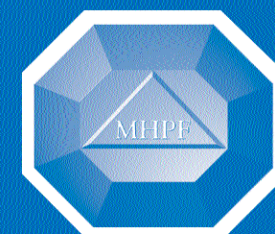


Cultural Competence and Prevention of Sexually Transmitted Diseases



SUMMARY REPORT

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Cultural Competence in the Prevention of Sexually Transmitted Diseases

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ABSTRACT: In response to widening racial and ethnic gaps in the incidence and prevalence of sexually transmitted diseases (STD), culturally competent health promotion programs have been introduced to address the complex interaction between culture, language, and health care. Efforts to curtail the transmission of sexually transmitted diseases have largely focused on changing personal behaviors through general prevention efforts such as disseminating information. Despite some general success, the incidence and prevalence of sexually transmitted diseases continues to rise in the United States.

Health promotion programs that incorporate culture into the context of the intervention have been thought to be more effective in reducing barriers to prevention and treatment of sexually transmitted diseases among racial and ethnic groups than those

designed for the population at large. This critique of the literature examined the use of elements and techniques of cultural competence utilized in STD prevention programming.

Most of the interventions in this critique incorporated at least one or more culturally competent elements or technique and also reported success in achieving the desired outcome. It is unlikely that a single element or technique was able to produce a successful outcome. Therefore, specifying the unit of measure of cultural competence and clarifying how cultural competence is defined within a study would greatly improve our understanding of how culturally appropriate interventions affect the outcome(s) of prevention efforts.

Key words: cultural competence, sexually transmitted diseases, ethnic groups, and HIV

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Introduction

By the year 2035, racial and ethnic Americans are expected to comprise more than 40 percent of the U.S. population. Many health professionals are attempting to design programs with culturally competent approaches that successfully address the health needs of burgeoning racial and ethnic populations (Blacks, Latinos, Asian/Pacific Islanders, and Native Americans). Despite widespread agreement on the need for culturally competent interventions, there are currently no guidelines that can describe how health professionals can effectively and consistently apply cultural competence to prevention efforts to improve health outcomes. The lack of a consensus definition for cultural competence and consequently, the difficulties associated with assessing and measuring an often vague and confusing concept have stymied progress in this area. However, health promotion strategies and interventions that infuse elements and techniques of cultural competence will potentially accelerate the reduction of health disparities among racial and ethnic Americans .

The Office of Minority Health, U.S. Department of Health and Human Services, made recommendations for national standards on culturally and linguistically appropriate services in health care . These standards were organized into three themes: culturally competent care, language access services, and organizational supports. The recommendations were put in place to

ensure respectful care that is available with the cultural beliefs, practices, and the preferred language of the individual.

Building on the concept of respect and the provision of culturally compatible services, we reviewed the literature on cultural competence and the prevention of sexually transmitted diseases (STD) to (a) assess how cultural competence is incorporated into prevention strategies and the potential impact of cultural competence on the outcomes of STD prevention programs among racial and ethnic groups. We summarized the research findings so that the information would be easily accessible to planners and evaluators of STD prevention programs. We also provided general recommendations on the use of cultural competence in prevention strategies, based on our review of the STD literature, but with broader implications for planning and implementing programs aimed at reducing health disparities and improving the health of racial and ethnic populations.

Definitions of Cultural Competence

There are various definitions of cultural competence (Table 1). According to Brach and Fraser (2000), cultural competence extends beyond cultural awareness or sensitivity to include possession of cultural knowledge and respect of different cultural perspectives and the use of knowledge and

skills effectively in cross-cultural situations

1. Cultural competence reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of individuals and their families to improve services, strengthen programs, increase community participation and close gaps in health status among diverse population groups.

Several implicit constructs are helpful in understanding the broader concept of cultural competence. They include multiculturalism, cultural sensitivity, cultural assessment, culturally competent behaviors and diversity awareness . During the 1960s and 70s, mental health professionals were among the first to conceptualize "multicultural" care. Multiculturalism is defined as incorporating and appreciating perspectives of varied racial and ethnic groups without assumptions of superiority or inferiority . In the 1980s, "multiculturalism" evolved into "cultural sensitivity" in response to the changing cultural diversity of the population. Cultural sensitivity is described as "the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs" 4.

The focus on population health began to shift to the health of the individual in 1980s and the goals of treatment and prevention

became more individualized. Treatment goals addressed the specific concerns of the individual with respect to culture, race or ethnicity and experiences as members of a racial and ethnic group and provided one with the necessary tools to make informed decisions about health care (Table 2). As an overlay to the shifting paradigm, there was a distinct need in the 1990's for an appropriate response to the growing diversity of the population and the persistence of health disparities between racial and ethnic groups and those of European ancestry. Coggins (2000) defined cultural competence to reflect this paradigm shift (Table 2). Cultural competence is defined as a habit of exhibiting the appropriate behavior with respect to the diverse cultural, ethnic, and racial patient population. Coggins' definition emphasized that cultural competence should become a habitual exhibit of appropriate behavior with respect to the individual's cultural background 3.

Sexually Transmitted Diseases

Prevention efforts to reduce sexually transmitted diseases can be augmented by culturally competent interventions. The Centers for Disease Control and Prevention's publication, *Tracking the Hidden Epidemics: Trends in STDs in the United States* estimated that there are 15 million new STD cases a year this country.

Three million people a year in the United States become infected with chlamydia, 600,000 with gonorrhea and approximately 70,000 with syphilis. Incidence of the human papillomavirus and herpes are respectively 5.5 million and 1 million estimated new cases a year. These diseases are responsible for infertility, pelvic inflammatory disease, and damage to the central nervous system and even death. STDs are often hard to track and are sometimes undiagnosed, but even more striking are the incidence and prevalence of sexually transmitted diseases among racial and ethnic groups.

Racial and ethnic groups are disproportionately affected by the spread of sexually transmitted disease. The CDC reports that sexually transmitted diseases, such as gonorrhea, are 27, 2.5 and 3.9 times higher among Blacks, Hispanics and American Indians/Alaska Natives respectively, than rates reported for White, non-Hispanics in 2001 (Figure 1). Primary, secondary and congenital syphilis rates are also higher among racial and ethnic groups (Figures 2, 3 and 4). HIV is one of the leading causes of death among Blacks, Hispanics and whites in the United States. Whites comprise 69% of the U.S. population yet account for only 31% of the new AIDS cases, whereas Blacks who are 12% of the population account for 49% of the new AIDS cases. Hispanics comprise 14% of the population and account for 19% of the new AIDS cases in the United States and

approximately, 1% of the new AIDS cases are among Asian Pacific Islanders and Native Americans (Figure 5).

Despite very high levels of STD levels within racial and ethnic populations in the United States, very limited prevention research has incorporated the concept of cultural competence into the educational and informational programs.

Review Strategy

An advisory committee consisting of three consultants with expertise in cross-cultural education provided guidance on the framework for this review. The purpose of the search was to identify articles on that utilized elements and techniques of cultural competence to prevent sexually transmitted diseases. The research team searched MEDLINE, Ovid, and AIDSLINE databases for articles written between 1980 and 2002. The year 1980 was determined as the starting point for three reasons: (1) a shift in sensitivity toward other cultures (2) the beginning of the AIDS epidemic and (3) the increasing diversity of the US population. The following were keywords used in the search: cultural competence (ies), cultural sensitivity, cultural diversity, cross-cultural interventions, transcultural, culturally diverse, multicultural populations and special populations. We also specified the following racial and ethnic groups in the literature search: African-Americans or Blacks, Hispanics or Latinos, Native Americans,

and Asian/Pacific Islanders. These terms were coupled with words and phrases such as STD or sexually transmitted diseases and/or HIV or AIDS/Acquired Immunodeficiency Syndrome and prevention strategies.

Studies selected for inclusion in the review were those that (1) reported original findings, (2) were conducted in the United States, and (3) specifically reported prevention strategies for sexually transmitted disease among racial and ethnic groups. These studies included quantitative and qualitative findings and the description of the implementation of incorporated elements and techniques of cultural competence in program planning, including the development of training models.

We identified elements or implied constructs of cultural competence, inclusive of cultural values, linguistic compatibility, cross-cultural training, racial and ethnic concordant staff, interpreter or translation services, community workers and training. We also utilized the nine techniques of cultural competence to identify the culturally competent techniques utilized in the prevention of sexually transmitted diseases¹. The techniques of are as follows:

Interpreter Services- the provision of sign language or translation services to improve communication between people who speak different languages.

Recruitment and Retention- hire and retain staff members who are from the community. Training-programs that help to educate

practitioners and others about how to communicate ways that increase cultural awareness and produces changes in attitudes about cross-cultural interactions.

Coordinating with Traditional Healers- coordination of care with traditional healers to avoid incompatible therapies (producing an atmosphere of cultural awareness and sensitivity to the patient's needs). Use of Community Health Workers- liaison(s) to the community that provide ways to overcome barriers associated with prevention messages and are able to serve as mediators and endorsers of the health care system.

Culturally Competent Health Promotion- a process that encourages healthy behaviors that decrease risk, increase knowledge and change attitudes by incorporating culturally specific and sensitive messages into the health promotion efforts (i.e. screening tools and health literature).

Including Family and/or Community Members- the inclusion of family members in health care decisions to encourage compliance and treatment decisions.

Immersion into Another Culture- a decision to become deeply engaged in the practices of a culture other than one's own.

Administrative and Organizational Accommodations-change physical environments and assessment procedures so that they are sensitive to the unique languages, cultures and environmental constraints of the population (e.g., directions or procedures written in appropriate languages).

Summary of Findings

The literature search identified 19 studies addressing cultural competence and the prevention of sexually transmitted disease. The majority of the studies were published in the mid-to-late 1990s. African-Americans (n=8), Asian/Pacific Islanders (n=3), Latino (n=2), and multiple race groups (n=6) (i.e. Latino, African-American and European American) were studied (Table 3). Seventeen studies reported quantitative findings and two studies described the incorporation of cultural competence in training models for HIV prevention. HIV/AIDS was the primary focus in all but two studies. Of the nineteen studies, thirteen were based in community settings and six were located in local health care clinics.

Elements of Cultural Competence

Each study included one or more elements of cultural competence. Elements of cultural competence included employing lay health workers or community health workers, use of translated materials or interpreters, culturally relevant videotapes, and utilization of racial and ethnic concordance to identify with study participants (Figure 6).

The most commonly used element of cultural competence was racial and ethnic concordance. Fourteen studies matched the race or ethnicity of the presenter, videotape subjects or staff to the race/ethnicity of the

target audience

Seven studies identified cultural values as a means to engage participants in the intervention. Cultural values describe characteristics that are important to a particular culture. An example of their use would be the design and implementation of a prevention program that emphasized cultural values such as respect or family support 19, , ,11,7, 9,15 .

An important element described in the literature was cross-culturally trained staff (n=5). Such staff is skilled in communicating with and relating to people of diverse ethnic backgrounds. In a number of studies, staff members underwent training to understand cultural differences in order to reduce communication gaps between cultures 7, 15,21, .

Six studies used culturally competent videotapes in their interventions 6,14,17,11,12, . In most instances, the videotapes were filmed in familiar settings, and matched the ethnicity and language of the audience.

Two studies used linguistic compatibility as an element of cultural competence. Linguistic compatibility refers to the use of idioms or familiar language (i.e. slang) in the planning or implementation of the intervention 14,9.

Other elements of cultural competence noted in the literature were interpreter or translation services and the use of community health workers. Eight studies employed interpreters or translators. In these studies,

native speakers or staff members of the same ethnicity provided translation or interpreter services to Asian/Pacific Islanders and Latino populations in their native language or dialect 19,13, 18, 10,23 24, 6,7.

Four studies used community workers throughout the implementation of the study. Community workers are typically lay health workers that are from the community in which they serve or liaisons that have been put in place to serve the community. These liaisons distribute information, gather valuable input on how to structure information for the community and mobilize the community to action. The purpose of the community workers was to help facilitate the intervention through recruitment efforts or helping participants to understand the nature of the study 6,7,8,9.

Techniques of Cultural Competence

We identified four techniques of cultural competence using Brach and Fraser's (2000) model for cultural competence 1. The four techniques were culturally competent health promotion, cultural competence training, interpreter services and employing community workers (Table 4). We adopted Brach and Fraser's model to distinguish the types of techniques used in the studies. There was some overlap between the elements of cultural competence and the culturally competent techniques. However, the techniques were used to classify and distin-

guish different pathways of cultural competence whereas elements represented discrete actions.

The most frequently adopted technique was culturally competent health promotion (n=16) which included, but not limited to, using culturally relevant videotapes or racial or ethnic concordant staff to educate the public or encourage certain practices (i.e. increased condom usage).

The second most common technique was interpreter and translation services (n=8). Interpreter or translation services were necessary to ensure that there was a two-way communication process. This technique lowered the incidence of misunderstandings and maximized prevention efforts.

The third most commonly used technique was employing community workers (n=4). Community workers are often the liaisons between health care agencies and the community that they serve. Some community workers may even serve as advocates for the community. In our review, community workers were primarily employed in the recruitment and implementation of the intervention.

The fourth technique mentioned in the literature was cultural competence training (n=2). Training activities may include activities that increase cultural knowledge and understanding; skills building in bicultural and bilingual interviewing; increasing sensitivity and awareness; and the provision of multicultural health and demographic information to service area populations .

Our review cited two models that attempted to develop cultural competence training. The focus of one model was to train African-American women in a drug treatment program to be peer leaders²². The second model incorporated the Afrocentric principles of Nguzo Saba and NTU (a central African concept translated as "essence of life") into the AIDS education training. Nguzo Saba embodies the seven principles of Kwanzaa (unity, self-determination, collective work and responsibility, cooperative economics; purpose; creativity and faith). These principles were paired with the principles of NTU (harmony, interconnectedness, authenticity and balance) to design and implement a culturally appropriate AIDS education program for black psychologists²⁰.

During this review, we also examined the essential outcomes of interventions that incorporated cultural competence in the design and implementation. The key outcome variables indicated in the intervention (Table 5.) measured whether or not the desired outcomes of the interventions were achieved. Key outcomes were the reduction of drug use, AIDS knowledge and attitude, sexual risk reduction, self-efficacy (primary reliance on self to effect changes in behavior), and perception of risk.

Seven of the twelve interventions focused solely on the African-American population. The major findings from three of the seven interventions were that African Americans responded more favorably to an ethnically

matched presenter and culturally-specific message as opposed to having a presenter that was not matched to the audience's ethnicity. Participants in these studies retained more AIDS-related knowledge, were more sensitive to their personal risk factor for HIV infection or expressed more intent to use condoms with steady partners^{14,12,11}.

Interventions with Asian/Pacific Islanders found noted expected changes in AIDS related knowledge and attitude toward intended practices such as condom use or having multiple partners. The authors also note there were few prevention programs that devoted attention to the specific needs of the Asian/Pacific Islander population^{13,23}

Racial or ethnic populations that were homeless or intravenous drug users (IDU) did not experience the same degree of significance for behavioral (IV drug use and multiple partners), cognitive (knowledge score) or psychological (depression, distress, and coping scores) outcomes. Nyamathi et al.⁷ recruited homeless and Latina IDUs for a culturally sensitive intervention. The women were randomized into a two-hour gender and culturally sensitive program or a traditional program that included a basic AIDS education program and community resources. Participants in this intervention did not experience significant differences in expected behavioral, psychological, or cognitive outcome variables. Women in the specialized group and the traditional group showed a decrease in

Discussion

Cultural competence is a broader and more complex concept than indicated by the current literature on STD prevention. Reflectively, the application of culturally competent elements and techniques varied throughout the literature. All of the studies reviewed included some element or technique of cultural competence in their prevention strategy. However, explicit constructs were not specified nor definitions of cultural competence given. The research literature could advance the understanding of cultural competence and prevention efforts, if concepts and terms were more clearly defined or operationalized as specific measures.

It is unlikely that any single element of cultural competence could improve the outcomes of STD prevention among racial and ethnic populations. A few studies which compared purported culturally competent interventions with standard interventions have shown relative improvements in outcomes such as risk perception, sexual

distress, depression and high-risk behaviors, such as multiple partners and use of IV drug use. Both groups also increased their knowledge of AIDS and enhanced their attitude towards AIDS scores. In addition, Weeks et al.¹⁵ reported that out-of-treatment African American and Puerto Ricans in a culturally targeted intervention found the culturally enhanced program to be more "attractive" as indicated by retention rates for the program. In phase two of the program, out-of-treatment African American and Puerto Rican drug users did not experience significant outcome differences between the enhanced condition and the standard condition at follow up, 5-10 months after the intervention¹⁹. Nonetheless, one intervention that recruited inner-city women and focused on a woman's sense of communal effectance (a concept derived from an Afrocentric worldview) reported significant reduction in the incidence of STD. Participants in the AIDS prevention subgroup experienced improved behavioral outcomes and a lower incidence of sexually transmitted disease as opposed to women participating in the general health promotion group and the standard care group²¹.

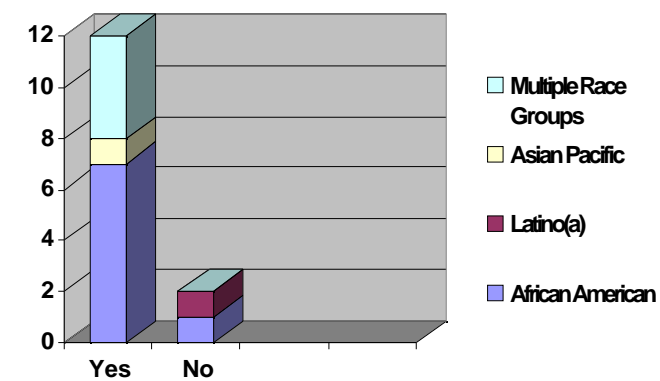


Figure 7
Number of Studies that Reported Achieving the Desired Outcome of the Intervention

behavior, self-efficacy, and knowledge or attitude towards STD/HIV. Furthermore, the majority of the studies showed that individuals were more responsive to positive behavior change in prevention strategies presented by racial and ethnic concordant staff. Studies also found that prevention strategies were more readily accepted if presented in the native language or included the cultural values of the target population. Culturally competent approaches are promising but still warrant attention to the evaluation of program effectiveness.

Cultural competence in STD prevention is a prerequisite for engaging participants through effective communication. Effective communication conveys trust and respect between individuals. In the paradigm shift (Table 2), we note that cultural competence implies active decision-making. The expectation of a culturally competent intervention is that there will be some exchange between program planners and participants, including input and recommendations on how to best affect behavioral change in order to decrease the incidence of sexually transmitted diseases among racial and ethnic groups.

Recommendations

The following recommendations are provided to aid the understanding and incorporation of cultural competence in prevention strategies and interventions.

- Provide contextual meaning and operational definitions of cultural competence in peer-reviewed publications to advance the understanding of this important concept.
- Specify the measurable elements (i.e. constructs) of cultural competence incorporated in interventions and provide specific descriptions of cultural competent techniques to aid the evaluation of prevention strategies and interventions.
- Give increased attention to effectiveness and impact evaluations of cultural competence interventions.
- Include an ongoing cultural competence assessment of program participants as part of the assessment instrument of the program. (Questions should include how staff can better meet the cultural needs, focus on specific cultural approaches that may work best for the participant and the culture's view about the genesis of the disease).
- Incorporate standards for measuring systemic cultural competence into standards of professional bodies, including those used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and by the National Committee for Quality Assurance (NCQA).
- Include in quality improvement efforts culturally and linguistically appropriate patient survey methods, and process and outcome measures that reflect the needs of multicultural populations.
- Make on-site interpreter services available in health care settings with significant populations of limited-English-proficiency (LEP) patients. (Other kinds of interpreter services should be used in settings with smaller LEP populations, limited financial, or human resources).
- Develop health information for individuals that are written at the appropriate literacy level and are targeted to the language and cultural norms of specific populations.
- Incorporate community health workers into the prevention process to facilitate prevention efforts in the community.
- Incorporate group approaches to health promotion and provision of services to better understand the differences in the way each cultural group views health and disease.
- Assess cultural and religious values and beliefs that influence the participant's perception of disease and care processes.
- Involve a culturally diverse advisory group to provide program planners with appropriate referral agencies that will meet the needs of the participants.
- Address immigration issues with respect to the dominant and subcultures within a particular nationality by frequently examining the census migration data of one's city, county, or state.

- Address the issues of historic and contemporary personal and societal prejudices that are directed towards each ethnic, racial and gender group.
- Provide directional signs and information in multiple languages to communication barriers for diverse clients using the services.
- Provide programs to educate individuals on how to navigate the health care system and become an active participant in their care.
- Provide ongoing staff training that focuses on ethnic specific case studies and strategies used to provide culturally competent solutions.
- Provide ongoing staff training that includes a culturally competent facilitator, diverse ethnic patients who share their personal experiences while working with the staff to brainstorm and develop future appropriate culturally competent steps that are effective in health promotion strategies among ethnic and racial populations.
- Ensure administrative commitment and support for the integration of culturally competent services, through personal policies, treatment planning, participant information, and an ongoing mechanism for resolving conflicts and complaints.

Table 1
Selected Definitions of Cultural Competence

Cross, 1989	"...a set of congruent behaviors attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations"
Zweifler and Gonzalez, 1998	"...capacity of providers to effectively identify the health practices and behaviors of diverse populations and thereby intervene and educate across cultural and language barriers."
Campinha-Bacote, 1999	"...an ongoing process of seeking cultural awareness, cultural knowledge, cultural skills, and cultural encounters"
Brach and Fraser, 2000	"...a step beyond cultural awareness or sensitivity. ... possession and use of cultural knowledge and respect of different cultural perspectives in cross-cultural situations 1."
Coggins, 2000	"... habit of exhibiting the appropriate behaviors with respect to the diverse cultural, ethnic, and racial patient population 3."
Bureau of Primary Health Care (USDHHS), 2001	"...a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations"
Betancourt, 2002	"...the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs"

Table 2
"Paradigm Shift in Treatment and Prevention Efforts" (Coggins, 2000)

OLD/PAST	NEW/PRESENT/FUTURE
Expect same patient behavior	Expect client behavior to be different based on race, ethnicity, and culture
Expect shared understanding and interpretation of patient behavior	Expect difference in cross-cultural meanings and communication processes including styles
Treat everyone the same	Focus on divergent/cultural approaches to the diversity with clients/individuals

Table 3
Studies on Cultural Competence and Sexually Transmitted Disease,
1988-2002

<i>ERacial/Ethnic Groups Studied:</i>	
<i>Blacks</i>	<i>8</i>
<i>Latinos</i>	<i>2</i>
<i>Asian Americans</i>	<i>3</i>
<i>Multiple Groupings</i>	<i>6</i>
<i>Study Settings:</i>	
<i>Community</i>	<i>13</i>
<i>Clinic</i>	<i>6</i>

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