Research Articles

Cultural Competence Development in Health Education Professional Preparation Programs

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ABSTRACT

To date few studies have been conducted to assess the preparation of health educators in the area of cultural sensitivity and competence. The purpose of this study was to assess efforts and opportunities offered by health education professional preparation programs to prepare health educators in the area of cultural competence. One hundred fifty-seven department chairs or program coordinators completed a survey to elicit information regarding cultural competence and professional preparation programming. Results of the study suggest that most health education professional preparation programs are not offering courses entirely devoted to cultural competency. Nonetheless, it appeared that most programs are adequately addressing cultural competency content-related areas in their courses. The results also showed that most faculty members are committed and feel comfortable with addressing issues of cultural competency with their students. Findings from this survey support the need for the implementation of standardized cultural competency training for faculty members, cultural competency required courses for students, and for discipline-specific standards for cultural competency among health educators.

INTRODUCTION

Culture has been defined as the values, beliefs, attitudes, and customs that influence an individual's perception of health and illness as well as their health practices and behaviors.[1–3] The literature suggests that cultural patterns are influenced by a person's country of origin, socioeconomic status, rural vs. urban upbringing, gender, age, and religious practices.[4–6] Given the importance of culture in the health status of individuals, it has been argued that understanding cultural concepts is vital to the delivery of health related programs including health education.[4, 7, 8] This is of particular importance considering the increasing diversification of the U.S. population. [9, 10] It is estimated that by 2020, the percentage of the White, non-Hispanic population will decrease to 61% of the U.S. population.[11]

The roles and responsibilities established by the Role Delineation Project[12], the Competency–based Framework for Professional Development of Certified Health Education Specialist [NCHEC],[13] and the most recent National Health Educator Competencies Update Project[14] established the assessment, planning, implementation, and evaluation of programs as the key job responsibilities for health educators. What these seminal documents fail to address directly is the increasing cultural, racial, ethnic, and national origin diversity present among members of the U.S. population. The lack of explicit guidelines in these guiding documents for the profession relative to dealing with cultural diverse population could have profound implications for the effectiveness of programs targeting traditionally disadvantaged population groups, which may espouse cultural beliefs and practices different from the mainstream population in the US.[15, 16] Moreover, researchers have established the need, opportunity, and method for addressing multicultural issues in health education.[1, 15, 17–19]

Realizing the challenges and opportunities faced by health care organizations in general[20] and health educators in particular in reaching diverse populations, the

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American Association of Health Education (AAHE)[21] released its *Cultural Awareness and Sensitivity: Guidelines for Health Educators* publication in 1994. In that document the organization called for health educators to become culturally aware and sensitive. However, there is no published evidence that the guidelines were widely adopted by health educators. In its continued effort to attract and better serve diverse populations, AAHE established the Multicultural Involvement Committee in 1994 with the mandate to "fulfill the AAHE goal of cultural pluralism."[22] This standing committee has sponsored a series of research-based presentations at the annual meeting and its annual forum at the conference focuses on an issue of interest to diverse populations.

While the field of Health Education has failed to develop a comprehensive plan for addressing the diversification of the U.S. population, much has been written to address the changing demographics in sister disciplines such as medicine. In 2004, the Institutes of Medicine (IOM) released a landmark report addressing the need to diversify the U.S. health care workforce. Among the recommendations were the following: managing admission processes to facilitate a more diverse student body, decreasing financial barriers experienced by members of under represented groups, and making diversity a component of accreditation processes.[23] Wells argued for the inclusion of diversity in the nursing field in a way that extended beyond respecting an individual's differences, but that also included changes in institutional settings.[16] Moreover, the elimination of health care disparities has been a driving force since the release of the Guidelines for Cultural Competence by the Office of Minority Health. Woolf, Johnson, Fryer, Rust, and Satcher have argued that health disparities and differences in access to health care services account for differences in mortality rates among different population groups.[24] Others have recommended reforms in the health care system to address health disparities among U.S. populations.[25, 26]

The continued diversification of the U.S. population and the need to effectively reach them with culturally appropriate programs led the Joint Committee on Health Education and Promotion Terminology to expand the terminology utilized and accept the more contemporary term *cultural competence* which it defined as: "The ability of an individual to understand and respect values, attitudes, beliefs, and mores that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing, and evaluating health education and promotion programs and interventions."[27] In contrast to the earlier term *cultural sensitivity*, the newer concept requires health educators to take into account the needs of diverse populations in their programs and services. Therefore, educational institutions have a professional responsibility to provide learning opportunities related to cultural competence to the students they prepare. It should be noted that achieving cultural competence is an ongoing process with a marked beginning and a life long commitment to achieve.

To date few studies have been conducted to assess the preparation of health educators in the area of cultural sensitivity and competence.[28–31] These studies have focused on the professional preparation of health educators as a way to address cultural sensitivity and competence among this group. Results of these studies showed that while many health educators are expected to address the needs of multicultural groups, most professional preparation programs (e.g., college, university) do not provide adequate training in this area. While these studies have assessed how professional preparation programs in health education prepared health educators in the area of cultural sensitivity, the results of such investigations do not provide an assessment of how health education professional preparation programs are currently addressing cultural competence in their programs. The purpose of the present study was to assess efforts and opportunities offered by health education professional preparation programs at colleges/universities to prepare health educators in the area of cultural competence.

METHODOLOGY

Sample

The study participants were selected from the *AAHE Directory of Institutions: Offering Undergraduate and Graduate Degree Programs in Health Education, 2003 Edition*.[32] The 2003 directory included the names of 255 institutions, the name of the department chair or program coordinator, and contact information. While the directory might not have included the names of all the institutions that offer a degree in health education, the directory included the names of institutions that self-identify as providing degrees in the field of health education, including those programs accredited by the AAHE/National Council for the Accreditation of Teacher Education (NCATE), the Council on Education for Public Health (CEPH), and the Society for Public Health/AAHE Baccalaureate Program Approval Committee (SABPAC).[32] The directory also included information on the type of degree(s) offered at each institution. The principal investigator (PI) received an updated version of the directory from AAHE that included the names of 31 additional institutions. All department chair or program coordinators were invited to participate in the study. One hundred and fifty seven department chairs or program coordinators returned a completed survey for a 55% response rate.

Of the study participants, one hundred and twenty-four chairs or program coordinators (79%) indicated that their institutions offer a degree in health education, while thirty-three reported that they do not offer a degree in this field. Based on the zip code on the business reply envelopes, these institutions were located in 42 states across the nation. Out of those who offer a degree in health education, 44% of the programs offer both undergraduate and graduate degrees in health education, while 39% offer only an undergraduate degree, and 17% offer only a graduate degree. Based on the information provided by the directory, it was determined that 39% of the institutions

offer only an undergraduate degree, 19% offer only graduate degree, and 42% offer both degrees. A one-way Chi-square analysis ($\chi^2 = .47$, df = 2, p = .79) indicated that the sample was no different from the population with regards to type of degree offer at these institutions.

Instrument

The authors developed a written survey based on an instrument developed by Doyle, Liu, and Ancona[29] and works from the multicultural health education literature. The survey included the definitions of cultural competence and health education program,[27] as the understanding of these terms were critical for the purpose of the present study. A panel of three health educators, with expertise in the areas of multicultural health and cultural competence, established the content validity of the survey. All three health educators provided input into the wording of each of the questions. If one of the individuals suggested deleting or modifying the question, all three needed to agree before it was done. In addition comments were solicited from three college professors, who were former chairs or program coordinators, pertaining to clarity and wording of each of the questions and responses. The comments provided by these three individuals resulted in additional modifications to the questions.

The survey included twenty closed-ended questions and three open-ended questions requesting information regarding the number of courses in each program with a focus in cultural competency, percentage of core courses that address cultural competence, participants' opinion regarding the level of commitment in the area of cultural competency by the students in the program, and possible changes needed in the program in this area. Since most of these questions were descriptive in nature, and as such they did not fit a particular scale, the reliability of these items was not calculated. The survey also asked participants to report on each content and skills covered in the courses dealing cultural competence. The participants were asked to choose for a list of ten content areas and nine skills taught in the courses. The responses were then coded as a yes or no response for each item. Reliability analysis with the current data resulted in a Kuder-Richardson = .758 for the question regarding content areas and Kuder-Richardson = .798 for the question regarding skills. Finally, the survey asked the level of commitment, knowledge, comfort of faculty members in the area of cultural competency, level of involvement of faculty members with ethnically/racially/diverse groups outside academia. The responses for these questions include a five-point Likert scale reflecting the response categories of very committed to not committed; very knowledgeable to not knowledgeable; very comfortable to not comfortable; and very involved to not involved. These responses were similar to a scale used in a previous study.[31] A reliability coefficient, from these four items, calculated with the current data resulted in a Cronbach's alpha = .826.

Data Collection and Analysis

The present study followed a descriptive research design during a five-month period. Each of the study participants received, via regular first class mail, a package including the survey, a cover letter, and a business reply envelope. The cover letter, addressed to each participant, explained the purpose of the investigation, issues regarding anonymity, and contact information for the PI. Implied informed consent was obtained from all study participants as required by the Institutional Review Boards from each of the institutions represented by the authors. As an incentive, participants were offered a copy of the preliminary results of the study.

One hundred individuals completed and returned the survey within six weeks of the initial mailing. In order to increase the response rate, a second and a third follow-up package, including another copy of the survey, was sent only to non-respondents after weeks seven and fifteen of the initial mailing. An identification code was used in each survey to identify initial respondents from non-respondents, without compromising the confidentiality and anonymity of the participants. Only those who did not respond to the initial mailing (N=186) received the second mailing. Forty-six individuals completed the survey after the second mailing, while another eleven participants completed the survey after the third mailing. In addition to the follow-up package, the PI contacted the participants through e-mail before the initial mailing and between each of the subsequent mailings to remind participants of the importance of their participation in the study. The PI received approximately twenty undelivered e-mail messages due to wrong e-mail addresses or the participant no longer working in the institution. When possible, the PI looked for the correct contact information of the chair/program coordinator through the institution's website. Moreover, the researcher received e-mail responses from five participants indicating that they no longer worked at the particular institution and, if they knew, they provided the researcher with the contact information of the current chair/program coordinator.

The Statistical Package for the Social Sciences (SPSS v12) was used for data analysis. In order to ensure the anonymity of the participants, the responses to the survey were entered into a database without the identification code. Descriptive statistics were calculated to examine the responses of the participants.

RESULTS

Results of the present study indicated that less than one-third of the programs (27%) offer a course entirely devoted to cultural competency. The titles of these courses range from "Cross-cultural health education," "Cultural issues in health education," "Multicultural aspect of health," to "Race, ethnicity and health." While most respondents (88%) indicated that their programs address cultural competency through their core (i.e., required) courses, almost half (46%) reported that less than twenty-five percent of these courses address issues related to cultural competence. The participants reported that most courses that include issues related to cultural competence, address cultural competence through instructional activities (82%) followed by

class project (62%) (Table 1).

The majority of the programs (87%) reported that they referred students to other department/programs within their institution for courses dealing with cultural competency-related area (see Table 1). The participants indicated that they referred students to departments such as psychology, sociology, anthropology, and nursing among others. Some of the participants also indicated that their institution has several "diversity" related courses that are required as part of their undergraduate degrees. When asked if they provided cultural/diversity training or education programs for their faculty members, the majority of participants (80%) reported that they do not provide this type of educational opportunity (Table 1).

The participants were asked to identify the ethnic, racial, and underrepresented groups addressed as part of their courses. More than 90% of the participants identified African Americans and Hispanics as the two groups most covered as part of their courses. In addition, over two-thirds of the participants reported that their courses also cover issues related to American Indian and Asia/Pacific Islander groups (Table 2). Separate questions sought to identify the cultural competency related content areas and skills addressed as part of these courses. The majority of the respondents indicated that "relationship between health and culture" and "relationship between health and social issues" were two content areas most covered in their courses. In addition, over seventy-five percent of the participants reported that their courses address "health beliefs and practices of different ethnic/racial groups," "cultural beliefs and values of different ethnic/racial groups," "health profiles of different ethnic/racial groups," "health issues and diseases disproportionately affecting ethnic/racial diverse groups," and "demographic profile of diverse populations."

When asked what cultural competence-related skills were addressed in their courses, eighty-five percent of the participants reported that their courses prepare their students to be able to "design culturally appropriate health education and health promotion programs for diverse ethnic/racial communities." Over two-thirds of the participants reported that their courses also train their students to be able to "develop the ability to understand and respect values, attitudes, and beliefs among diverse ethnic/racial groups," "implement health education and promotion programs for diverse ethnic/racial communities," "develop culturally appropriate strategies and materials," and "provide health education and promotion programs to diverse ethnic/racial communities." Finally, among those programs that referred their students to other programs for cultural competence-related courses, seventy-six percent of the participants reported that courses outside their program addressed "cultural beliefs and values of different ethnic/racial groups" (Table 2).

Over seventy percent of the participants reported that the faculty members in their department were either very committed or committed to cultural competency and were either very comfortable or comfortable in addressing this topic. However, only sixty-three percent were either very knowledgeable or knowledgeable in the area of cultural competency. Similarly, only fifty-three percent of the faculty members were either very involved or involved with ethnically/racially/ diverse groups outside academia and fifty-eight percent reported that the students graduating from their pro-

Table 1. Information Regarding Cultural Competence Courses Among the Programs

Category	n	%	SE
Offer course entirely devoted to cultural competence			.03
Yes	33	27	
No	91	73	
Address cultural competence through core course			.02
Yes	109	88	
No	15	12	
Percentage of core courses that address cultural competence			.12
0–25	51	46	
26–50	13	12	
51–75	8	7	
76–100	37	34	
Address cultural competence through [a]			
Instructional activities	101	82	.03
Class project	76	62	.04
Service learning	67	54	.05
Other activities	15	12	.03
Referred students to other programs for courses that address cultural competence			.04
Yes	108	87	
No	16	13	
Provided cultural/diversity training or education programs for your faculty members			.04
Yes	24	20	
No	99	80	

[a] Participants reported more than one response; thus, total percentage is more than 100.
Note: Number and percentage are based on those who answered the question; table does not include missing data.

Table 2. Cultural Competence Related Content Areas and Skills Address as Part of Courses

Category [a]	n	%	SE
Ethnic, racial, underrepresented groups address in courses within program			
African American/Black	113	93	.02
Hispanic/Latino	112	92	.02
American Indian/Alaska Native	86	71	.04
Asian/Pacific Islander	81	67	.04
Immigrants	54	45	.04
Refugees	38	31	.04
Gay/Lesbian/Bisexual/Transgender	12	10	.03
Other	24	20	.02
Cultural competency related contents areas within program			
Relationship between health and culture	114	93	.02
Relationship between health and social issues	110	90	.03
Health beliefs and practices of different ethnic/racial groups	105	86	.03
Cultural beliefs and values of different ethnic/racial groups	103	84	.03
Health profiles of different ethnic/racial groups	102	84	.03
Health issues and diseases disproportionately affecting ethnic/racial diverse groups	98	80	.04
Demographic profile of diverse populations	95	78	.04
Becoming a culturally competent health educator	74	60	.04
Appropriate disease prevention strategies among ethnic/racial diverse groups	73	60	.04
Complementary and alternative health practices	72	59	.04
Other	11	9	.02
Cultural competence related skills within program			
Designing culturally appropriate hlth educ & hlth prom prog for diverse ethnic/racial communities	102	85	.05
Developing the ability to understand and respect values, attitudes, and beliefs among diverse ethnic/racial groups	90	75	.04
Implementing hlth educ & prom prog for diverse ethnic/racial communities	88	73	.04
Developing culturally appropriate strategies and materials	87	72	.04
Providing hlth educ & prom prog to diverse ethnic/racial communities	86	72	.04
Designing instruments to conduct needs assessment with clients of diverse ethnic/racial backgrounds.	62	52	.04
Identifying resources in the areas of racial/ethnic diversity and cultural competency	59	49	.04
Designing instruments to evaluate hlth educ & prom prog for diverse ethnic/racial communities	51	43	.04
Designing media campaigns for clients of diverse ethnic/racial backgrounds	48	40	.04
Other	7	6	.02
Cultural competence-related content areas within other programs			
Cultural beliefs and values of different ethnic/racial groups	41	76	.06
Relationship between health and social issues	31	57	.07
Demographic profile of diverse populations	28	52	.07
Relationship between health and culture	26	48	.07
Health beliefs and practices of different ethnic/racial groups	24	44	.07
Health issues and diseases disproportionately affecting ethnic/racial diverse groups	21	39	.07
Complementary and alternative health practices	14	26	.06
Health profiles of different ethnic/racial groups	11	20	.06
Becoming a culturally competent health educator	10	19	.05
Appropriate disease prevention strategies among ethnic/racial diverse groups	8	15	.05
Other	8	15	.05

[a] Participants reported more than one response; thus, total percentage is more than 100.
Note: Number and percentage are based on those who answered the question; table does not include missing data.

gram were either very committed or committed to cultural competency (Table 3). Finally when asked about possible changes needed in the program in order to prepare their students to become culturally competent, fifty-seven percent of the participants indicated that they will need to hire new faculty members from other ethnic/racial/cultural backgrounds (Table 4).

Table 3. Faculty Members, Students, and Cultural Competence

Category	n	%	SE
Faculty members' commitment to cultural competency			.09
Very committed	47	38	
Committed	46	37	
Somewhat committed	20	16	
A little committed	8	7	
Not committed	2	2	
Faculty members' knowledge about cultural competency			.08
Very knowledgeable	20	16	
Knowledgeable	57	47	
Somewhat knowledgeable	33	27	
A little knowledgeable	10	8	
Not knowledgeable	2	2	
Faculty members' comfort level with cultural competency			.08
Very comfortable	31	25	
Comfortable	56	46	
Somewhat comfortable	25	20	
A little comfortable	7	6	
Not comfortable	3	3	
Faculty members' level of involvement with diverse ethnic, racial, cultural groups outside academia			.09
Very involved	17	15	
nvolved	44	38	
Somewhat involved	33	28	
A little involved	18	15	
Not involved	5	4	
Students commitment to cultural competency			.08
Very committed	17	14	
Committed	52	44	
Somewhat committed	39	33	
A little committed	9	7	
Not committed	2	2	

Note: Number and percentage are based on those who answered the question; table does not include missing data.

DISCUSSION

Despite a documented need, data from this study suggests most health education professional preparation programs are not offering courses entirely devoted to cultural competency. Instead, most programs address cultural competency through their core-required courses. Perhaps most troubling findings from this study indicated that the majority of the surveyed programs referred students to other departments/programs within their institution for courses dealing with cultural competency. While no value judgment is made on the quality of those other departments/programs, they might not have the credentials to address cultural competence from a health education standpoint. For example, a sociology course might address cultural competence differently from a psychology course or a health education course. While all three courses might have some common elements, the focus of the information in a health education course will better prepare students by making an abstract concept more relevant to the training needs of future health educators.

Most participants reported that African Americans and Hispanics are the two groups most discussed as part of their courses. This result supports the finding presented by Doyle, Liu, and Ancona.[29] While African-Americans and Hispanics constitute approximately twenty-five percent of the population, we must recognize that other racial/ethnic groups are also growing at fast rates and should be part of any discussion in health education courses. Moreover, it seems that most programs are adequately addressing cultural competency content-related areas (e.g., cultural and health beliefs, health disparities, etc.) in their courses as shown by the responses of the participants. These results showed a significant improvement in the area of preparation of culturally competent health educators when compared to results from previous studies.[28,29,31] However, students in the field of health education may not be getting all the skills needed to appropriately address the needs of racially/ethnically diverse groups. While most programs are teaching students how to design and implement culturally appropriate health education and health promotion programs, only half of the programs are teaching students how to design culturally appropriate instruments for needs assessment and evaluations and how to identify resources in this area. As indicated above, these skills (e.g., assessing needs, evaluating program, acting as a resource) are three key responsibilities of health educators.

The results of the present study showed that most faculty members at these institutions are committed and feel comfortable with addressing issues of cultural compe-

Table 4. Changes Needed in the Program to Better Prepare Students in Cultural Competency

Statement[a]	n	%	SE
Hire faculty member(s) from other ethnic/racial/cultural group(s)	71	57	.04
Bring guest speakers from different ethnic/racial/cultural backgrounds to lecture in our courses	54	44	.04
Offer cultural competence training to faculty members	53	43	.04
Work with community organizations to offer cultural events	52	42	.04
Offer new cultural competence-related course(s)	49	40	.04
Other changes	22	18	.03
No changes are needed	10	8	.02

[a] Participants reported more than one response; thus, total percentage is more than 100.
Note: Number and percentage are based on those who answered the question; table does not include missing data.

tency with their students. Still, there seems to be room for improvement when it comes to the level of knowledge of faculty members in this area. Nonetheless, it is important to note that the perception of level of commitment, comfort, and knowledge could be misleading as these terms could be subject to misinterpretation. Future studies are needed to better measure these concepts. Findings from this study also indicate that most programs do not offer cultural/diversity training or education programs for their faculty members, and some of them acknowledge the need for this type of training in order to better prepare their students for entry into the workforce. The need for cultural/diversity training or education programs is supported by results from a recent study that indicated that participation in cultural/diversity focused education influence the level of cultural competency among health educators.[30] Further studies are needed to determine which educational activities work best in this effort.

While over half of the programs in the present study identified the need to hire more diverse faculty members, given the economic and budgetary issues at most institutions, hiring new faculty members is not as feasible as some of the other possible changes. In order to better prepare students to become culturally competent, professional preparation programs in health education must, at a minimum, get involved with diverse groups outside academia, access resources (e.g., guest speakers, cultural events) within their surrounding communities, incorporate more cultural competence related content and skills into their core courses, and provide internships or service-learning activities that provide students with the opportunity to gain multicultural experiences. One way to incorporate cultural competence skills into health education courses is by using "A guide to choosing and adapting culturally and linguistically competent health promotion materials,"[33] and other materials available at The National Center for Cultural Competence. These simple steps may help improve, in the short-term, courses in the health education professional preparations in the area of cultural competency. In addition, these steps may help increase the students' commitment in addressing issues of cultural competence.

Several limitations should be considered when examining these results. First, participants' bias can be anticipated in any self-reported survey; therefore, some bias can be anticipated given the respondent's interest in responding to a survey on cultural competence. Second, the sample respondents for this study were selected from the "Directory of Institutions"[32] published by AAHE; thus, it is possible that errors in the listing of each program limited the contact of the appropriate person and/or program to complete the survey. It is also possible that some participants were hesitant to disclose information that might show their programs in less than a favorable light in regard to cultural competence. Consequently, even after three mailings, the return rate was less than anticipated; hence, bias in the responses can be expected. Price, Murnan, Dake, Dimmig, and Hayes argued that surveys research in health education should attain a response rate of 60% or greater to reduce non-response bias.[34] Still, we could contend that the difference between a response rate of 60% and 55% is minimal; hence, the response bias between respondent and non-respondent is limited.

Moreover, it is important to recognize that while the "Directory of Institutions" might not be the best available list, it is a respectable list as it contains the names of institutions accredited by the AAHE/NCATE, CEPH, and SABPAC. In addition, there was no difference between the sample and the population based on type of degree offered at the institutions. Thus, it could be argued that there are more similarities than differences between respondent and non-respondent institutions. Nevertheless, further research is needed in order to better generalize these findings. Finally, based on the definition of cultural competence provided by the Joint Terminology Committee,[27] cultural competence examined only issues related to culture/race/ethnicity and not issues of diversity (e.g., aging or sexual orientation) as interpreted by some of the respondents, which were beyond the scope of this investigation. Replication of this study should be conducted every five years or so to determine what, if any, cultural competency changes have occurred in professional preparation programs. Moreover, future research in this area should include

questions regarding the number of credits of courses in cultural competency, more in-depth information regarding the courses, preparation of faculty members teaching cultural competence courses, definitions of cultural competency used by faculty members beyond race and ethnicity, and issues related to health disparities among ethnic and racial groups. In spite of these limitations, the findings describe how health education professional preparation programs currently address cultural competence as part of their programs.

IMPLICATIONS

Results from the present study indicate that some "form" of cultural competency-related education is being taught in health education professional preparation programs. Data results also indicate "mixed reviews" regarding the amount of cultural competency training provided for the faculty as well as a required cultural competency course for students. Although over two-thirds of the study participants indicated their commitment towards cultural competency preparation in health education, the vast majority reported that they had "outsourced" cultural competency courses from various departments/programs within their given institution and they do not offer cultural/diversity training or education programs for their faculty members. Several implications could be drawn from this study:

1. Students in health education professional preparation programs would greatly benefit from a required cultural competency course or courses in health education. Professional accreditation bodies such as the AAHE/NCATE, the CEPH, SABPAC, and NCHEC should establish the requirement of such courses to ensure standardized objectives and content areas throughout the professional preparation of health educators. For example, these courses should provide a service-learning component in order for students to practice many of the cultural competencies in an academic-community partnership type of setting.

2. Faculty members could benefit from a standardized cultural competency training to be conducted on an annual basis. This training could be conducted by professional organizations in the field of health education. Formal cultural competency training would provide faculty with current content updates, tools, and information in order to enhance their ability to become culturally competent and to assess and revise the cultural competency-related content in the courses they teach. This would also provide faculty with updated strategies in order to better prepare their students in the area of cultural competency as they enter the workforce.

3. The profession of health education would also benefit from the development of discipline-specific standards that address cultural and linguistically competent health education programs. These cultural competency standards should be incorporated into the most recent "Competency-based Hierarchical Model" presented by the National Health Educator Competencies Update Project.[13] The development and implementation of cultural competency standards across the health education field would encourage health education professional preparation programs across the country to address these standards in health education courses.

4. Health education professional preparation programs should devise a strategic plan entailing hiring new faculty members representative of the institution's racial and ethnic student population as well as surrounding community. A short-term approach to this would be to hire racially and ethnically diverse health education professionals in the part-time and lecturer status until a full-time tenure-track position becomes available.

Final thoughts to consider are the direct benefits of individuals who possess and practice cultural competencies consistently in the field of health education. Culturally competent academicians lend themselves towards educating and training future health education professionals. A culturally competent health professional is critical not only to the profession but to clients, institutions, and public communities in which it serves.

REFERENCES

1. Airhihenbuwa CO. Culture, Health Education, and Critical Consciousness. *J Health Educ*. 1995; 26(5): 317–319.

2. Bohanna P. *We, the alien: An introduction to cultural anthropology*. Prospect Heights, IL: Waveland Press; 1992.

3. Spector RE. Cultural diversity in health and illness. 6th ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2004.

4. Brislin R. *Understanding culture's influence on behavior*. Fort Worth, TX: Harcourt Brace; 1993.

5. Canales M. Othering: Toward an understanding of difference. *Adv Nurs Sci*. 2000; 24(2): 16–31.

6. Frankenberg R. *The social construction of whiteness: White women, race, matters*. Minneapolis, MN: University of Minnesota press; 1993.

7. Cox T, Beak R. *Developing competency to manage diversity: Readings, cases, activities*. San Francisco, CA: Berrett-Koehler Publishers; 1997.

8. Denboba DL, Bragdon JL, Epstein LG et al. Reducing health disparities through cultural competence. *J Health Educ*. 1998; 29(5): S47–S53.

9. Berstein R. *Census brief: Current Population survey coming to America: A profile of the nation's foreign born (2000 update)*. Washington, D.C.: U.S. Department of Commerce; 2000.

10. U.S. Census Bureau. *United States Census 2000*. vailable at: http://www.census.gov. Accessed January 24, 2005.

11. U.S. Census Bureau. *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*. 2004. Available at: http:// www.census.gov/ipc/www/usinterimproj. Accessed August 16, 2004.

12. National Task Force on the Preparation and Practice of Health Educators. *Framework for the development of competency-based curricula for entry-level health educators*. New York: Author; 1985.

13. National Commission for Health Education Credentialing, Inc. *A competency–based framework for professional development of certified health education specialist*. New York: Author; 1996.

14. National Commission for Health Education Credentialing, Inc. *National Health Edu-*

cator Competencies Update Project. 2005. Available at: http://www.nchec.org/aboutnchec/cup/press_release05.htm. Accessed June 30, 2005.

15. Nunez A. Transforming cultural competence into cross-cultural medicine: The time is now. *J Am Med Womens Assoc*. 2000; 53(3): 121–123.

16. Wells MI. Beyond cultural competence: a model for individual and institutional cultural development. *J Community Health Nurs*. 2000; 17(4): 189–99.

17. Airhihenbuwa CO. *Health and Culture: Beyond the Western Paradigm*. Thousand Oaks, CA: Sage Publication; 1995.

18. Pinzón HL, Pérez MA. Multicultural Issues in Health Education Programs for Hispanic/Latino Populations in the U.S. *J Health Educ*. 1997; 28(5): 314–316.

19. Luquis R, Pérez M. Achieving Cultural Competence: The Challenges for Health Educators. *J Health Educ*. 2003; 34(3): 131–138.

20. Goode T, Cohen E. *Rationale for cultural competence in primary health care (National Center for Cultural Competence Policy Brief 1)*. Washington, D.C.: U.S. Department of Health and Human Services, Office of Minority Health, 5; 1999.

21. American Association for Health Education (formerly Association for the Advancement of Health Education). *Cultural awareness and sensitivity: Guidelines for health educators*. Reston, VA: Author; 1994.

22. American Association for Health Education. *AAHE Committees*. 2005. Available at: http://www.aahperd.org/aahe. Accessed: October 27, 2005.

23. Institute of Medicine. *In the nation's compelling interest: Ensuring diversity in the health care work force, 2004*. Available at: http://www.iom.edu/report.asp?id=18287. Accessed October 24, 2005.

24. Woolf SH, Johnson RE, Fyer GE et al. The health impact of resolving racial disparities: An analysis of U.S. mortality data. *Am J Public Health*. 2004; 94(12): 2078–2081.

25. Chin J. Culturally competent health care. *Public Health Rep*. 2000; 115: 25–33.

26. Robinson RG. Community development model for public health applications: Overview of a model to eliminate population disparities. *Health Promot Pract*. 2005; 6 (3): 338–346.

27. Joint Terminology Committee. Report of the 2000 Joint Committee on Health Education and Promotion Terminology. *J Sch Health*. 2002; 72(1): 3–7.

28. Redican K, Steward SH, Johnson LE et al. Professional Preparation in Cultural Awareness and Sensitivity in Health Education: A National Survey. *J Health Educ*. 1994; 25(4): 215–218.

29. Doyle EI, Liu Y, Ancona L. Cultural competence development in university health education courses. *J Health Educ*. 1996; 27(4): 206–213.

30. Luquis R, Perez M. Health Educators and Cultural Competence: Implication for the Profession. *Am J Health Stud*. In Press.

31. Beatty CF, Doyle EI. Multicultural curriculum evaluation of a professional preparation program. *Am J Health Stud*. 2000; 16(3): 124–132.

32. American Association for Health Education. Directory of institutions offering undergraduate and graduate degree programs in health education. *J Health Educ*. 2003; 34(4): 219–235.

33. Bronheim S, Sockalingam S. *A guide to choosing and adapting culturally and linguistically competent health promotion materials*. Washington, D.C.: National Center for Cultural Competence, Georgetown University Center for Child and Human Development; 2003.

34. Price JH, Murnan J, Dake JA et al. Mail survey return rates published in health education journals: An issue of external validity. *J Health Educ*. 2004; 35(1): 19–23.