagree.

Statements Relevant to Attitudes/Awareness:

1. It is important to be aware of the sexual orientation/identity of your clients.
2. I am comfortable working with gay, and/or bisexual male clients.
3. I am comfortable working with lesbian clients
4. Being gay, lesbian, bisexual, or transgender is a choice.
5. I am comfortable talking about same-sex sexual behavior with clients.
6. I am comfortable working with transgender clients.
7. Part of our work is to assist clients in dealing with societal discrimination related to their LGBT identity.
8. A person's sexual orientation/identity should not block that person's access to basic rights and freedoms.
9. You can provide effective services for LGBT people and still think that it is morally wrong to be LGBT.
10. Lesbian and gay couples should have all the same parenting rights as heterosexuals do (for example, adoption, fostering and access to fertility services).
11. Understanding the interaction of a client's race, gender, and sexual orientation/identity is important.
12. I would feel comfortable if I leaned that my child's teacher was gay, lesbian, or bisexual.
13. I would feel comfortable working closely with a gay or bisexual male coworker.
14. I would feel comfortable working closely with a lesbian coworker.
15. It would disturb me to find out that my doctor was gay, lesbian, or bisexual.
16. My work environment is a safe place for LGBT people.

Scale of all the following questions is from 1 to 5, where 1 indicates strongly agree, 3 indicates neither agree nor disagree, and 5 indicates strongly disagree.

Statements Relevant to Skills:

1. If I heard negative stereotypes related to a person's sexual orientation, I would address those stereotypes.
2. If I heard negative stereotypes related to race/ethnicity, I would address those stereotypes.
3. People in my work environment confront negative stereotypes related to sexual orientation/identity.
4. People in my work environment confront negative stereotypes related to race/ethnicity.
5. I have confidence in my interviewing skills with white gay and bisexual male clients.
6. I am effective at getting white gay and bisexual male clients to identify partners.
7. I have confidence in my interviewing skills with gay and bisexual male clients of color.
8. I am effective at getting gay and bisexual male clients of color to identify partners.
9. I have confidence in my interviewing skills with lesbian clients.
10. I have confidence in my interviewing skills with transgender clients.
11. I am effective at getting transgender clients to identify partners.

Appendix I

DIS Encounter Narrative

This story was shared with DIS at the beginning of the second training in the western NC region as an illustration of a negative DIS encounter.

Last fall I was home visiting my parents when I got a call on my cell phone— "This is ____ from the NC Department of Health. We need you to come in IMMEDIATELY." I inquired about the reason, and was told, "Due to HIPAA laws there is nothing I can tell you. It"s VERY important—can you come in tomorrow?!" I was nervous...although I knew from a friend in another state that he'd given my name to the health department there as a previous partner after testing positive for HIV and syphilis. I knew he hadn't given it to me because we'd had sexual contact a long time ago and he'd been tested negative for both since. I asked for the man's credentials ("Are you a nurse, a doctor?") and he told me simply, "I work for the State." We made an appointment for the next morning. He seemed to be on a complete power trip, offering no information and certainly not trying to make me feel at all comforted or empowered in participating with him.

When I arrived I was greeted by a young man wearing casual clothes. He brought me to a back room in the county health department and sat me in a chair, then stood over me, pacing the room. "Someone you've had sexual contact with tested positive for HIV and syphilis. Today we're going to talk about your lifestyle and social habits, about your sexual activity, we're going to test you for syphilis and treat you, regardless of your test results. And we'll give you an HIV test. At the end, you will tell me ALL of the partners you've had for the last YEAR and we'll make a list." He made me feel like I was being interrogated, and was shaming in the way he paced the room and spoke down to me (literally and figuratively). I was informed that I was REQUIRED to undergo these tests for the state (not given any right to refuse) and when I explained that I was living out of state and was about to leave town, I was told that this wouldn't work ... until he finally decided that he could bring me to the Durham County Health Department to get the rapid test there for HIV, so I wouldn't have to wait for results (which have to be given in person, by law).

This young man drove literally 85 miles down the highway to the Durham County Department of Health—we both almost got in a car accident on the way (me following him). At the clinic, I underwent all the tests. He disappeared for this segment, and then was told by the doctor that I had to be given injections of penicillin for the syphilis. Fortunately, I knew about the oral antibiotic alternative, so I could advocate for myself. The doctor almost refused to give me this alternative, but I was firm in my advocacy and ended up having to threaten to refuse treatment at all... I'm so glad I knew that I COULD refuse treatment—the first guy made me feel like a prisoner, dirty and without rights. He seemed frustrated by my advocating for myself and when I asked questions about the reporting system that led to him calling me, he gave me short cryptic answers.

In the end, I tested negative for everything—the Department of Health worker came in briefly to tell me that "we could skip talking about [my] social habits," and then left. I was

given no option to leave feedback, no way to contact him afterward. This was easily the worst testing experience I've ever had. Even being well-educated on the health care system, knowing my patient rights, knowing about the origin and treatment of STDs, I was made to feel little, dirty, and guilty/ punished. I would NEVER go back to the Department of Health for testing because of the way I was made to feel—disempowered, blamed, and undesirable.

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