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ABSTRACT

This manual is designed to aid health care practitioners in providing culturally appropriate HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) education, counseling, and care. Cultural competency is defined as the ability to work effectively with culturally diverse clients and communities because the individual agency or system exhibits culturally appropriate attitudes, beliefs, behaviors, and policies. It goes beyond cultural sensitivity or awareness to put into practice culturally appropriate interventions and ways of relating. The manual consists of six chapters. Chapter 1 clarifies cultural terminology. Chapter 2 provides nine self-assessment exercises for individuals concerning cultural competency. Chapter 3 outlines eight steps in providing culturally appropriate HIV/AIDS educational interventions. Chapter 4 examines culturally appropriate HIV counseling. Chapter 5 discusses providing culturally specific HIV counseling, education, and care for African American, Latino/Hispanic, Native American, and Asian American populations. Chapter 6 explores organizational cultural competency, providing worksheets and exercises for assessment of organizations. Appendices include a model of a cultural competence continuum, a list of resources and references, a list of relevant organizations, and guidelines for developing printed materials. (Contains 27 references.) (ND)

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Culturally Competent HIV Counseling and Education

Elizabeth Randall-David, Ph.D.

Prepared in conjunction with the
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and
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Culturally Competent HIV Counseling and Education

Elizabeth Randall-David, Ph.D.

1st Edition
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Acknowledgments

I want to express my gratitude to the many people who gave of their time, intellect and energy to help develop this manual. A special thanks to Sharon Barrett, the former director of the National Hemophilia Program, Maternal Child Health Bureau who was key to the conceptualization and inspiration for this project. Her vision, commitment and support led to a number of projects requiring cultural sensitivity and competency, especially the development of the Chapter Outreach Demonstration Program (CODP) aimed at identifying persons of color with hemophilia and facilitating their entry into the comprehensive hemophilia treatment system.

In conjunction with CODP, two manuals were developed to aid outreach specialists and clinical practitioners in working with persons from culturally diverse communities (Randall-David, *Strategies for Working with Culturally Diverse Communities and Clients* and Broullon and Williams, *Chapter Outreach Demonstration Project: Reaching Out to Culturally Diverse Hemophilia Populations*). Originally this manual was intended to be included in that series. However, given the overwhelming request for the two above mentioned manuals from health educators and providers outside the hemophilia community, it was decided that this manual should be more generic so that it could be used by a broad range of providers.

Many individuals working with diverse cultural communities have shared their ideas and experiences with me. I would especially like to thank Suzanne Broullon, Maria Cruz, Ed Jones, Marion Odubiyi, Marcy Shulman, and Mirelle Tribie for their encouragement and input. A special thanks to Susan Augur, Kathryn Kerr, Debra Heath, and Kermit Nash for giving input on various drafts of the organizational cultural competency tool.

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On a personal note, I would like to thank my parents, Betty and Jim Randall, who have always supported my efforts and who contributed pieces to this manual.

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Preface

America
is not like a blanket
one piece of unbroken
cloth, the same color,
the same texture, the
same size. America is more
like a quilt....many
pieces, many colors,
many sizes, all woven
and held together by
a common thread.

Jesse Jackson

This analogy of the quilt as a description of the population of the United States has replaced the old notion of the U.S. as a melting pot. Indeed the United States is fast becoming a multicultural society. Racial and ethnic minorities are the fastest growing segments of the U.S. population. According to the 1990 Census, "minorities" are the **majority** in 21 of the U.S.'s largest cities and the dominant group in 51 of the 200 cities over a population of 100,000. By the year 2000, racial and ethnic groups are expected to make up over 25% of the total population and one in three children under the age of 19 years will be from a racial or ethnic "minority" group.

The full extent of the nation's multiculturalism can be further appreciated by looking at an expanded definition of cultural group to include any cluster of people with a common sense of identity. Looking at an expanded definition of cultural group to include any cluster of people with a common sense of identity, this definition would encompass such diverse groups as homeless persons, drug users, migrant laborers, gay and bisexual persons, members of various religious groups, prisoners, and many others.

Today health care educators and providers are faced with the challenge of providing services to an increasingly diverse population. In the HIV arena, there is a growing awareness among health care providers that HIV education, counseling and care should be conducted in a culturally sensitive and appropriate fashion. However, many health care professionals do not know exactly how to translate that awareness into action. Few know enough about their clients'* cultural beliefs, practices, attitudes and values to deliver culturally competent education and counseling. Many providers are

not aware of how their own cultural values may be brought into the health care encounter.

This manual is designed to aid busy health care practitioners in providing culturally appropriate HIV education, counseling, and care. **It is not a cookbook. There are no recipes.** There is no **one** way to work effectively with any particular cultural group. This manual will, however, present some guiding principles, exercises and worksheets that will facilitate communication with clients from diverse communities.

This manual celebrates cultural diversity as an opportunity to expand our approaches as health care practitioners. Rather than seeing cultural differences as barriers, we can view them as enablers or facilitators. Once we understand our own culture and our clients' culture, we can work more effectively with clients from a variety of different backgrounds.

Betsy Randall-David, RN, Ph.D.

*Throughout the manual the term "client" is used to refer to any individual or group of individuals with whom the service provider is working. A client may be an adult, a child, or a family.

Clarifying Cultural Terminology

Culture Defined

The word "culture" means many things to different people. For the purposes of this manual we will use the definition that follows: **an integrated system of learned behavior patterns that are characteristic of the members of any particular group.** This broad definition of culture encompasses the following key features:

- It is made up of components that range from the most superficial visible factors - such as diet, dress, appearance and music - to the assumptions people make about themselves, their relationships with others, and their own values and priorities.
- It includes everything that a group of people thinks, says or does, and covers a wide range of customs, experiences, beliefs, rituals and practices.
- It is passed from one generation to another.
- It sometimes is referred to as our "software" or "blueprint" because it programs or guides our attitudes, values, beliefs, and behaviors - often on an unconscious level.

Cultural Group

We will use an expanded definition of a cultural group to mean **any group of people who share a world view, language, history or lifestyle** . For example, the health care profession is a culture with its own set of beliefs (e.g., the germ theory explains disease as being caused by microorganisms), language (e.g., "biomedicalese"), and values (e.g., confidentiality of client information is critical). Even when clients share other aspects of our cultural heritage, they may still have differences, because they are not part of the health care profession.

No cultural group is homogenous or monolithic. There are many differences within cultural groups based on a number of variables, including:

- ethnicity
- age
- social class
- socioeconomic status
- religion
- education
- language
- gender identity
- sexual orientation
- occupation
- length of time in the United States
- legal status
- residence (urban, suburban, rural)
- residence in country of origin
- amount and type of contact with elders
- degree of assimilation
- life experiences

It is important to remember that there may be differences among members of the same cultural group, so overgeneralizing and stereotyping must be avoided. It is often tempting to think that one has an understanding of how a particular cultural group views the world, based on experiences with several members from that group. However, all clients should be related to as unique individuals who may or may not hold all the same values, attitudes and beliefs as others from their same cultural group. Cultural information is helpful as a guide - giving the health practitioner certain parameters within which to explore any particular client's values and beliefs.

■■■ Cultural Competency

Cultural competency is the ability to work effectively with culturally diverse clients and communities because the individual agency or system exhibits culturally appropriate attitudes, beliefs, behaviors and policies. It goes beyond cultural sensitivity or awareness to put into practice culturally appropriate interventions and ways of relating. In its most developed aspect, cultural competency includes advocacy **for** as well as provision of services **to** culturally diverse clients and communities. See *Cross, et al (1989) for a more comprehensive description of the cultural competency continuum.*

In order to offer culturally relevant services, the health practitioner must first be aware of his or her own cultural "baggage". The next chapter will provide guidance on becoming a culturally competent practitioner.

The Culturally Competent Practitioner

Often health care practitioners focus on the cultural systems of their clients without acknowledging the importance of their own cultural values, attitudes, and beliefs. However, in order to become a culturally competent practitioner, one must first understand one's own cultural heritage and how it influences one's world view and interactions with others, including clients from other cultures.

Becoming a culturally competent practitioner is an **ongoing process.** There really is no end point but varying points on a continuum of competency. Nevertheless, a number of authors have defined what they believe to be the essential ingredients of a culturally competent provider *(Sue, Arredondo, McDavis 1992).* The following is a compilation of these characteristics.

A culturally competent practitioner:

- has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage.
- is aware of his/her own values and biases and how they may affect clients from culturally diverse communities.
- is comfortable with differences that exist between themselves and clients in terms of culture and its effect on values, beliefs, and attitudes.
- possesses knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect both their clients and themselves personally and professionally.
- understands the historical events that may have harmed particular cultural groups.
- possesses specific knowledge and information about the particular cultural group(s) s/he is working with.
- respects the unique, culturally defined needs of clients from diverse communities.
- understands that diversity **within** cultures is as important as diversity **between** cultures.

- seeks out opportunities to learn more about various cultural communities through:
  - interactions with clients
  - participation in cultural diversity workshops
  - reading of articles and books on cultural dynamics
  - participation in community events
  - consultations with cultural experts in the community
- makes continued, sincere attempts to understand the others' point of view.
- is flexible and tolerates ambiguity well.
- has a sense of humor.
- is open minded and non-judgmental.
- is willing to relinquish control in clinical encounters.
- has the willingness to risk failure and to look within for the source of frustration, anger, and resistance.
- acknowledges that process is as important as product.

Clearly, there are few, if any, totally culturally competent practitioners. However, the above list of characteristics can guide practitioners in their journey to become more understanding and responsive to the needs of their clients from culturally diverse communities.

The following series of exercises are designed to facilitate practitioners' exploration of their own cultural heritage and its influence on interactions with clients.

Exercise 1

Who Are You?

Awareness of your own cultural background is the first step in becoming culturally aware. Below are words that describe some characteristics of culture. Circle words from this list or add your own words to describe your cultural identity. This sheet will not be shared.

Race/ethnicity:
African American
Asian American
Native American
European American
Latino/Hispanic
Other_____

Class:
Lower socioeconomic
Middle socioeconomic
Upper socioeconomic

Gender:
Female
Male

Politics:
Radical
Progressive
Liberal
Conservative
Reactionary

Republican
Democrat
Independent
Unregistered

Sexual Orientation:
Heterosexual
Gay/homosexual
Lesbian
Bisexual
Other_____

Family roles:
Wife/husband
Significant other
Mother/father
Stepmother/stepfather
Son/daughter
Stepson/stepdaughter
Grandmother/Grandfather
Granddaughter/grandson
Aunt/Uncle
Extended Family Member
Other_____

Religion:
Protestant
Jewish
Muslim
Catholic
Pentecostal
Other_____

Age:
Child
Teenager
Adult
Older person/elderly

Occupation:
Unemployed
Semi-skilled
Service worker
White collar
Blue collar
Professional
Other_____

Language:
Literate
Semi-literate
Illiterate
English
Spanish
Other_____

Community:
Rural
Urban
Suburban

Northeast
Southeast
Midwest
Southwest
Northwest

Other:
Veteran
Disabled/differently abled
Immigrant
Other_____

Who Are Your Clients?

Select words from the above list that describe your clients and their lives.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Some Discussion Questions

What 3 or 4 adjectives from the list best describe how you identify yourself at this time?

With these descriptions in mind, what do you feel are the advantages and disadvantages of being this kind of person in your personal life today? In your professional life?

What are the advantages and disadvantages of being this kind of person and working with the larger community?

What are the advantages and disadvantages of being this kind of person and working with various culturally diverse communities? Are there differences among communities?

Exercise 2

Early Cultural Awareness

Think about the first time you had contact with someone you realized was culturally different from you.

Briefly describe the situation/event.

- How old were you?
- What were your feelings?
- What were your thoughts?

What did your parents and other significant adults say about those who were culturally different from your family?

- What adjectives were used?
- What attitudes were conveyed?

As you got older what messages did you get about minority groups from the larger community or culture?

As an adult how do others in the community talk about culturally different people?

- What adjectives are used?
- What attitudes are conveyed?
- How does this reinforce or contradict your earlier experience?

What parts of this cultural baggage make it difficult to work with clients from different cultural groups?

What parts of this cultural baggage facilitate your work with clients?

Exercise 3

The Grandparents' Exercise

"All children are my children. I teach them the songs and whatever else I can. That's what grandmothers are for - to teach songs and tell stories and show them the right berries to pick and roots to dig. And also to give them all the love they can stand. No better job in the world than being a Grandmother!"

Leila Fisher
Wisdom Keepers,
1993 Calendar

Imagine your grandchildren asked you to leave them a legacy of important teachings. What would you teach your grandchildren about:

- Whom they should obey?
- Who makes decisions (at home, in school, in the community)?
- Whom to respect and how to show respect for others?
- How they should act in public so they will be a credit to, or bring honor upon, their family?
- How important they are and can expect to be in the community?
- Whom they should seek advice from when they need it ?
- Whom to trust?
- What it means to be successful in life?
- What provides "security"?
- Why people work?
- What type of work they should prepare for?
- Who their friends should be?
- Where they should live?
- Whom they should marry and at what age?
- How many children they should have?
- What is expected of children when they are young and when their parents are old?
- What to depend on others for?
- When to be self-sufficient?
- What they can share with others and what should be kept secret?
- How to plan for the future?
- What should be remembered from their heritage?
- What was better when you were young?
- What you wish for your grandchildren that you could not be or have?
- What it is they can depend upon as always being good or important?
- What they should be wary or afraid of?
- How they can improve on who they are or what they have?
- What they should be willing to sacrifice to insure a better life for more people?

Modified from: "A Human Profile: Survival Kit for Overseas Living:, Robert Kohls, 1979.

Exercise 4

The Ten "Commandments"

List the 10 "commandments" or rules that defined relationships and behaviors in your family as you were growing up.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Find someone from a different cultural background. Discuss the similarities and differences in your cultural rules. How do these rules affect your interactions with clients who share similar rules? How do these rules affect your interactions with clients who do not share similar rules?

Exercise 5

Carrying Your Cultural Baggage

What about your ethnic background do you feel proud of? What are the strengths that you bring from that background that will help you in working with persons from other cultural groups?

What about your ethnic background do you find embarrassing or wish you could change? In other words, what in your cultural baggage do you find detrimental? Why?

What aspects of your cultural baggage might lead to your being rejected by members of another cultural group?

Think about a time when you were in the minority at an event. How did it feel? What were you concerned about? Did you feel you had to act or speak differently than you normally do?

What are three things you could do or say that would help persons from other cultural groups better understand your background?

Exercise 6

The Provider and the Client: An Exercise to Determine the Cultural Values of Both

Write down the answers to each of the questions listed below.

1. Time
   - Is it important to be on time for an appointment?
   - Are there differences depending on who you're meeting (e.g., supervisor vs. friend)?
   - Are there differences based on what's happening in your life (e.g., very busy, have a sick child, etc.)?
   - Do you plan ahead or deal with things as they happen?

2. Family
   - How important is family of origin to you?
   - How important is family of choice to you?
   - Do you value family loyalty and interdependency?
   - Have you struggled to become independent?

3. Children
   - Is it important for you to have children?
   - If yes, for what reasons (e.g., pass on family name, someone to love and be loved by, security in old age, a way of being recognized in your community as a woman, man, other)?
   - If no, why?

4. Cause of illness
   - Do you believe in the germ theory (i.e., infections are caused by micro organisms)?
   - Do you believe in divine retribution (i.e., illness is caused by punishment for sins, God's will)?
   - Do you believe that illness is caused by certain behaviors that we engage in (e.g., too much "high" living, excesses of food, drink, sex, etc.)?

5. Support
   - Whom would you talk to about a health problem you were having?
   - Whom would you talk to about an emotional problem?
   - Have you ever been to a support group before (e.g., 12 step program or therapy group, other)?

Are you more likely to talk about problems with a friend, family member, minister, other?

6. Personal matters
   How do you feel talking to a stranger about personal matters, such as a problem you're having in your closest relationship?
   Are there some things you're more likely to tell a stranger than a close friend (e.g., stranger on the plane phenomenon)?

7. Non-verbal communication
   Do you maintain eye contact when you speak? are spoken to?
   Are you comfortable with long silences in conversations?
   How close do you stand when talking with someone you don't know, to someone you do know?
   Do you greet friends with a hug, kiss, or some other form of expression?

8. Communication style
   Are you emotionally expressive or do you value keeping your emotions under control/hidden?
   Are you more expressive with some emotions than others (e.g., happiness vs. sadness)?

9. Death
   How would you feel if you were told that you had a life-threatening illness?
   Who would you tell if you knew you had less than six months to live?
   What would you do differently if you were told that you had less than six months to live?

10. Authority
    How do you feel about following the orders of persons in authority?
    Do you feel it is important to be able to ask questions before following the advice or orders of persons in authority?
    Are there certain types of authority you are more likely to follow than others (e.g., doctors, supervisors, police)?

Walking In The Others' Shoes

Now think about a client who comes from a cultural background that is different from your own. Go through each of the above questions and answer them as you imagine that client would respond.

What cultural values were similar?

What cultural values were different?

How would you feel if you were told:

- you couldn't have any (more) children?
- you shouldn't have sex anymore?
- you should go to a mental health counselor?
- you were dying?

How do you think clients feel when they are given these messages?

Exercise 7

Comfort/Discomfort Questionnaire

Consider each sentence as carefully as you can, then circle the number indicating your feeling.

1 - Strongly agree, 2 - Agree, 3 - No opinion, 4 - Disagree, 5 - Strongly Disagree

1. I would feel comfortable working with a gay man.
   1 2 3 4 5

2. I would enjoy attending social functions where lesbians and gay men were present.
   1 2 3 4 5

3. I would feel comfortable if I learned the person with whom I live is homosexual.
   1 2 3 4 5

4. If a member of my gender made a sexual advance toward me, I would feel angry.
   1 2 3 4 5

5. I would feel comfortable knowing that I was attractive to members of my gender.
   1 2 3 4 5

6. I would feel comfortable being seen in a bar for gay people.
   1 2 3 4 5

7. I would feel comfortable if a member of my own gender made an advance toward me.
   1 2 3 4 5

8. I would feel comfortable if I found myself attracted to a member of my own gender.
   1 2 3 4 5

9. I would feel disappointed if I learned my child was homosexual.
   1 2 3 4 5

10. I would feel nervous being in a group of homosexual people.
    1 2 3 4 5

11. I would feel comfortable knowing that my clergyman was homosexual.
1 2 3 4 5

12. I would be upset if I learned that my brother or sister were homosexual.
1 2 3 4 5

13. I would feel that I had failed as a parent if I learned that my child was homosexual.
1 2 3 4 5

14. If I saw two men holding hands in public, I would feel disgusted.
1 2 3 4 5

15. If a member of my own gender made an advance towards me, I would feel offended.
1 2 3 4 5

16. I would feel comfortable if I learned my daughter's teacher was a lesbian.
1 2 3 4 5

17. I would feel comfortable if I learned that my spouse or partner was attracted to members of his or her own gender.
1 2 3 4 5

18. I would feel at ease talking with a homosexual person at a party.
1 2 3 4 5

19. I would feel uncomfortable if I learned that my boss was homosexual.
1 2 3 4 5

20. It would not bother me to walk through a predominantly gay section of town.
1 2 3 4 5

21. It would disturb me to find out that my doctor was homosexual.
1 2 3 4 5

22. I would feel comfortable if I learned that my best friend of my own gender was homosexual.
1 2 3 4 5

23. If a member of my gender made an advance toward me, I would feel flattered.
1 2 3 4 5

24. I would feel uncomfortable knowing that my son's male teacher was homosexual.
1 2 3 4 5

25. I would feel comfortable working with a lesbian.
1 2 3 4 5

Scoring: For the following statements, you must reverse the scoring: 3, 4, 6, 9, 10, 12, 13, 14, 15, 17, 19, 21, 24. To do so, change the number you wrote for the item as follows:

Change 1 to 5
2 to 4
3 remains the same
4 to 2
5 to 1

When you have written in these new numbers and crossed out the old numbers, add up your total number of points. From this total score subtract 25.

This is your score:_____

The scale measures the degree to which you have dread or discomfort in being in close quarters with lesbian and gay people. The minimum score is 0 and represents the least dread and discomfort. The maximum score is 100 and represents the greatest amount of dread and discomfort. In general, a score of 0 to 25 is highly comfortable; 26 to 50 is moderately comfortable; 51 to 75 is moderately uncomfortable; and 76 to 100 is highly uncomfortable.

Reactions: In the space provided, write what you have learned about yourself from this exercise.

Source: Modified from "A Strategy for the Measurement of Homophobia." Journal of Homosexuality.

Exercise 8

The Heterosexuality Questionnaire

One would seldom consider asking a person of heterosexual orientation any of the following questions. The fact that they are often asked of openly gay persons reveals homophobia and acceptance of stereotypical thinking. Imagine asking a straight person the following questions...

1. What do you think caused your heterosexuality?
2. When and how did you decide you were heterosexual?
3. Isn't it possible that your heterosexuality is just a phase you may grow out of?
4. Is it possible that your heterosexuality stems from a neurotic fear of others of the same sex?
5. If you've never slept with another person of the same sex, isn't it possible that all you need is a good gay lover?
6. To whom have you disclosed your heterosexual tendencies? How did they react?
7. Why do you heterosexuals feel compelled to seduce others into your lifestyle?
8. Why do you insist on flaunting your heterosexuality? Can't you just be who you are and keep it quiet?
9. Would you want your child to be heterosexual, knowing the problems s/he would have to face?
10. A disproportionate majority of child molesters (some 95%) are heterosexual. Do you consider it safe to expose your child to heterosexual teachers?
11. With all the societal support and affirmation marriage receives, the divorce rate is still spiraling upward. Why are there so few stable relationships among heterosexuals?
12. Why do heterosexuals place so much emphasis on sex?
13. Considering the menace of overpopulation, how could the human race survive if everyone were heterosexual like you?
14. If you needed help, could you trust therapists who were heterosexual to be objective? Don't you feel they might be inclined to influence you in the direction of their own leanings?
15. How can you become a whole person if you limit yourself to compulsive, exclusive heterosexuality and fail to develop your natural, healthy homosexual potential?
16. There seem to be very few happy heterosexuals. Techniques may have been developed that might enable you to change if you want to. Have you considered trying aversion therapy?

Exercise 9

Combating Racism: Moving From Concern to Action: A Personal Inventory

Indicate whether you have taken action on the items listed below. Check the appropriate column.

Yes	No	
_____	_____	Have I intentionally and aggressively sought to educate myself further on issues of racism (by talking with others, viewing films/videos, finding reading material, attending lectures, joining a study group, etc.)?
_____	_____	Have I spent some time reflecting on my own childhood/upbringing and analyzing where/how/when I was receiving racial messages?
_____	_____	Have I spent some time recently looking at my own attitudes and behaviors as an adult to determine how I am contributing to or combating racism?
_____	_____	Have I evaluated my use of language, light and dark imagery and other terms or phrases that might be degrading or hurtful to others?
_____	_____	Have I openly disagreed with a racist comment, joke, reference, or action?
_____	_____	Have I made a clear promise to myself that I will interrupt racist comments, actions, etc., that occur around me - even when this involves some personal risk?
_____	_____	Have I grown in my awareness of racism in TV programs, advertising, and news coverage? Have I objected to those in charge?
_____	_____	Have I admitted publicly (in any setting) that I acknowledge my own racism and am actively striving to be an effective ally of all racial groups?

Yes	No	
_____	_____	Have I taken steps to organize discussion groups or a workshop(s) aimed at unlearning racism with friends, family members, colleagues, members of my house of worship?
_____	_____	Have I probed political candidates - at all levels - to determine their stance and commitment to work against racism?
_____	_____	Have I contributed *financially* to an agency, fund or program that actively confronts the problems of racism?
_____	_____	Have I contributed *my time* to an agency, fund or program that actively confronts the problems of racism?
_____	_____	Do my personal buying habits support stores and companies that demonstrate some awareness about and sensitivity to the issues of racism?
_____	_____	Have I investigated the curricula of local schools in terms of their treatment of the issue of racism (textbooks, films, assemblies, faculty, staff, administration)?
_____	_____	Have I made an inventory of the images (decorations, posters, signs, etc.) with which I surround myself at home, work, schools and house of worship?
_____	_____	Do I see myself as a resource person for referrals - directing other people to agencies, individuals, and groups who assist others in dismantling racism?
_____	_____	Have I sought out and seen any films focusing on racism and/or civil rights?
_____	_____	Do I view myself as a role model - an ally who fights racism in all its forms?
_____	_____	Have I made a contract with myself to *keep paying attention* to the issue of racism over weeks, months, and years?

Modified by Betsy Randall-David from an earlier adaptation by Andrea Ayvazian of work done by James Elder, University of Maryland, and Judy H. Katz, author of White Awareness: Handbook for Anti-Racist Training.

Steps In Providing Culturally Appropriate HIV/AIDS Educational Interventions

Step One:	Recognize your own cultural baggage
Step Two:	Learn about the community
Step Three:	Build rapport with the community
Step Four:	Explore creative strategies for getting the message out to the community
Step Five:	Design culturally appropriate interventions using information gained above and work collaboratively with key community individuals and organizations
Step Six:	Evaluate the intervention.
Step Seven:	Design ways to formally give recognition to community members who are actively involved in the project
Step Eight:	Sustain the project

Step One — Recognize your own cultural baggage

As mentioned in the last chapter, the first step in becoming a culturally competent practitioner is becoming aware of one's own cultural baggage. It is particularly important to understand your own feelings and beliefs about sex, death, support systems, disease etiology, non-biomedical healers or practitioners, religion, drug use, children, family, authority and persons from different ethnic, class and educational backgrounds.

In order to design culturally appropriate HIV/AIDS educational interventions, one must next learn about the various culturally diverse communities.

Step Two — Learn about the community

A. How does one learn about other communities?

1. By reading:

- novels written by members of similar communities
- biographies and autobiographies written by members of this cultural group
- community newspapers
- academic literature

2. By watching T.V. or listening to the radio

3. By engaging in informal conversation with members of the cultural group

4. By conducting interviews with:
   - informal and formal leaders in the community
   - agencies already serving the community

5. By conducting focus groups with members of the community

   ** See specific references on how to conduct focus groups. One excellent reference is **Methodological Review: A Handbook for Excellence in Focus Group Research** available through HEALTHCO (202) 862-1900 or through Porter Novelli, Washington, D.C. (202) 973-5800.*

6. By making observations while walking or driving through the community at different times of the day and week

7. By participating in community life and events
   - health fairs
   - festivals, pow-wows, celebrations
   - sports events
   - religious events
   - other events where members of the community gather

B. What does one need to learn about the community?

1. The political and social history of the community and its previous relationships with "outsiders".

2. The sources of health information (e.g., media, family members, friends, health providers, traditional healers, cultural heroes).

3. The history of relationships with the formal health care system and where members are currently getting care.

4. The perceived barriers to care (e.g., transportation, health provider attitudes, childcare, hours of operation, etc.).

5. The priority of needs or what's "on top" for them (e.g., food, shelter, clothing, utility bills, childcare, etc.).

6. The natural support system (e.g., what has worked in the past when they needed emotional and other types of support).

7. The attitudes toward children and childbearing (e.g., is having children a way to be recognized as a woman in the community, or are children a means of being taken care of in old age?).

8. The attitudes toward sexuality:
   - between married partners
   - between unmarried partners
   - between partners of same sex
   - between partners of different races or ethnic groups
   - bisexuality
   - sex for drugs or money
   - masturbation

9. The attitudes toward drug use and abuse.

10. The role of religion in health and illness, and attitudes toward fatalism and predetermination.

11. The health beliefs regarding cause of illness (e.g., hot/cold theory, evil eye, fate, germ theory, etc.).

12. The attitudes toward death.

13. The attitudes toward male and female roles (**who** is the decision maker about **what** types of issues, who has power in different spheres of influence?).

14. The family ties and structure, and who influences decisions and actions (e.g., in many cultures, the elderly are revered as founts of wisdom and they greatly influence the actions of younger members of the community; in other communities, gang members may consider their peers as extended family and have more allegiance to them than to their blood relatives).

15. The people in their social networks who influence, support and make important decisions.

16. The communication styles that exist in the community (e.g., direct vs. indirect communication styles).

17. The daily realities that may pose additional challenges and/or create barriers.

18. The community approach to health care (e.g., crisis management vs. prevention orientation).

19. The structural barriers (e.g., policies, economic conditions, laws, rules, etc.) that affect the cultural community.

20. Community attitudes toward help from outsiders.

Step Three — BUILD RAPPORT WITH THE COMMUNITY

A. Involve community members in <u>every</u> step of the process.

This includes:

1. Planning (conceptualizing the project)
2. Designing intervention strategies
3. Implementing the educational intervention
4. Publicizing the project
5. Conducting an ongoing assessment and evaluation of the program's effectiveness
6. Fundraising for continuation of the project beyond initial funding
7. Institutionalizing the project so it becomes part of the ongoing efforts of the community or organization

B. Network with community-based organizations that already have good working relationships with the target population.

1. Attend interagency or coalition meetings.

2. Establish or renew personal relationships with key members of community organizations.

3. Learn about their organizational goals and <u>priorities</u>
   - Ascertain what areas they might need assistance
   - Identify ways your project staff can be helpful to the community-based organization, and offer to assist or collaborate by:
     - sharing resources (e.g., office space, meeting space, photocopying, etc.)
     - sharing staff (outreach, case management, laboratory analysis, etc.)

- conducting in-service trainings
- providing technical assistance in grant writing or facilitating contact with other sources of funding
- developing programs or materials
- providing other needed services (e.g., translation if appropriate, client advocacy, transportation, etc.)
- lobbying key governmental agencies, etc.
- planning/participating in health fairs and other health events such as health screenings, etc.

4. Build trust with community-based agencies and key members of the community
   - Explain the goals and objectives of your project
   - Convey your sincere desire for the project to be responsive to the needs of the community (and ultimately "owned" by the community)
   - Suggest some ways for the community to be involved in the project
   - Elicit ideas about ways a community member(s) think(s) the community can best be involved
   - Don't make promises that may be difficult to keep
   - Keep appointments and attend all mutually agreed upon meetings
   - Convey the feeling that you are there to learn from the community and that you recognize, respect, and value the expertise and experience of community members
   - Convey flexibility and openness to seeing things in new ways
   - Follow the customs of the community (e.g., in some communities it is customary to begin meetings with a prayer, in others it is important to address and introduce people with formal titles)
   - Remember that it takes time to establish trust
   - Clarify the expectations of all involved in the project on a regular basis
   - Be aware that frequent contact is important and that it takes time to nurture new relationships and contacts

Step Four

EXPLORE CREATIVE STRATEGIES FOR GETTING THE MESSAGE OUT TO THE COMMUNITY

A. Limit the use of lectures and workshops.

These methods are of limited usefulness for many of the communities that health professionals are trying to reach. If group presentations are utilized, employ strategies that already exist in the community. For example, in the African American community, the "call and response " method of communicating between preachers and their congregations is often used in other settings where African Americans are teaching or imparting messages to others in their

community. The leader/ teacher/preacher states a message in an emphatic way and the audience calls back a response. This method of communication is highly participatory and engages the audience much more actively than the standard lecture or workshop presentation.

B. Learn about the learning style of the members in the community.

Most communities respond better to active participation than to a passive receptive approach. It has been found that most audiences retain more when they hear, see and then do. People will remember 10% of what they read, 20% of what they hear, 30% of what they see, 50% of what they see and hear, 70% of what they verbalize and 90% of what they do. Thus, it is important to utilize many different strategies for getting the message out to culturally diverse communities.

C. Use a <u>format</u> that actively engages the community.

1. Consider using ways the community is already getting messages out to their members. These may include the following:
   - church newsletters and neighborhood flyers
   - community electronic media (e.g., local radio and cable T.V.)
   - regular radio and T.V. (e.g., soap operas, talk shows, plays, etc.)
   - word of mouth (individually or in groups)
   - announcements or speeches at church, community events (e.g., town meetings, street fairs, sports events, tribal gatherings or family reunions
   - plays or street theater (often interactive)
   - talk circles
   - music (e.g., gospel, rap, folk, etc.)
   - art (e.g., murals, posters, photo exhibits, billboards)
   - magazines, comic books, photo-novellas
   - videos, movies (watching or making their own)
   - dance
   - storytelling
   - games
   - crafts
   - distribution of useful items with imprinted messages (e.g., t- shirts, visors, keychains, buttons, jewelry)

2. Determine what language is most appropriate
   - Are there differences between which language is spoken and which one is written or read?
   - What is the "street" vocabulary or vernacular used to describe sexuality, drug using, and other behaviors related to the project?
   - Are there rules for communicating verbally and non-verbally that are critical for project staff to understand and use?

3. Limit the use of brochures
Since most people remember only 10% of what they read, brochures should be seen as an adjunct to the other channels of information transfer. Should you wish to develop print materials, refer to the guidelines in Appendix D.

D. Choose a <u>messenger</u> for imparting the message who is respected by the targeted segment(s) of the community.

1. Determine who the "cultural heroes" are (e.g., sports figures, musicians, political figures, media personalities, movie stars, religious/spiritual leaders, healers and other health workers, educators, authors, beauty queens, elders or other revered community people).

2. Determine other influential opinion leaders in the community (e.g., beauticians, barbers, bartenders, block/neighborhood leaders, tenant association leaders, union leaders, business leaders, community organizers, leaders of fraternities, sororities, and other voluntary organizations , postal-workers, coaches, guidance counselors, law enforcement personnel, elected officials, ministers, business owners, health providers, bus drivers, etc.). Opinion leaders or influential people in some subcultures may not be known to the larger community (e.g., drug dealers, street walkers or pimps, gang leaders, etc.).

3. Determine the most appropriate age, sex, race, occupation or status of the messenger (e.g., Should it be a peer or someone older with respect and authority?).

4. Determine whether it would be more effective if the messenger is an "outside expert" or someone from within the community who is revered.

5. Use "testimonials" of heroes or respected members of the community who have successfully adopted new or desirable behaviors.

6. Ensure that the messenger is sensitive to the emotional and cultural nuances of the health information and the community's likely response to it.

E. Design a <u>message</u> that is simple, uncomplicated and "do-able". The message should meet the following criteria:

1. Is clear and consistent (i.e., consistent across time, across agencies and organizations, and consistent with the cultural values of the community).

2. Is age and language appropriate.

3. Takes into account the priorities of the community and follows the agenda of the community rather than imposing an agenda from the outside.

4. Empowers the community and encourages its members to take charge over the activities related to their health and well-being. Many cultural communities have a rich tradition of self help. With some education and encouragement, community members can get in touch with their inner strengths, take charge of their lives, and help themselves change unhealthful behaviors and practices.

5. Recommends actions that are realistic and do-able. Specify the behaviors that will foster a healthier lifestyle.

6. Emphasizes positive aspects of behavior change rather than using fear messages.

7. Includes positive alternatives to risky behaviors.

8. Recommends actions that are culturally acceptable and appropriate . The community values, norms, attitudes, beliefs, life experiences, and living conditions must be considered and incorporated into the strategy and the message.

9. States recommendations in terms that are easily understood by the community.

10. Avoids the use of technical jargon, scientific terms and ambiguous phrases.

11. Talks about benefits valued by the community rather than benefits valued by health providers.

F. Offer education in settings that are familiar, safe and calm. People learn best in these environments.

1. Determine a location that is trusted by the community (e.g., health departments or other health facilities may not be trusted by all members of the community you are trying to reach).

2. Locate natural gathering places (e.g., laundromats, ballfields, malls, playgrounds, beauty parlors, bars or juke joints, community centers, homes

or housing projects, church meeting halls, school buildings or grounds, street corners or any place where people gather or congregate).

3. Locate places where members of the community may already be gathering for other purposes (e.g., schools, shelters, ESL classes, sororities and fraternities, soup kitchens, pharmacies, local grocery stores or bodegas, small retail shops, health centers, mental health facilities, drug treatment programs, jails, daycare centers, etc.).

4. Locate places that are easily accessible to community members by being within walking distance, on public transportation line or accessible by wheelchair if needed.

5. Determine the best times of day, week and year to offer educational interventions in order to avoid conflict with already scheduled events (e.g., church nights, sporting events etc.) and to capitalize on already assembled groups of people (e.g., concerts, family reunion, pow-wows, etc.).

Step Five

DESIGN CULTURALLY APPROPRIATE INTERVENTIONS USING INFORMATION GAINED ABOVE AND WORK COLLABORATIVELY WITH KEY COMMUNITY INDIVIDUALS AND ORGANIZATIONS

A. Use a variety of approaches and strategies so that the problem can be approached from both the individual and community levels.

1. Combine workshops and individual counseling with creative interventions such as those listed in Step Four, C, page 25.

2. Plan interventions that engage community members in discussion, storytelling, debate and interviews, since most people learn by active participation.

B. Use multiple communication channels.

1. Use print media (e.g., newspapers, brochures, flyers, etc.) along with electronic media (e.g., radio, T.V., videos, etc.).

2. Use personal testimonies by respected members of the community as well as presentations by health educators, outreach specialists and health workers.

C. **Use multiple reinforcing messages.**

1. Deliver the same message in different words and in different formats.

2. Ensure that the health messages are congruent and reinforce each other.

D. **Make the interventions fun even when dealing with serious problems.**

1. Use formats such as theater, art, music, etc. that impart the message in an enjoyable way.

2. Use humor when appropriate to alleviate the anxiety and stress often associated with serious topics.

E. **Personalize the approach and message so that community residents can relate to the issue on a personal as well as intellectual level.**

1. Use personal pronouns (e.g., "I", "We") whenever possible to relate the message to a specific community.

2. Use spokespersons from the community to testify to the importance of the message.

F. **Involve extended family members - especially the elderly - in the intervention when appropriate. They are important and influential members of most communities.**

1. Use family members as educators, referral agents, caregivers and support persons.

2. Involve family members in all levels of the treatment planning and implementation.

G. **Hire staff or utilize people from the community in as many levels of the project as possible.**

1. Ensure that community residents are not just in volunteer positions but that they get paid for their time.

2. Understand the possible resistance some communities exhibit toward help from outsiders. Empower the community to discover solutions to its own health problems.

Step Six EVALUATE THE INTERVENTION.

A. **Gain input from the community on an ongoing basis. Evaluate how the interventions are being received and whether or not they are having the intended effects.**

- Evaluation methods
  - focus groups
  - informal interviews
  - structured interviews
  - pre/post tests/questionnaires
  - written surveys or verbal questionnaires
  - observations
  - documentation of changes in behavior through appropriate records

For more information about evaluation, see: Michael Patton (1990), Qualitative Evaluation and Research Methods. Newbury Park, CA: Sage Press.

B. **Remember that not all communities respond well to written materials and tests. Design of an evaluation tool that is culturally appropriate is as important as designing a culturally appropriate intervention.**

Avoid paper and pencil tests to gain pre- and post-intervention data. Instead utilize more participatory methods to elicit knowledge, attitudes and behaviors before and after the intervention. Examples of this approach include role-plays, responding to questions verbally especially if they are asked in a game format, or a sentence completion exercise.

C. **Be flexible and refine your approach based on your evaluation and community input.**

D. **Inform the community of what you have learned from your project so that the members have the benefit of this new information.**

Step Seven

DESIGN WAYS TO FORMALLY GIVE RECOGNITION TO COMMUNITY MEMBERS WHO WERE ACTIVELY INVOLVED IN THE PROJECT.

A. Recognize the important contributions of community members. Examples of tangible rewards include:

1. certificates of appreciation
2. gifts (e.g., pins, watches, briefcases, etc.)
3. awards banquets

B. Feature community members in media coverage of the project. Examples of increased visibility for community participation in the project include:

1. Interviews on T.V. and radio talk shows
2. Feature articles in local newspapers, magazines and newsletters.

Step Eight

SUSTAIN THE PROJECT

A. Work with community members on an ongoing basis to figure out ways to institutionalize the goals and objectives of the project so that the project lives on after the funding ends. The ultimate goal of the project is for the community to "own" the issue and see the goals and objectives as their own.

1. Network with other agencies in the community and encourage them to incorporate aspects of the project into their mission.
2. Work with elected officials to develop ways the project can inform public policy and legislation.

B. Work with community members to design leadership development procedures if needed to ensure that there are people from the community who can continue the efforts of the project beyond the funding cycle.

1. Identify community members who have demonstrated commitment to the project.

2. Identify community members who could serve as mentors for less experienced leaders.

3. Identify formal as well as informal training opportunities for newly emerging leaders.

C. Work with community members to identify additional funding sources if needed and provide technical assistance in order to secure further funding.

1. E lore both public and private funding opportunities.

2. Explore local, state, regional and national funding sources.

3. Identify experienced resource persons willing to assist community members in preparing grants.

Culturally Appropriate HIV Counseling

■■■ General Guidelines for Cross Cultural Counseling

It is impossible to know all the attitudes, beliefs, values and practices of our clients, particularly those from cultural backgrounds that are different from our own. What we can develop is an awareness of the range of world views and how these affect the behaviors and feelings of our clients and of ourselves as people and as practitioners. The goals of cross-cultural training are to facilitate the development of a professional stance that views the client's needs from his/her perspective, and integrate the client's world view, cultural beliefs and strengths into an individualized treatment plan.

1. **Take the time to build trust**. There are many historical events that have not facilitated understanding and communication among people from culturally diverse backgrounds, so it is important to acknowledge this past and indicate through our actions that we do not intend to perpetuate this history. Some examples of past experiences, which might influence how clients from various cultural groups view the health profession, include: the Tuskegee syphilis experiment, certain oral contraceptive experiments and other "clinical trials" that may have had varying degrees of informed consent or community understanding associated with them. Given this historical backdrop it is understandable that there are conspiracy theories about the etiology of HIV and a general distrust of the health care system among many clients from culturally diverse communities.

2. **Convey respect for your client and his/her values**. Ask the client how s/he prefers to be addressed. While young clients may actually prefer to be called by their first names, many older clients and those from various cultural communities consider being called by their first name a sign of disrespect.

3. **Be aware of cultural differences in** body space, eye contact, touching, use of silence, emotional expressiveness and other **non-verbal behaviors**.

    - In general, Latinos and African Americans prefer closer body space. European Americans use a moderate amount of space between people, and Native American and Asian American clients prefer greater distances between themselves and others.

    - European Americans value constant eye contact while other ethno-cultural groups believe that continual eye contact is a sign of

disrespect. In some groups, eye contact is maintained when speaking but not when listening.

- African Americans and Latinos are more emotionally expressive and touch more frequently in greeting and social interaction than do other cultural groups. Native Americans and Asian Americans tend to be less emotionally expressive and likewise do not employ much touch in relating to others.

- Allow the client to choose seating for comfortable space and eye contact.

- Do not assume that head nodding or smiling indicate understanding. Many cultural groups value politeness, and clients may smile or nod to be agreeable even when they don't understand the message.

- Observe other non-verbal ways of relating. Ask clients to explain any behaviors that are ambiguous in meaning.

4. **Assure that the interaction between you and your client is confidential.** This is especially important for clients from communities where loss of face and shame surround certain health issues.

   - Certainly HIV/AIDS is a highly stigmatized disease in many communities but this response may be exacerbated in rural areas and other communities where there have been relatively few persons living with AIDS.

   - Drug use, gay and lesbian lifestyles, multiple sexual partners, and other forms of individual expression may likewise be frowned upon in many communities.

   - In small and tight knit communities there is often a very active grape vine which communicates much community information and misinformation. Thus, it is critically important to assure clients that every attempt will be made to maintain their confidentiality.

   - Make it clear to the client where personal information shared by her/ him will be recorded and who has access to these records.

5. **Demonstrate your own willingness to openly share information before asking others to share.**

- In the HIV arena, health practitioners ask clients to share very personal information about themselves and their partners and families. Even though our professional training warned against personal sharing, it is important to model self-disclosure and be willing to risk sharing first. Share a couple of personal things about yourself so that the client has some sense of who you are as a person before relating to you as a professional. This will be especially important for clients from cultural backgrounds that value the personal (e.g., many Latino, African American communities).

6. **Use language that is appropriate for the client.** Avoid slang, technical jargon, and complex sentences.

   - Pair medical or scientific terms with street language or common vernacular in order to educate and communicate. For example, a health practitioner might say to a client, "People with syphilis, or some folks might say "bad blood", have a higher risk for getting other STDs, or some folks call them "VD".

   - Speak at a rate that promotes understanding and demonstrates respect for the client.

   - Avoid the tendency to speak louder to clients who have different language patterns or vocabulary than your own. Try to rephrase the message rather than repeating it in a louder tone of voice.

7. **Check frequently with the client to make sure your message was heard and understood** (e.g., "Sometimes when I am explaining this I have so much to say that I miss something. Could we go over the important points to be sure I covered everything?"). Then ask the client to paraphrase what you have just told him/her.

8. **Accept the responsibility for possible misunderstanding or miscommunication** (e.g., "I want to be sure I understand what you are saying."). Summarize or paraphrase the main points of the client's message and then check out your understanding by asking, "Did I get that right?" or "Is that essentially correct?".

9. **Use open ended questions or questions phrased in several ways to obtain information. Preface questions with permission that they do not have to be answered (e.g., "If you feel comfortable telling me, I'd like to know...").**

- Clients feel more in control of the interview or interaction, if they feel that they have permission to answer only those questions with which they are most comfortable.

- Amazingly when clients feel more in control they are less likely to answer incompletely, inaccurately or with a response that they think the practitioner wants to hear. More complete and accurate information will be elicited when the client feels as though s/he has options.

10. **Avoid asking very personal questions until you have established rapport and realize what is considered public and private for your client's cultural background.**

    - Health practitioners working in the HIV/AIDS arena have become so comfortable talking about sex, drug use, bodily functions, dying, and a host of other personal topics that they sometimes forget that not every one else is as comfortable with these discussions. In many cultures these topics are taboo to talk about with anyone; in other cultures one does not discuss these topics with strangers or persons of the opposite sex.

11. **Maintain consistency between your actions, non-verbal behavior and your words.** Following through on your promises is especially important for clients from culturally diverse backgrounds for whom actions speak louder than words.

12. **Involve the family and family concerns in the treatment or counseling plan.** The family is often a source of strength and support as well as a source of health advice and information.

    - Use a broad definition of family to include anyone whom the client considers to be family. This definition may include partners, spouses, lovers, extended family members, godparents as well as blood relatives.

13. **Use a translator or interpreter as needed.** Be aware of who is considered appropriate for this role in various cultures (i.e., consider the age, sex, social class, etc., of the translator with respect to the client).

- In many traditional cultures (e.g., Asian American and Native American) it is considered inappropriate for a younger person to be a translator for an older person.

- In some cultures (e.g., many Latino communities) it is inappropriate for a male to translate for a woman or visa versa, especially about very personal matters (e.g., sexual health concerns).

- In many cultures a person of a higher social class would feel uncomfortable discussing personal matters in front of an interpreter from a lower class.

14. **Determine the client's reading ability before using written materials.**

    - Make sure printed materials are in the language used by the client and are at a literacy level that is appropriate for the client.

    - Remember that many clients from culturally diverse communities rely more on the spoken word than on the written word. Use of pictures or other visuals may be more effective than written materials. *(See Chapter 3 for more comprehensive guidance.)*

15. **Determine the level of acculturation** (i.e., the degree to which the client has adapted to mainstream American ways vs. retaining his/her ethnic or traditional ways). This is especially important in order to gauge how closely the client is likely to adhere to traditional values and beliefs.

    - Clients who have close ties with their country of origin may ascribe to many traditional health beliefs and practices that might affect their readiness to utilize more biomedical approaches.

    - For clients who are still tied to traditional health practices, work within their belief system to help them combine the traditional with the biomedical. Utilize traditional healers as adjuncts to the treatment team.

16. **Incorporate the cultural strengths and values into your education and treatment plan.**

    - Utilize the strong value of family to encourage clients to adopt more healthful behaviors. Often men will change behaviors to protect their wives or children while women will protect themselves because they don't want to get sick and not be able to care for their children.

    - Work within the strong religious beliefs of many cultural groups by incorporating these beliefs into the health message. Encourage clients to help God by taking better care of themselves.

    - Use the deep respect for the elderly, which is a value found in many cultural groups, by educating elderly members of the family or community and including them as part of the treatment team or using them as lay educators.

    - Build on cultural practices, reinforcing those that are positive and promoting change only in those which are harmful. It is not necessary to change health practices that are neutral or helpful. Concentrate on helping the clients change only cultural practices that are injurious or might compromise their health status. When facilitating change of behavior, be sure to do so within the cultural value system of the client.

17. **Anticipate that there will be multiple needs such as medical, legal, financial, nutritional, social, and psychological.**

    - For many clients, HIV is just one of a long list of problems they must cope with. In fact, it may not even be the most pressing need for them. They may have of other pressing concerns, such as a financial crisis, an overdue bill or the threat of domestic violence. Start first with those needs that the client identifies as the most important and then work towards your agenda.

    - Remember that many cultural groups believe strongly in the close connection between the physical, emotional and spiritual domains. It is important to offer the client a holistic approach to problem solving rather than solely concentrating on the physical domain.

18. **Expect and acknowledge differences between your own experiences and views and those of your client.** It's O.K. to have differences but it is important to acknowledge these dissimilarities so they don't unconsciously interfere with the communication between the health practitioner and the client.

    - Beliefs about causes of illness, attitudes toward death and dying, patterns in caregiving and caretaking, views toward children, sexuality, help seeking behaviors, etc., vary a great deal depending on one's cultural background.

    - Share your views with the client and elicit the client's as well.

The following model developed by E. Berlin and W. Fowkes (1983) and modified by Tafoya and Wirth (1992) will help with this process:

The **LEARN** Model

L	Listen with empathy (active listening).
E	Elicit client world-view. Access client perception of the problem/need. Explain your perceptions of the problem/need.
A	Acknowledge and discuss the differences and similarities.
R	Recommend action/intervention/treatment.
N	Negotiate action/intervention/treatment.

Tafoya (1992) states that all too often the practitioner listens (**L**) by focusing on the "problem", missing important information such as strengths within the client and client's support system, which may be important to integrate into the treatment plan.

The practitioner often explains (**E**) his/her perception without eliciting the client's perspective or world-view. While the client is speaking the practitioner is planning and beginning to recommend action (**R**).

The (**A**) and (**N**) steps are most often eliminated. Failure to implement these two steps is a recipe for failure when working with culturally diverse clients.

19. **Above all be genuine, sincere, respectful and non-judgmental.**

    - Convey an interest in getting to know the client as a unique individual who brings both strengths and needs into the helping encounter. When health practitioners convey a willingness to meet the client halfway and express a genuine concern for their well being, the client will forgive a lot of ignorance, missteps, and missed communication.

    - Being "real" is more important than knowing everything there is to know about every cultural community.

20. **Remember that we learn about ourselves by learning about others.**

A Guide For HIV Specific Counseling Sessions

1. Build Rapport

Hello, my name is _____ and I'm going to be talking with you today about some health concerns, specifically HIV.

And your name is?

How would you like me to address you?

2. Establish Baseline HIV Knowledge

First of all, I'd like to ask you, "What do you already know about HIV?"

Possible follow-up suggestions might include:

- Tell me what the letters "H", "I", "V" stand for
- How do people get HIV?
- What's the difference between HIV and AIDS?
- What kind of signs or symptoms do people get when they have AIDS?

HIV and AIDS are very serious. That's why I spend so much time educating and counseling people about the disease. [I have 2 children and I'm concerned about their future...*insert your own personal information here.*]

3. Discuss Prevention

Tell me what you know about how people can avoid getting infected with HIV? How can they protect themselves?

Follow-up by:

- Providing correct information about modes of transmission and methods of prevention
- Clearing up misinformation: One way to do this might be by asking the client where s/he heard the information, then validate the client by saying, "That's a common belief (or feeling)." Then correct the misinformation by stating "Actually scientists have found that..."

Do you have any questions about how you can get HIV? How you can avoid it?

Tell me about any experiences you have had trying to protect yourself from any sexually transmitted disease, or as some people call them V.D. or venereal diseases.

For example:

- Have you ever tried using a condom?
- How easy is it for you to bring up the topic of using condoms with your partner?
- How might s/he react?
- Have you ever felt like you would be physically hurt if you suggested using a condom?
- Would you like to role-play talking about condoms? You play the part of your partner and I'll try different ways to bring up the topic.
- I know that in some communities, using condoms is seen as taboo or against religious or cultural values. How do people in your community or family feel about using condoms? How do you feel?

Tell me about any other ways you have tried to protect yourself from a sexually transmitted disease.

How do people in your family feel about having more than one sexual partner? About having sex with a same-sex partner? How do you feel?

4. Assess Risk

Now, I'd like to ask you about some ways you might have come into contact with HIV. Some of these questions are very personal, but I need to ask them to help you assess if you are at risk of getting infected with HIV. You have the right not to answer any question you are really uncomfortable with. But, if you want to know more about why I'm asking you the question, just *tell* me. I ask everybody these same questions so I can give them the best help possible.

Since the virus has been around for a long time, I need to ask you if any of these statements describe your life since 1978.

Since 1978 have you:

_____ had a blood transfusion
_____ had sex with a person who had a blood transfusion
_____ had infusion of clotting factor, if you have hemophilia
_____ had sex with a person with hemophilia

_____ received donated semen, eggs, or transplanted organs or tissues
_____ been exposed to blood in the work setting

Since 1978 have you:
_____ used injectable drugs and shared "works"
_____ had sex with a person who uses or used injectable drugs and shared "works"
_____ had sex while so stoned, high, or drunk that you can't remember the details
_____ had sex for drugs or money

Since 1978 have you had sex with:
_____ a man who has had sex with other men ("gay" or "homosexual")
_____ a man who has had sex with both men and women ("bisexual")
_____ a woman who has had sex with a man who is homosexual or bisexual
_____ a person who has served a jail or prison term
_____ a person who you thought or knew was infected with the AIDS virus
_____ more than one person (number in last year____, number in last 5 years ___)
_____ a person who has had more than one partner
_____ a person from Africa or Haiti, or a person who travels often to these areas
_____ a partner who has had gonorrhea (clap), syphilis (bad blood), herpes, genital warts, chlamydia
_____ someone against your will
_____ anyone without using a latex condom
_____ anyone with whom you shared sex toys like a vibrator, dildo, etc.

In the last year have you:
_____ had a sexually transmitted disease such as gonorrhea (clap), syphilis (bad blood), herpes, genital warts, chlamydia
_____ had hepatitis
_____ had symptoms which might mean HIV infection
  _____ purplish blue spots on skin, under mouth, nose, eyelids or rectum
  _____ recurrent yeast infections
  _____ recurrent high fever
  _____ night sweats
  _____ rapid weight loss for no apparent reason
  _____ swollen lymph nodes
  _____ constant fatigue
  _____ diarrhea
  _____ white spots in mouth
_____ had acupuncture, a tattoo, electrolysis (hair removal), ears pierced (ask about sterilization procedures)

Follow-up any affirmative answers with questions to get more information about the high-risk activities.

What have you heard about the connection between drugs and HIV?

How common is substance use or taking of street drugs among your family and friends? (What about alcohol?)

Who do you drink or drug with? Under what circumstances? Have you tried to change this behavior? Tell me about that.

What questions about HIV and AIDS would you like to ask me?

5. Assess Attitudes Toward Having Children

When you were a child did you want to be a parent someday?

As you got older, did this thinking change? If so, in what way? How do you feel about being a parent now?

What are some of the reasons people in your community have children?

Some possible probes might include:

- to have someone to love?
- to be loved by?
- to be recognized as a female or male by the community?
- to have someone to take care of you in old age?
- to pass on family name, land, traditions, etc.?

6. Assess Health Care Practices

What kinds of treatments do you regularly use or have tried for health problems?

What home remedies do you use?

What other natural therapies have you tried?

Have you tried any alternative therapies (non-FDA approved therapies)?

What medications are you taking?

Are there other practices such as prayer, meditation, biofeedback, visualization, or anything else that you've tried to handle your emotional or physical problems?

7. Assess Attitudes Toward Death And Dying

What are your family's attitudes and practices surrounding dying? How are yours alike or different from those?

Are there types of death or places one might die that you particularly fear or dislike?

Are there special rituals or ceremonies performed when someone is dying in your community?

What are the usual ways of dealing with grief in your community?

How do people in your family feel about death?

Are the dead believed to have any influence on the living?

What are your beliefs about life after death? How do these affect your views of dying?

What role should a friend, health provider, or others play in case of a death? When, if ever, does one offer condolences? What other actions may be expected?

8. Assess Support System

When you have problems, like with a relationship, who do you turn to for help?

When you're sick, who do you turn to for help?

Who do you consider "family"? How can we involve them in supporting you?

What are the community's attitudes toward the mental health agencies? counseling?

How do people feel about talking about their problems with strangers?

How do people feel about mental illness?

Describe any healers, religious figures, or helping people in your community who help you when you have an emotional problem or physical illness.

Tell me about any experiences you may have had with support groups or self-help groups?

Tell me how your religious or spiritual beliefs have helped you cope with problems or illnesses in the past.

Describe any other ways you have coped with tough times. How might these ways be helpful to you now?

Providing Culturally Specific HIV Counseling, Education And Care

Cultural differences between providers and their clients are often seen as obstacles that impede effective communication and practice. However, the provision of effective HIV education, counseling and care depends a great deal on integrating aspects of the clients' cultural system into the providers' interventions. Rather than seeing cultural values as hindering forces, the culturally competent practitioner seeks to identify the cultural strengths of each client. The practitioner then works within this framework, turning culturally determined values, attitudes and practices into helping forces. Not only does this approach recognize the importance of the client's cultural value system but it validates the inherent strengths that all clients possess. It is a positive reframing of the old need-based or deficit-based approach.

This chapter discusses some of the cultural strengths of four different ethnocultural groups and proposes ways that these can be incorporated into HIV education, counseling and treatment with clients who closely identify with these values. **It is vitally important that the following suggestions not be taken as a recipe for working with all members of these four ethnic groups.** No group is monolithic and there will be members of every group for whom the following values do not ring true. **In order to provide effective services to any community of people, practitioners must learn about the cultural values and behaviors of the specific community and of individual clients.**

It is hoped that after considering these examples, readers will be able to apply their understanding of other cultural groups (e.g., gay and lesbian persons, homeless people, migrant farmworkers, injection drug users, prisoners, sex workers, etc.) to design culturally specific HIV counseling, education and treatment interventions for diverse communities and clients.

African American Cultural Strengths

- **Strong kinship bonds and sense of family and community**
  - Involve the extended family in HIV education and counseling sessions and in treatment planning.
  - Emphasize that by protecting oneself, you will not burden family members with your care or the care of your children.
  - Emphasize that the client will be protecting future generations by modeling responsible sexual behavior and drug use.
  - Emphasize that by staying healthy the client can build future generations and ensure the continued existence of a strong African American community.
  - Emphasize in African American churches and other institutions the importance of the community caring for its own members who have HIV.
  - Involve key respected members of the community as peer educators.

- **Strong religious belief system**
  - Emphasize that it is the individual's responsibility to help God with His plan for them (i.e., work with God rather than giving all the responsibility for their future to God).
  - Ask clients not to judge their fellow man/woman but to leave God to judge the actions of other individuals.
  - Involve African American ministers in HIV prevention and care efforts.
  - Suggest ways that church members can help those with HIV/AIDS (e.g., making home visits, providing child care, transportation, food, respite care, etc.).

- **Strong history of self help**
  - Emphasize the importance of the African American community "owning" the problems in their communities and taking leadership roles in finding solutions or effective strategies for dealing with these problems.
  - Rename support groups to be "self help" groups for people coping with HIV.
  - Utilize the many wonderful "cultural heroes" and role models from the African American community as credible messengers for HIV prevention messages.

- **Present time frame focus**

  - Focus on client's priorities first, and then move to provider's agenda.
  - Focus on risk reduction rather than risk elimination.
  - Emphasize short term effects of behavior change rather than long term effects (e.g., client will look and feel better if s/he doesn't do drugs rather than the client will live longer).

- **Action valued over words**

  - Avoid negotiation and communication with partners as goals. Instead discuss strategies for non-verbal means for ensuring protection (e.g., putting condoms on partners without their knowing it).
  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

- **Importance of children**

  - Understand that children fulfill many roles and thus the decision to postpone or not have children is a complex one. Discuss the significance of children for each client.
  - Discuss quality of life issues for children brought into a world where both parents are sick or the children themselves have a chance of being sick.
  - Evaluate the ability of others in the community, especially the grandparents, to care for children whose parents are too sick to care for them (i.e., traditionally the grandparents or other relatives may care for children over an extended period of time, so an HIV crisis in the family may not pose an additional strain on them).

Latino/Hispanic Cultural Strengths

- **Emphasis on family as primary social unit and source of support. (Familisimo)**
  - Involve family members in HIV education, counseling and treatment and in the emotional and physical support of people with HIV/AIDS.
  - Use the family as a support group rather than referring client to a support group of strangers since Latinos may avoid discussing their problems/concerns outside the extended family.
  - Emphasize adoption of safer behavior for good of the group.
  - Emphasize that client should change behaviors so s/he acts as a good role model for the younger generation.
  - Accept individuals because of who they are not because of what they have or have not done, so accept family members who may have contracted HIV (e.g., homosexuals, drug users, etc.). This corresponds to cariño - a deep sense of unqualified caring and protection.

- **Importance of personal contact. (Personalisimo)**
  - Take time to establish rapport since Latino clients will be more likely to trust health care workers and with whom they have established a personal relationship.
  - See clients in person because Latinos value face to face interactions over less personal modes such as telephone or computer communications.
  - Expect that the client may not be punctual for appointments and don't hurry though the encounter, because being on time and being efficient are seen as far less important than interpersonal relationships.

- **Respect in social relationships which dictates the appropriate deferential behavior from others on basis of age, socioeconomic position, gender and authority status. (Respeto)**
  - Treat each client with the utmost respect to maintain the person's sense of integrity.
  - Encourage Latinos to ask questions and make sure they understand the information and advice, because Latinos respect authority figures and often accept their suggestions without question.

- **Importance of smooth social relations. (Simpatico)**
  - Emphasize politeness and respect rather than assertiveness and direct criticism, so be sure to check for understanding of your message, because the client might appear to understand HIV related information and agree to suggested behavior change when in fact s/he is merely avoiding conflict.
  - Avoid suggestions of openly confronting his/her sexual partner as part of negotiating safer sex practices.

- **Traditionally Prescribed Sex Roles**
  - Use concept of machismo or man's role to assume responsibility for and protection of the family to encourage men to adopt safer behaviors to protect the whole family.
  - Use the value of women as child rearers and child educators to encourage them to protect themselves in order to protect their children.
  - Give women options they can control.

- **Importance of Children**
  - Emphasize that parents should take care of their own health so they will be around for their children.
  - Emphasize importance of modeling responsible sexual behavior and drug use.

- **Strong religious belief system**
  - Emphasize that it is the individual's responsibility to help God with His plan for them (i.e., work with God rather than giving all the responsibility for their future to God).
  - Ask them not to judge their fellow man/woman but to leave God to judge the actions of other individuals.
  - Utilize religious leaders in HIV prevention and care efforts. Include Santeras and espiritistas, spiritual leaders who are believed to possess psychic powers and knowledge of spells, charms and incantations, in HIV efforts.
  - Suggest ways that church members can help those with HIV/AIDS (e.g., making home visits, providing child care, transportation, food, respite care, etc.).
  - Incorporate folk healers into treatment plan. Work in alliance with them. Illness traditionally has its roots in physical imbalances or supernatural forces

through God's will, magical powers, evil spirits, powerful human forces or emotional upsets.

- **Present orientation and action oriented**

  - Focus on client's priorities first and then move to provider's agenda.
  - Focus on risk reduction rather than risk elimination.
  - Emphasize short term effects of behavior change rather than long term effects (e.g., client will look and feel better if s/he doesn't do drugs rather than the client will live longer).

- **Action valued over words**

  - Avoid negotiation and communication with partners as goals. Instead discuss strategies for non-verbal means for ensuring protection (e.g., putting condoms on partners without their knowing it).
  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

Native American Cultural Strengths

- **Importance of community cohesion - "the honor of one is the honor of all"**
  - Involve the extended family in education, counseling, and treatment planning, since kinship bonds extend beyond blood relatives to non-related friends and members of the tribe or clan.
  - Ensure tribal sanction for all prevention activities.
  - Emphasize the importance of adopting safer sex practices and responsible drug use so that the group can flourish and not die out.
  - Utilize the cooperative spirit of the community to promote peer educators.
  - Involve the elderly, who are deeply respected, in HIV education and in developing treatment plans.
  - Involve the whole community in caring for members with HIV/AIDS.

- **Strong belief in the interplay of the spiritual, physical, and psychological spheres**
  - Utilize sweat lodges, vision quests, talking circles to help HIV infected and affected clients get in touch with their feelings, fears, and strengths.
  - Utilize traditional healing ceremonies such as sweat lodges, blessings, sings etc. in the treatment plan.
  - Involve medicine people in the development of the treatment plan.
  - Ensure that the client with HIV/AIDS is being taken care of in his/her usual surroundings by family, friends and neighbors.
  - Combine traditional ways with western biomedical approaches (e.g., hang a dream catcher or medicine bag on the IV pole).
  - Call upon the Winds of the Four Directions to show the way in counseling and treatment (east=knowledge, south=warmth and affection, west=courage and strength and north=wisdom and healing).

- **Present time frame focus**
  - Focus on client's priorities first, and then move to provider's agenda.
  - Focus on risk reduction rather than risk elimination.
  - Emphasize short term effects of behavior change rather than long term effects (e.g., client will look and feel better if s/he doesn't do drugs rather than the client will live longer).

- **Action valued over words**

  - Avoid negotiation and communication with partners as goals. Instead discuss strategies for non-verbal means for ensuring protection (e.g., putting condoms on partners without their knowing it).
  - Utilize direct, tangible, action-oriented approaches to counseling as opposed to introspective talk and listen methods.
  - Emphasize practical approaches to behavior changes that are concrete.

- **Importance of children**

  - Understand that children fulfill many roles and thus, the decision to postpone or not have children is a complex one. Discuss the significance of children for each client.
  - Discuss quality of life issues for children brought into a world where both parents are sick or the children themselves have a chance of being sick.
  - Evaluate the ability of others in the community, especially the grandparents, to care for children whose parents are too sick to care for them (i.e., traditionally the grandparents or other relatives may care for children over an extended period of time, so an HIV crisis in the family may not pose an additional strain on them).
  - Emphasize the importance of modeling responsible sexual and drug use behavior for future generations.

- **History of self reliance and self help**

  - Emphasize the client's inner strengths and ability to make important decisions about his/her lifestyle and behaviors.
  - Understand the principle of non-interference, which allows people to make their own mistakes and decisions. Since support and assistance for a member of the extended family is not seen as interference, involve these significant people in HIV education, counseling and treatment efforts.
  - Stability is valued over change, so emphasize the continuity of the tribe or community by the adoption of healthful and safe behaviors.

- **View of death as closing-off of this world and moving-on to the spiritual world**

  - Understand that the client may view illness as something that happens on the journey toward the spiritual world.
  - Be aware that this client may be more accepting of death than other clients.
  - Involve spiritual healers to help with the transition from this world to the spiritual world.

Asian American Cultural Strengths

- **Importance of the extended family group**
  - Since the family is valued over the individual and bringing honor to the family is a strong value, emphasize that the adoption of responsible sexual and drug behaviors will reflect well on the family unit. Conversely, irresponsible behaviors will bring shame to the family.
  - Involve the family in HIV education, counseling and treatment planning.
  - Since the elderly are well respected involve them as HIV educators and care givers.
  - Personal problems are not discussed outside the family so consider the extended family as the support group rather than referring client to a support group of strangers.

- **Strong emphasis on education**
  - Frame HIV counseling in educational terms rather than counseling ones.
  - Emphasize practical approaches to behavior change that are concrete and goal directed. Focus on the present and immediate future rather than long term effects of behavior change.
  - Encourage peer education.

- **Interplay of the spiritual, physical and mental spheres**
  - Understand that emotional problems are sometimes manifested somatically.
  - Involve healers such as Buddhist monks or folk healers in both HIV counseling and treatment efforts, since medical intervention is often believed to interfere with one's spirit.
  - Help clients get in touch with their inner strengths and help them develop the skills and resources needed to help themselves, because self-healing is valued.
  - Utilize traditional healing methods such as acupuncture, coining, herbs, and accupressure along with western biomedical approaches.

- **Importance of children**
  - Emphasize the importance of providing good role models for the next generation by the use of responsible sexual behaviors and refraining from drug abuse.

- Emphasize that the adoption of safer sexual practices will enable one to live to provide for one's children.

- **Modesty and chastity among women**

  - Respect this value when counseling women about HIV prevention behaviors and approach the topic of safer sex obliquely rather than directly.
  - Don't ask a lot of personal questions until rapport has been established. Rapport building may take several sessions.

Organizational Cultural Competency

It is vital that the organizations in which we work support the commitment that we have made to be more culturally competent. This chapter contains two tools to help staff and agencies assess how their policies, practices and services meet the needs of clients from culturally diverse communities. Cultural competency is a process with many points along the continuum from cultural destructiveness to cultural proficiency. These tools can help identify and target areas for organizational improvement. *(See Appendix A for a complete description of these stages.)*

The first tool is meant to be used in a group setting as part of a workshop or discussion on organizational cultural competency. Ideally, this exercise would be part of a larger discussion where individuals have had an opportunity to explore their own cultural competency. *Several of the exercises in Chapter 2 of this manual might serve this purpose.*

The second tool is meant to be used by an organizational task force or team that has the top level management's commitment and support for this assessment process. The team should consist of staff from all levels of the organization as well as board and community representation. Team members may choose to fill out the assessment form and then convene to discuss the assessment. Another approach might be to divide team members into subgroups and complete certain components of the assessment so the form is not too overwhelming for any individual or group of individuals. Regardless of the initial step of filling out the assessment form, the richness of the discussion generated by the form will be enhanced by the participation of the entire team.

It is essential that the discussion generated by the assessment be documented perhaps by audiotape or at least by extensive and detailed notes. After thorough discussion of the assessment, which may take several meetings, the team should then prioritize areas and action steps according to some criteria. The criteria might include how many resources are needed, how easily remedied are certain areas of need, the level of staff commitment, the anticipated benefits and risks for the community, and the anticipated benefits and risks for the organization. Areas where technical assistance is needed should be identified and potential resources named.

The idea of the assessment form is not to overwhelm or engender guilt or bad feelings. Instead, it is meant to be used as a tool for beginning or continuing an organization's examination of its ability to effectively serve clients from culturally diverse communities. The process is far more important than the product (i.e., the assessment tool itself is less important than the self-examination and discussion that it is likely to generate). It is hoped that organizations will adapt or use it in that spirit.

ORGANIZATIONAL CULTURAL COMPETENCY ASSESSMENT

I. ORGANIZATION/AGENCY

Organizational Philosophy

0 1 2 3 4 a) The agency's mission statement, goals and policies recognize the cultural diversity of its clients and reflect a commitment to serve those groups sensitively and competently.

0 1 2 3 4 b) Input from persons from culturally diverse communities is solicited in drafting the mission statement and agency goals and policies.

0 1 2 3 4 c) The agency defines cultural diversity to include gender, ethnic, racial, religious, sexual orientation, and socioeconomic diversity.

0=no progress; 1=some progress; 2=substantial progress. 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Organizational Documents

0 1 2 3 4 d) The agency's policy and procedures manual, personnel manual and brochures specifically refer to services for clients from culturally diverse communities.

0 1 2 3 4 e) Intake and assessment forms, care plans and other client forms reflect a sensitivity to the particular needs of clients from culturally diverse communities (e.g., are available in the languages utilized by clients from culturally diverse communities, etc.).

0 1 2 3 4 f) There is a policy for resolution of disputes involving cultural differences.

II. BOARD

Membership

0 1 2 3 4 a) The board's membership reflects the cultural diversity served by the agency/program.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

0 1 2 3 4 b) The current board consults organizations that represent culturally diverse communities to recruit members.

_____

_____

_____

Meeting Times

0 1 2 3 4 c) The meeting times are convenient for all board members (e.g., meeting times consider the constraints of people who work in jobs that won't let them take time off during the day without loss of pay).

_____

_____

_____

Meeting Location

0 1 2 3 4 d) Meeting locations are in a part of town easy to get to by all members (e.g., location easily reached by public transportation; carpooling and rides for those unable to drive).

_____

_____

_____

Child care

0 1 2 3 4 e) Child care is provided by the organization. (This is an especially important for board members who are single parents.)

_____

_____

_____

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Training

0 1 2 3 4 f) There is a procedure, such as a board orientation packet and/or orientation session, to educate new members about the history, mission, goals, etc., of the agency.

0 1 2 3 4 g) There is training to educate board members who are not from minority backgrounds regarding the values, concerns, beliefs, practices of the populations/ communities served by the agency.

0 1 2 3 4 h) Board members participate in training to examine their own cultural attitudes, beliefs and values.

Format of meetings

0 1 2 3 4 i) The format of meetings accommodates the learning and work styles of the board members (e.g., some people learn best from being actively involved in projects, others respond well to reports about activities, others need to see for themselves the projects, progress and problems).

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Leadership

0 1 2 3 4 j) Leadership mirrors the diversity of the board and target population.

0 1 2 3 4 k) There is a mechanism for promoting leadership development among board members with less experience in leadership positions.

Committees

0 1 2 3 4 l) Committees established by the board integrate into their work the agency's mission statement and goals, including those pertaining to cultural competence.

0 1 2 3 4 m) There is a committee dedicated to developing strategies for insuring agency-wide cultural competence (e.g., overseeing policies, staff training and development of services for clients).

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

III. STAFF

Positions

0 1 2 3 4 a) Staff positions reflect the population served by the agency/project in proportion to their representation in the community being served.

0 1 2 3 4 b) Recruitment efforts attempt to reach a diversity of potential applicants (e.g., word of mouth, advertisement in media and organizations used by a diversity of community residents and informal community networks).

0 1 2 3 4 c) Job descriptions indicate that candidates ideally will have an understanding of, and sensitivity to, serving culturally diverse populations.

0 1 2 3 4 d) Staff in personnel or human resources have been trained and are sensitive to the need to hire people who are culturally competent.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Skills

0 1 2 3 4 e) There is an adequate number of staff members who speak the same languages as the clients.

0 1 2 3 4 f) Bilingual staff are in positions with the most contact with clients (e.g., educators, clinicians, financial screening staff, receptionists). Note: At the very least there should be interpreters or translators available.

0 1 2 3 4 g) Service providers embrace client empowerment and self determination as desirable treatment outcomes by building the clients' decision-making and problem solving capacities.

0 1 2 3 4 h) Staff exhibit knowledge of mental health and social service issues affecting people from culturally diverse communities.

0 1 2 3 4 i) Staff demonstrate an understanding of the stress arising from racism, sexism, classism, and heterosexism.

Training

0 1 2 3 4 j) Administrators and other supervisory staff support and encourage staff training on cultural diversity and cultural competency.

0 1 2 3 4 k) Training methods are congruent with the learning styles of diverse staff members (i.e., some people learn best by lecture, others by observational methods or apprenticeship).

0 1 2 3 4 l) There is a structured opportunity for staff to examine their own cultural values and how these affect interactions with clients.

0 1 2 3 4 m) Training in cross-cultural communication, attitudes, values, beliefs and practices is encouraged and supported for all staff by providing funds, allowing time away from regular work duties, etc.

0 1 2 3 4 n) There is training in conflict resolution for all staff.

0 1 2 3 4 o) Resources are available to help develop staff skills in cross cultural communication (e.g., videos, articles, journals, books etc.).

_____

_____

_____

0 1 2 3 4 p) Language training is available and supported by the agency (e.g., time to attend, space made available for training, compensation for training, purchase of language materials).

_____

_____

_____

Supervision, Staff Development and Evaluation

0 1 2 3 4 q) Supervision is provided in a way that recognizes the diversity of staff work styles (e.g., cultural differences in approach to time, communication styles, structure of task, etc.).

_____

_____

_____

0 1 2 3 4 r) Mechanisms are built-in for valuing the important contributions of all staff (e.g., rewards, recognition, other culturally valued mechanisms).

_____

_____

_____

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

0 1 2 3 4 s) Staff performance reviews include cultural sensitivity and competency components.

0 1 2 3 4 t) People from diverse populations are present in all levels of the staff (i.e., there is not a concentration of power and decision making among certain ethnic/racial groups and a concentration of lower paid or prestigious jobs among other groups).

0 1 2 3 4 u) There are opportunities for leadership development and/or advancement for all staff, including those from culturally diverse communities.

Policies

0 1 2 3 4 v) Pay periods are congruent with the economic realities of staff from diverse communities (e.g., for people who live from paycheck to paycheck, more frequent pay periods helpful).

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

0 1 2 3 4 w) Policies and procedures reflect the needs of diverse staff members and are clearly spelled out (e.g., conditions of sick time, administrative leave, maternity (parental) leave, education leave, etc.).

0 1 2 3 4 x) Pay advances are made that cover all anticipated expenses for travel and other out-of-pocket costs.

0 1 2 3 4 y) Hours are flexible enough to accommodate needs of staff with other responsibilities and commitments.

0 1 2 3 4 z) Day care is available for staff.

0 1 2 3 4 aa) Parking for staff is free or transportation subsidies, parking costs, and carpooling are available.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

IV. PROGRAMS

Needs Assessment

0 1 2 3 4 a) A community needs assessment is done on a regular basis (i.e., every 1-2 years) by the agency to identify the perceived needs of the culturally diverse populations and design responsive programs.
Date of last assessment:_____

0 1 2 3 4 b) Agency utilizes the expertise of resource people from culturally diverse communities in planning and delivering agency programs and services, and in conducting the needs assessments.

Outreach

0 1 2 3 4 c) Agency programs and services are advertised in community channels of information (e.g., special language radio, T.V.; newspapers, church bulletins, flyers at malls; through community-based organizations; in laundromats, daycare centers, etc.

0 1 2 3 4 d) Active outreach is conducted (i.e., staff go out into the community to educate community members about the agency's programs and to recruit clients).

0 1 2 3 4 e) The agency makes home visits to provide education, counseling and appropriate medical services.

Communication

0 1 2 3 4 f) Posters, educational brochures, videos, etc. designed specifically for culturally diverse communities are available and visible in the waiting area, offices, exam rooms, etc.

0 1 2 3 4 g) Materials are in the language of the people using the services.

0 1 2 3 4 h) Educational materials are written at the literacy level of the population to be served.

0 1 2 3 4 i) Signs and other directions are in the language of the target population.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Childcare

0 1 2 3 4 j) There is an awareness of the needs of parents and their children (e.g., child care, toys, play area and snacks are provided by the facility, etc.).

Transportation

0 1 2 3 4 k) The facility or program is accessible by public transportation and is in a safe location, especially if programs are offered after dark.

Hours

0 1 2 3 4 l) Hours are convenient for the clients and suited to their lifestyle (e.g., evening or weekend hours for clients who will lose pay or work time during day hours).

V. ENVIRONMENT OF AGENCY

Milieu

0 1 2 3 4 a) Surroundings are pleasant and convey the message that clients are valued and deserve attractive places to meet and be served (i.e., it feels more like a hotel lobby than a bus station).

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Privacy

0 1 2 3 4

b) Offices and other places where clients discuss personal information and feelings offer privacy and insure that clients will not be overheard or seen.

Off-Site Meetings

0 1 2 3 4

c) There are opportunities to see clients outside the agency where they are more comfortable (e.g., client homes, neighborhoods, community centers, reservations, etc.).

VI. CLIENT INTERACTIONS

Needs

0 1 2 3 4

a) Providers tailor services according to the clients' needs, which includes assessing and understanding the client's cultural values, attitudes, beliefs and strengths.

Strengths

0 1 2 3 4

b) Staff recognize and draw upon clients' cultural strengths and informal support system (i.e., staff do not focus solely on problems/weaknesses or only make referrals outside clients' natural support systems).

Differences

0 1 2 3 4 c) Staff openly discuss cultural difference with their clients

Respect

0 1 2 3 4 d) Clients are valued by staff who educate and assist them in developing skills, and who honor the clients' ability to make responsible decisions about their own health care.

Satisfaction

0 1 2 3 4 e) Client satisfaction is formally assessed on a regular basis (i.e., annually to determine if clients feel respected, comfortable, understood, cared **about** and cared **for**, etc.).

VII. COMMUNITY INVOLVEMENT

Community Advisory Boards and Special Committees

0 1 2 3 4 a) People from culturally diverse communities are invited to sit on special committees and task forces.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

0 1 2 3 4 b) The membership reflects the diversity of the populations served by the agency.

0 1 2 3 4 c) Advisory boards and special committees have regular, defined and valued input regarding the development of policies, outreach efforts, evaluation of projects, data collection, and the development of materials, programs and resources.

Linkages With Other Agencies

0 1 2 3 4 d) The agency belongs to an interagency referral network that communicates, coordinates and collaborates for the benefit of clients from culturally diverse communities (e.g., culturally specific social services, counseling and support, transportation, etc.).

0 1 2 3 4 e) The agency collaborates with culturally diverse organizations on special projects of mutual benefit.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

0 1 2 3 4 f) Reciprocity of effort and resources is part of the modus operandi of the agency when working with other agencies.

0 1 2 3 4 g) The agency advocates for culturally diverse communities on the local, state and federal levels with regard to policies, funding, legislation, etc.

VIII. DATA COLLECTION AND EVALUATION

0 1 2 3 4 a) The agency collects, analyzes and makes available culturally specific data.

0 1 2 3 4 b) The agency has a clear evaluation plan for assessing the effectiveness of its cultural competency goals.

0 1 2 3 4 c) People from the diverse communities in the service area are involved in the evaluation process.

0=no progress; 1=some progress; 2=substantial progress; 3=goal achieved; 4=not relevant
Note: If not relevant (4), please explain.

Exercise 11

Culturally Competent Organizations

Objective: In a group setting, identify specific characteristics of culturally competent and incompetent health care agencies/organizations.

Setting: An area large enough to accommodate six to eight small groups of four to five people each. Need tables or a hard surface to write on large newsprint.

Time: 75 minutes

Materials: **Audiovisual and Other -**

1) Index cards that list the various organizational components that each group should focus on during the exercise
2) At least two sheets of large newsprint per small group
3) Two flip chart stands, if tape is not allowed on walls
4) Masking tape to hang newsprint
5) Markers

Procedure:

1) Divide the participants into eight groups, giving each group a set of cards that list specific organizational components, at least two sheets of newsprint and one to two markers. Encourage everyone to participate (5 minutes).
2) In the small groups, BRAINSTORM characteristics of the organizational components listed on the index cards. Write these ideas on the newsprint (20 minutes).
3) REASSEMBLE into one large group for small group presentations (5 minutes).
4) PRESENTATIONS of small group reports (4 minutes each) and hanging newsprint on wall (35 minutes).
5) REFLECT and DISCUSS where the participants' agencies fall on the cultural competency continuum (5 minutes).

(Adapted from: Davis and O'Malley, 1994)

NOTES TO FACILITATOR

Introduction and Directions:

"We are going to do an exercise to help us focus on how an organization, in this case a health care facility, can demonstrate cultural competency. Each of you is assigned to a small group. When I have finished giving instructions, please move to the area where your small group will be meeting. For approximately 20 minutes, each small group will be working to design either a culturally competent or culturally incompetent health agency according to the organizational components you have been assigned."

"The first task of each group is to pick one person who will write the group's ideas on the newsprint, one person who will be willing to be the group reporter when we reconvene, and one person who will be the timekeeper. I will be circulating among the small groups to be sure everyone understands the directions and to let you know when there are only five minutes left."

"I'm sure that each group will have lots of good ideas. Because of time constraints, each group needs to prioritize two to three key points under each of their organizational components to share with the larger group. I will be hanging the newsprint so people will have an opportunity to see all of your work."

"Any questions? Remember you are painting a picture of an organization on one end of the continuum or the other. Most organizations are somewhere in between."

SMALL GROUP ASSIGNMENTS: Eight groups are recommended. (However, six groups can be arranged if there are a small number of participants.) Assign each group a set of organizational components, which you will need to put on index cards before the actual training. The following groups of components and suggestions of specific characteristics for participants to consider during their brainstorm activities are recommended below. One group in a set, for example Group 1, would describe the assigned components of a hypothetical organization, a health agency in this case, as if it is at the culturally "incompetent" end of the continuum. The other group, Group 2, would describe the same components except it would be for a health agency that is culturally "competent."

Encourage participants to be specific and use all three senses: What would the organization sound like, look like, feel like?

Recommended Categories for the Group Assignments

Groups 1 & 2:

1. **Board**
   Composition, Goals, Working Style, Recruitment of New Members, Training/Orientation
   NOTE: Depending on group, this may be a Board of Health, Board of Directors, etc.

2. **Committees/Working Groups**
   Composition, Goals, Working Style, Recruitment of New Members

3. **Decision Making**
   How, Who, Process

Groups 3 and 4:

4. **Hours**
   (e.g., for Services, Meetings, Other Functions or Events)

5. **Educational Materials**
   Type, Language, Literacy Level, Targeted to Types of Clients, etc.

6. **Populations Served**
   (Who - age, sex, race, geographic location, sexual orientation, etc.)

7. **Outreach to New Clients**
   (e.g., Methods Used, Where, By Whom, When)

Groups 5 and 6:

8. **Staff**
   Recruitment, Orientation, Training and Staff Development, Assessment

9. **Supervision**
   Styles, Format, Frequency, Setting

10. **Personnel Policies**
    Leave, Flexible Hours, Compensatory Time, Diversity

Groups 7 and 8:

11. **Environment**
    Milieu, Privacy, Off-Site Meetings and Transportation

12. **Location**
    On-Site and Off-Site for Meetings and Events

13. **Outreach to Other Agencies/Service Providers**
    Linkage, Referral To, Referral From

14. **Programs/Services Offered**
    Determining Need, Design, Implementation, Marketing, Evaluation of Effectiveness

SMALL GROUP WORK: Circulate to make sure all groups are on task and are not spending all their time on one component. Make sure they are describing hypothetical organizations and are not slipping into descriptions or complaints about ones they actually know or work in. Encourage them to be creative and innovative since this is a brainstorming session. At the ten minute mark, warn groups that half of their time is up. At the five minute mark, let them know that they should be finishing up in the next couple of minutes.

SMALL GROUP PRESENTATIONS: Remind the group that they are creating a composite of an organization at each end of the continuum. This is an opportunity to get specific about what these general terms look and feel like to make it easier to identify and be aware of their implications. This may also make it easier to articulate "blind spots" or problem areas to others and work together for change in our own organizations.

Ask a small group who painted the picture of a culturally incompetent organization to share their work. **LIMIT THEM TO NO MORE THAN FOUR MINUTES!** Then ask the next group who painted a picture of a culturally competent organization, using these same components, to share. Repeat this process for the remaining groups. First the incompetent then the competent picture. Remember: Four minutes per group unless you can extend the time for this session.

Encourage participants to use the "Organizational Assessment" worksheet to take notes during the presentations of culturally competent organizations so they can take ideas back to their organizations. After a small group presentation, ask the large group: "What message is sent to others, if the organizations had the particular characteristics presented by the small group; how would they feel about going to obtain services there?"

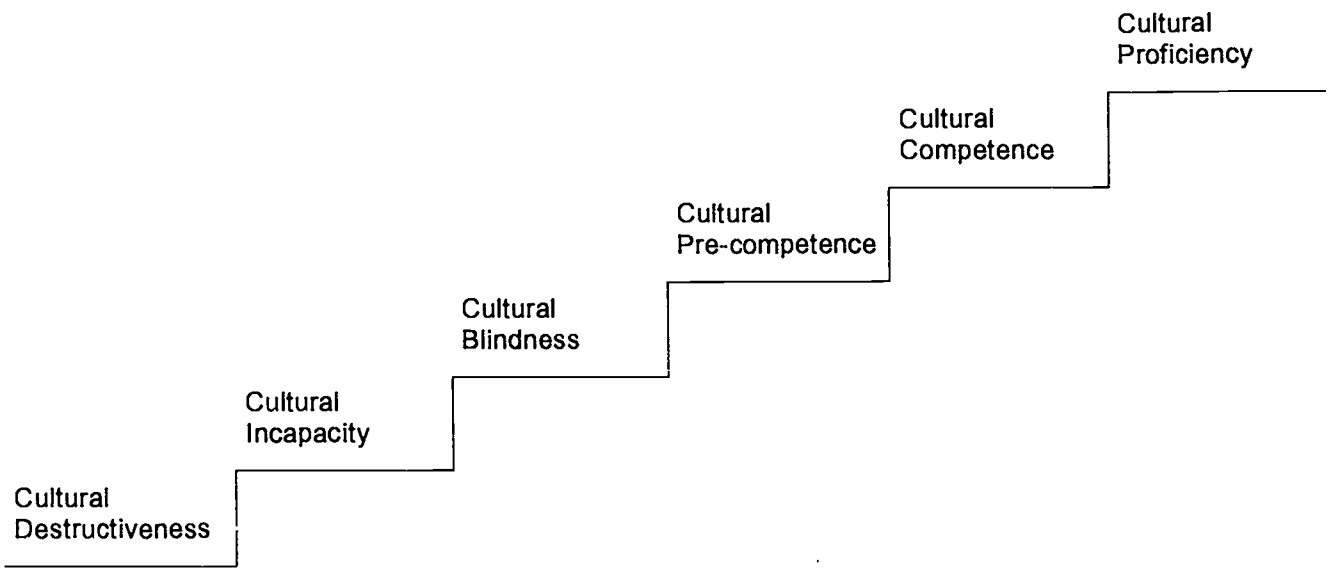
REFLECTION AND DISCUSSION: "Think about your own agency. In which areas are your organizations most like the culturally competent organizations we had described? In which ways are your organizations most like the culturally incompetent pictures? Do you fall somewhere along the continuum?"

Culturally Competent Organizational Assessment Worksheet

Components	What Organization Looks, Feels Like	Message Sent to Others (e.g., clients, other agencies) About Organization
1. Board		
2. Committees		
3. Decision Making		
4. Hours		
5. Educational Materials		
6. Populations Served		

Components	What Organization Looks, Feels Like	Message Sent to Others (e.g., clients, other agencies) About Organization
7. Outreach to new clients		
8. Staff		
9. Supervision		
10. Personnel Policies		
11. Environment		
12. Location		
13. Outreach to other agencies		
14. Programs/services offered		

Cultural Competence Continuum



■■■ Cultural Destructiveness

Attitudes, policies and practices that are intentionally destructive to a culture

■■■ Cultural Incapacity

Biased, paternalistic system that lacks capacity to facilitate growth in culturally diverse groups

■■■ Cultural Blindness

Culture/ethnicity/race make no difference in how services are provided; the "We're all human" approach

■■■ Cultural Pre-competence --- Cultural Sensitivity

- Awareness of the particular set of norms, values and beliefs associated with a particular group
- Awareness of the impact of culture upon interactions, experiences, etc.
- Desire and attempt to deliver services in a manner respectful of cultural diversity
- Workshops, training, hiring a diverse staff, etc.

■■■ Cultural Competence (All levels - Agency, Policy, Providers, Clients)

- Acceptance of and respect for differences
- Self-assessment regarding cultural competence
- Assessment of cultural norms, patterns, beliefs, etc.
- Responsiveness to the unique needs of diverse groups
- Adaption/Acculturation of service models
- Interplay between policy and practice.

■■■ Cultural Proficiency

- Seek to add to the knowledge base of culturally competent practice
- Develop culturally competent therapeutic approaches
- Hire staff who are specialists in cultural competence.

(Adapted From: Cross, T.L., Bazron, B.J., Dennis, K.W., and Issacs, M.R.. (1989). "Towards a culturally competent system of care: A monograph on effective services for minority children who are severally emotionally disabled".

Resources and References In Multicultural Issues

■■■ Useful References

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- Berlin, E. and Fowkes, W.: (1983). *A Teaching Framework for Cross-Cultural Health Care.* Western Journal of Medicine, Volume 139(6), pp. 934-938.
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- Gonzalez V., Gonzalez, J., Freeman, V., Howard-Pitney, B.: (1991). *Health Promotion in Diverse Cultural Communities.* Stanford, CA: Health Promotion Resource Center.
- Harwood, A. (Ed): (1981). *Ethnicity and Medical Care.* Cambridge, MA: Harvard University Press.
- Irish, D., Lundquist, K., Nelson, V. (Eds): (1993). *Ethnic Variations in Dying, Death and Grief: Diversity in Universality.* Washington, DC: Taylor and Frances.
- Jue, S.: (1988). *AIDS and Cross-cultural Counseling.* Focus, pp. 3-4.

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Useful References -- cont.

- Kain, C. (Ed): (1989). *No Longer Immune: A Counselor's Guide to AIDS*. Alexandra, VA: American Association for Counseling and Development.
- Ka'opua, L.: (1992). *Training for Cultural Competence in the HIV Epidemic*. Honolulu, Hawaii Area AETC.
- Kavanagh, K. and Kennedy, P.: (1992). *Promoting Cultural Diversity: Strategies for Health Care Professionals*. Newbury Park, CA: Sage.
- Kleinman, A., Eisenberg, L., and Good, B.: (1978). *Culture, Illness and Care: Clinical lessons from anthropological and cross-cultural research*. Anals of Internal Medicine, Volume 88, pp. 251-258.
- Lee and Richardson (Eds): (1993). *Multicultural Issues in Counseling: New Approaches to Diversity*. Alexandria, VA: American Association for Counseling and Development.
- National Technical Information Service: (1987). *Strategies for Diffusing Health Information to Minority Populations*. Springfield, VA: Order Number PB85160497HAS.
- Pedersen, P.: (1988). *A Handbook For Developing Multicultural Awareness*. Alexandria, VA: American Association for Counseling and Development

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- Pharr, S.: (1988). *Homophobia: A Weapon of Sexism*. Little Rock, AR: Chardon Press.
- Randall-David, E.: (1989). *Strategies for Working With Culturally Diverse Communities and Clients*. Washington, DC: Association for the Care of Children's Health. Available through Maternal and Child Health Clearinghouse, (703) 821-8955 Ext. 254.
- Roberts, R.N.: (1990). *Workbook for Developing Culturally Competent Programs for Families of Children With Special Needs*. Washington, DC: Georgetown University Child Development Center.
- Rogers, E.: (1983). *Diffusion of Innovations*. New York: Free Press.
- Sue, D. and D.: (1990). *Counseling the Culturally Different: Theory and Practice*. New York: Wiley and Sons.
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- Tafoya, T., and Wirth, D.: (1992). *Training for Cultural Competence: How not to repeat old mistakes.*
- Thomas, S., and Quinn, S.: (1991). *The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV*

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Education and AIDS Risk Education Programs in the Black Community. American Journal of Public Health, Volume 81 (11), pp. 1498-1505.

■■■ Presses

- Intercultural Press
  16 US Route One
  PO Box 700
  Yarmouth, ME 04096
  (207) 846--5168

- SAGE Publications, Inc.
  PO Box 5084
  Newbury Park, CA
  91359-9924
  (805) 499-9774

■■■ Newsletter

- *Cultural Diversity At Work*
  The GilDeane Group
  13751 Lake City Way, NE
  Suite 106
  Seattle, WA 98125-3615
  (202) 362-0336

■■■ Tapes

- "Racial and Cultural Bias in Medicine", 1991.
  American Academy of
  Family Physicians
  8880 Ward Parkway
  Kansas City, MO
  (816) 333-9700

- "Training for Cultural Competence in the HIV Epidemic", 1992.
  AIDS Education Project
  1319 Punahou Street
  Room 625
  Honolulu, HI 96826
  (808) 941-6322

■■■ Trainers

- University based trainers/professors in anthropology, sociology, social work, psychology and education.

- Organizations which specialize in diversity training:

  Equity Institute
  (415) 658-4577
  6400 Hollis Street, Suite 15
  Emeryville, CA 94608

  National Coalition Building Institute
  (202) 785-9400
  1835 K Street, NW, Suite 715
  Washington, DC 20006

Trainers -- cont.

National Multicultural Institute
(202) 483-0700
3000 Connecticut Avenue, NW
Suite 438
Washington, DC 20008-2556

ODT Inc.
(413) 549-1293
PO Box 134
Amherst, MA 01004

Onolwee Zwicke and Associates
(805) 682-2523
3887 State Street, Suite 22
Santa Barbara, CA 93110

SIETAR
Society for Intercultural Training, Education, and Research
(202) 466-7883
808 17th Street, NW, Suite 900
Washington, DC 20006-3953

VISIONS, Inc.
(617) 876-9257
68 Park Avenue
Cambridge, MA 02138

- Panel of persons from culturally diverse communities telling their stories.

Organizations Serving Culturally Diverse Communities

There are many organizations both public and private that offer educational and other resources for persons from culturally diverse communities. Check with your state AIDS program to obtain a listing of agencies in your area. The following is a list of **national** organizations that serve people of color with regards to HIV/AIDS issues.

ALIANA
3020 14th Street, NW
Washington, DC 20009
(202) 332-AIDS

American Red Cross
Aids Education Office
1730 D Street, NW
Washington, DC 20006
(202) 737-8300

Asian AIDS Project
300 4th Street, Suite 401
San Francisco, CA 94107
(415) 227-0946

Asian American
Psychological Association
16591 Mellville Circle
Huntington Beach, CA
92649
(310) 592-3227

Association of Asian/Pacific
Community Health
Organizations
1212 Broadway Suite 730
Oakland, CA 94607
(510) 272-9536

Association of State and
Territorial Health Officers
415 Second Street, NE
Suite 200
Washington, DC 20002
(202) 546-5400

BEBASHI
1233 Locust Street
Suite 401
Philadelphia, PA 19107
(215) 546-4140

Centers for Disease
Control
Department of Health and
Human Services
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-3311

Children's Defense Fund
25 E Street, NW
Washington, DC 20001
(202) 662-3510

COSSMHO (National
Coalition of Hispanic
Mental Health and Human
Service Organizations)
1030 15th Street, NW
10th Floor
Washington, DC 20005
(202) 371-2100

Indian Health Care
Association
245 East 6th Street
Suite 4999
St. Paul, MN 55101
(612) 293-0233

Indian Health Services
AIDS Activities Office
2401 12th Street, NW
Albuquerque, NM 87102
(505) 766-2374

NAACP
4805 Mount Hope Drive
Baltimore, MD 21215-3297
(410) 358-8900

National AIDS
Clearinghouse
PO Box 6003
Rockville, MD 20850
(800) 458-5231

National Association of County Health Officials
440 First Street, NW
Suite 500
Washington, DC 20001
(202) 783-5550

National Association of People with AIDS
1413 K Street NW
8th Floor
Washington, DC 20005
(202) 898-0414

National Black Women's Health Project
1237 Ralph David Abernathy Boulevard, SW
Atlanta, GA 30310
(404) 753-0916

National Center for Urban Ethnic Affairs
1521 16th Street, NW
Washington, DC 20036
(202) 232-3600

National Congress on American Indian
900 Pennsylvania Avenue, SE
Washington, DC 20036
(202) 546-9404

National Council of La Raza
810 First Street, NE
Suite 300
Washington, DC 20003
(202) 289-8173

National Hispanic Education and Communication Projects
1000 16th Street, NW
Room 401
Washington, DC 20036
(202) 452-0092

National Migrant Resource Program
2512 South IH 35
Suite 220
Austin, TX 78704
(512) 328-7682

National Minority AIDS Council
300 I Street, NE Suite 400
Washington, DC
20002-4389
(202) 544-1076

National Pediatric HIV Resource Center
15 South Ninth Street
Newark, NJ 07107
(800) 362-0071

National Urban League
500 East 62nd Street
New York, NY 10021
(212) 310-9000

Native American AIDS Prevention Center
3515 Grand Avenue
Suite 100
Oakland, CA 94610
(510) 444-2051
(800) 283-2437 (Hotline)

Office Of Minority Health Resource Center
PO Box 37337
Washington DC
20013-7337
(800) 444-6472

People Of Color Against AIDS Network
1220 South Jackson
Suite 25
Seattle, WA 98144
(206) 322-7061

People Of Color Leadership Institute
714 G Street, SE
Suite A
Washington, DC 20003
(202) 544-3144

Guidelines for Developing Effective Printed Materials

In order to develop effective printed materials, it is suggested that you follow the guidelines listed below:

- Cover design
  - Use bright colors and bold graphics to grab the attention of the reader.
  - Use images or photographs of people with characteristics similar to the target community in terms of race, gender, age, clothing, hairstyles, etc.
  - Avoid use of words on the cover that might embarrass the reader (i.e., if the reader will feel uncomfortable carrying around a brochure that says HIV/AIDS on the front, avoid this direct reference to HIV and utilize a more generic title such as What Every Cool Dude Needs To Know instead).

- Message
  - Aim for no more than 3 "take home" messages with one main message.
  - Emphasize a few points which focus on critical behaviors.
  - Use cultural values of the target community to illustrate the main messages (i.e., if children are highly valued by members of the target community, use the protection of children as a way of "selling" the importance of your message).

- Layout
  - Use as few words as possible and combine with lots of white space in margins and between sections.
  - Try to convey as much information as possible thorough the use of graphics, illustrations, pictures, and drawings.
  - Use 10- to 12-point type for the text since this is the most readable size. Use an easy-to-read print style.
  - Use highlighting techniques such as **boldface**, lists, *italics*, bullets, underlining and white space to emphasize important points.
  - Use 50-70 characters per line to avoid lines that are too long or too short.
  - Avoid using all capital letters.
  - Use ragged right margins rather than the more formal justified margins.
  - Avoid the use of charts, graphs, and other presentations commonly associated with a more scientific presentation.

- Organization of material
  - Organize similar concepts together.
  - Use subheads for sections of the brochure.
  - Use one idea per paragraph to emphasize each important concept.
  - Use short sentences (approximately 9-10 sentences per 100 words) and only one subject per sentence.
  - Use a summary paragraph to end a section and to recap major points.

- Choice of words
  - Use short, familiar, "real" words that are in the everyday conversation of the target community.
  - Use as direct and clear vocabulary as is culturally appropriate (i.e., don't use ambiguous phrases like "avoid the exchange of bodily fluids" since there might be many interpretations of this message). Instead state the message directly in clear terms.
  - Avoid use of technical jargon and polysyllabic words when possible.
  - Define technical or difficult terms.
  - Avoid abbreviations except when commonly understood.
  - Use active voice and strong verbs.
  - Use conversational and personal words such as "you", "we", names, etc.
  - Be consistent in choice of words and don't interchange words.

- Evaluating effectiveness of materials
  - Conduct a SMOG test (or some other test for readability of the materials) to ensure that the brochure is at the reading level of the target community.
  - Conduct focus groups or less informal methods for review of the materials by members of the target community to ensure that the message is understood and that the brochure is user friendly.

You, Whoever You Are

You, whoever you are!

All you continentals of Asia, Africa, Europe, Australia in different of places

All you on the numberless islands of the Archipelagoes of the sea!

All of you of centuries hence when you listen to me

All of you each and everywhere whom I specify not, but includes just the same.

Health to you! Goodwill to you all from me and America Sent!

Each of us is inevitable.

Each of us is limitless.

Each of us with his or her right upon the earth.

Each of us allowed the eternal purports of the earth.

Each of us here as divinely as any is here.

Walt Whitman, 1819-1892