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An Overview and Evaluation of Cultural Competence Training for Public Health Professionals

An Overview and Evaluation of Cultural Competence Training for Public Health Professionals

Melva Thompson-Robinson, DrPH
Darrlyn Cornelius, MPH

Abstract
Cultural competence training for public health professionals was conducted around the state of Florida. The training was a joint effort between the Florida Department of Health and Institute of Public Health at Florida A&M University. The goal of this training was to increase in participants' knowledge of cultural competence and its relevance in improving the health status of the citizens of Florida. This project was conducted in three phases. The first phase was development of a training curriculum and materials. The curriculum focused on two primary areas, culture and its relationship to health and the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings. The second phase was the implementation of the trainings. Six trainings were conducted around the state. Each session was for one full day. Participants were from county health departments and minority community-based organizations that receive funding from the Florida Department of Health. Evaluation of the training project was the third phase. Evaluation occurred on two levels, process and impact. Several different measures indicated that participants learned about culture and cultural competence. All results of the evaluation indicate that the training was an overwhelming success.
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Introduction

Our public health systems are facing numerous challenges and changes in order to maintain the health of all citizens. Cultural competence is one of the skills that have been identified as being needed by public health administrators in order to be successful in leading efforts to address these challenges and changes (Boedigheimer, 2001). Cultural competence is the desire, skills, and knowledge necessary to enable organizations, systems, and/or individual providers to work effectively and provide services consistent with the cultural context of the client (Thompson, 1998). Unfortunately, most public health administrators have not received formal education in the area of cultural competence (US Public Health Service, 1995).

The provision of training in the areas of cultural competence and other cultural issues is a recognized method for addressing this knowledge deficiency (Malone, 1997). In general, these trainings cover an assortment of topics and take on a variety of different forms (Landis, 1983) (Chrisman, 1997). For example, some forms of training focus more on the awareness of cultural differences (Flavin, 1997; Landis, 1983; Nakanishi, 1993. Other forms focus more on building skills to assist participants in working with culturally diverse clients (Chrisman, 1997; Kavanagh, 1992; Landis, 1983; Salcido, 1995) while other forms of training are more experiential, where participants learn by doing (Bennett, 1986; Landis, 1983).

Despite all of these training efforts, there is virtually no research regarding the impact, effectiveness, and success of these trainings and cultural competence trainings, in particular (Chrisman, 1997). The purpose of this article is to describe cultural competence training for public health professionals offered by the Office of Equal Opportunity and Minority Health at the Florida Department of Health and the Institute of Public Health in the College of Pharmacy and Pharmaceutical Sciences at Florida A&M University. The results of the evaluation of these training sessions are also presented.

Methods

Through funding from the Office of Equal Opportunity and Minority Health at the Florida Department of Health, cultural competence training for public health professionals was developed, conducted, and evaluated by the Institute of Public Health in the College of Pharmacy and Pharmaceutical Sciences at Florida A&M University around the state of Florida. The goal of this training was that upon completion, participants would have an increase in their knowledge of cultural competence and its relevance in improving the health status of the citizens of Florida. This goal was accomplished through the following objectives:

- Upon completion of this training, participants would be able to:
- Define culture and related terms
- Discuss culture and its influence on health
- Describe the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings

- Apply aspects of the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings

This training occurred in three phases between April and June 2001.

Phase I of Project: Development of Training Curriculum

The first phase of this project was the development of a training curriculum and materials. The Institute of Public Health was responsible for the development of the curriculum and materials. The training curriculum covered six modules as follows:

- Module 1: Introduction and Pre-Assessment
  In this module, an overview of the training day was given. Participants completed an icebreaker activity and the pre-assessment tool, assessing participants' knowledge, attitudes, and self-efficacy to the provision of culturally competent services.
- Module 2: Culture and Its Influence on Health
  Participants often enter cultural trainings with their own definitions of terminology related to cultural competence. The purpose of this module is to define culture and related terms, and discuss the relevance of culture to health.
- Module 3: Cultural Competence
  The purpose of this module is to define the term cultural competence. The definition of cultural competence that was given during this module was that cultural competence is the desire, skills, and knowledge necessary to enable organizations, systems, and/or individual providers to work effectively and provide services consistent with the cultural context of the client (Thompson, 1998).
- Module 4: Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings
  In this module, the conceptual framework for the provision of culturally competent services in public health settings is reviewed and discussed.
- Module 5: Application of Cultural Competence
  For this module, participants apply the newly learned concepts to their own circumstance through participation in a group activity.
- Module 6: Conclusion and Post-Assessment
  Lastly, in this module, the training session was wrapped up and participants completed appropriate evaluation forms.

Each training session lasted for one full 8.0-hour day. These sessions had a didactic as well as an experiential component. The Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings (Thompson, 1998) was the basis on which the training curriculum was developed. The Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings is an ecological approach that incorporates contextual elements as well as the service delivery system and clients in the provision of culturally competent services. This framework describes how the service delivery system, client, and contextual elements interact in the provision of culturally competent services in public health settings. Included in this description are characteristics, which facilitate and optimize these interactions.

The authors developed the training curriculum and materials as well as conducted the trainings. In addition to the Conceptual Framework for the Provision of Culturally Competent Services in the Public Health Setting, the training was based on the authors' work with the South Carolina Department of Health and Environmental Control and research in the area of cultural competence. Each participant received materials during the training that were designed to serve as a resource once he/she returned to his/her office.

Phase II of Project: Implementation of Training Curriculum

In the second phase of the project, implementation of the training curriculum occurred. Trainings were held in six sites around Florida over six weeks. The sites for the trainings were identified by the Florida Department of Health. To ensure adequate space for each training session, participants, representing the state and county health departments and community-based organizations receiving funding from the Florida Department of Health to address health disparities, were asked to pre-register for a training session. The Office of Equal Opportunity and Minority Health made decisions about participant selection by site. Trainings were held in Miami, Tampa, Orlando, Jacksonville, Tallahassee, and Pensacola. The Office of Equal Opportunity and Minority Health selected these sites in order to minimize the travel burden on organizations that they were targeting for attendance.

Phase III of Project: Evaluation

The third phase of the project was an ongoing evaluation of the training program. This evaluation occurred at the process and impact levels. The process evaluation examined the training program's

fidelity to the developed curriculum as well as the quality of the curriculum and training. The impact, or short-term, evaluation, was conducted to determine whether changes occurred in participants' knowledge, attitudes, and beliefs regarding cultural competence and its incorporation into service provision.

Methods of Process Evaluation

Multiple methods were used for the process evaluation. In terms of monitoring the implementation of the trainings, tracking of the registrations for each session and debriefing between the Institute of Public Health and Office of Equal Opportunity and Minority staffs were done. Each person wishing to participate in the training session was asked to complete a registration form and demographic sheet. Data from these forms was entered into Microsoft Access for tracking purposes and then exported into SPSS version 10.0 for further analysis.

Informal debriefings were completed to gather the impressions of project staff after each training session. These debriefings either took place either the evening immediately following the training sessions or several days later, depending upon staff availability. Based on these debriefings, minor alterations were made to the training session in order to enhance the learning experience for all participants.

With regards to monitoring the perceptions of the participants, a session evaluation form was developed. This evaluation form asked participants to rate the quality of the session, content, and instruction. This form was distributed to all participants at the end of each training session. For those participants that had to leave the training session early, attempts were made to have them complete the evaluation form prior to leaving. Quantitative data collected from these forms was entered into SPSS version 10.0 for analysis. Descriptive statistics were calculated. A content analysis, looking for themes, was done with the qualitative data from the comment section of these forms.

Methods for Impact Evaluation

The impact evaluation focused on whether observable changes occurred in participants' knowledge, attitudes and beliefs based on the training session. This change was assessed through the administration of a pre-assessment at the beginning and post-assessment at the end of each training session. The questions on these assessment forms were divided into two sections. The first section examined knowledge, attitudes, and beliefs related to the provision of culturally competent services. The second section inquired about the participants' ability to meet each of the objectives of the training session. All data from the assessments were entered into SPSS version 10.0 for analysis. Descriptive statistics as well as one-way analysis of variance were calculated. The current sample size was not adequate to calculate construct validity and reliability of the assessment tool. The tool; however, was reviewed by authors in light of the literature on cultural competence to establish face and content validity.

Participants also completed a "Contract with Myself." This form asked participants to comment on the information learned through participating in the training, how they plan to use the information in daily work activities, skills and knowledge needed in cultural competence, and other activities they planned to undertake to enhance their knowledge of cultural competence in the future. Participants completed and returned this form at the end of the training session. Forms were then copied and the originals were returned to participants four to six weeks after completion of the training session. A question-by-question content analysis was then done.

Results

Results of Process Evaluation

One hundred and sixty-six (166) attended a training session at one of the six training sites. The following table outlines the demographic information of the participants, based on responses provided on the registration forms (Table 1).

Based on the responses on the session evaluation forms, participants found the content appropriate, the trainer to be effective and that they learned about cultural competence.

With regards to the content analysis of the comment section of the evaluation form, those participants that responded indicated that they liked the trainer and the training. These participants also felt that this training should be offered in such a way that more people from their work unit could attend

Results of Impact Evaluation

At the beginning and end of each training session, participants completed an assessment of their knowledge, attitudes, and beliefs about cultural competence. Response categories for most items were 1=Strongly Agree, 2=Just Agree, 3=Just Disagree, and 4=Strongly Disagree. For these items, a higher score was deemed better. For those items marked (***), the response categories were reversed, 1= Strongly Disagree, 2= Disagree, 3=Just Agree, 4= Strongly Agree. The lower the score for the item was deemed better. The results of the pre/post-assessments are presented in Table 2.

Table 1: Demographic Information of Participants in the Cultural Competence Trainings

Gender of Participants	***Frequency***	***Percent***
Female	114	68.7
Male	51	30.7
Missing	1	.6
Total	166	100.0
Age of Participants	***Frequency***	***Percent***
Under 25 years	13	7.8
25 to 34 years	27	16.3
35 to 44 years	39	23.5
45 to 54 years	62	37.3
55 to 64 years	21	12.7
65 years and older	2	1.2
Missing	2	1.2
Total	166	100.0
Race of Participants	***Frequency***	***Percent***
African American (Non-Hispanic)	68	41.0
Asian/Pacific Islander	2	1.2
Caucasian (Non-Hispanic)	71	42.8
Hispanic/Latino	14	8.4
Native American/American Indian	1	.6
Other	8	4.8
Missing	2	1.2
Total	166	100.0
Educational Level of Participants	***Frequency***	***Percent***
Less than high school diploma/GED	2	1.2
High School Diploma/GED	6	3.6
Some College, but no degree	24	14.5
Associate Degree	15	9.0
Bachelor Degree	35	21.1
Some graduate study, but no graduate degree	28	16.9
Masters Degree	29	17.5
Study Beyond Masters	10	6.0
Doctorate	14	8.4
Missing	3	1.8
Total	166	100.0

Participants' Years of Experience in Current Position	***Frequency***	***Percent***
Less than 1 year	60	36.1
1 to 5 years	51	30.7
6 to 10 years	20	12.0
More than 10 years	33	19.9
Missing	2	1.2
Total	166	100.0
Primary Target Population of Participant's Organization	*Frequency*	*Percent*
African American (Non-Hispanic)	61	36.7
Asian/Pacific Islander	2	1.2
Caucasian (non-Hispanic)	14	8.4
Hispanic/Latino	12	7.2
Native American/American Indian	2	1.2
Other	65	39.2
Missing	10	6.0
Total	166	100.0
Types of Cultural Trainings Attended by Participants in the Past	*Frequency*	*Percent*
Cultural Competence	4	2.4
Cultural Sensitivity	9	5.4
Cultural Awareness	10	6.0
Diversity	30	18.1
More than one training	95	57.2
Missing	18	10.8
Total	166	100.0

A one-way analysis of variance was calculated to determine if statistically the results of the post-assessment were different from the pre-assessment. Based on this calculation, 12 items out of 22 were statistically different from pre-assessment to post-assessment. Of these 12 items, five were statistically different at the $p \leq .05$ level and seven were statistically different at the $p \leq .01$ level.

The pre/post-assessment also included items related to the objectives of the training. The response categories for each of these items was 0=Absolutely No, 1=I Need Help, and 2=Definitely Yes. At post-assessment it was desired that mean scores be as close to two as possible. The mean scores for each item related to the pre/post-assessment are shown in Table 3.

A one-way analysis of variance was calculated to determine if statistically the results of the post-assessment were different from the pre-assessment. All of these items were statistically different from pre-assessment to post-assessment at the $p \leq .01$ level. Based on these results, participants indicated that they did learn about culture and cultural competence as well as are able to apply aspects of cultural competence and the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings.

One hundred and twenty-seven participants in the training completed and returned the "Contract with Myself." Based on the content analysis of "Contract with Myself," major themes emerged for each of the items to which participants were asked to respond. With regards to the first item, "The key point(s) that I learned in Cultural Competence Training: Eliminating Racial and Ethnic Health Disparities in Florida is/are," two themes emerged due to a high response frequency. The first theme that emerged was about understanding culture and its importance, other cultural terms, and cultural competence. Most participants indicated that they did not know how

Table 2: Results of Section I of the Pre/Post-Assessment

Section I of Pre/Post-Assessment	Pre-Assessment		Post-Assessment		F Statistic	P-Value
	N	Mean	N	Mean		
All customers who seek services should be treated the same.	170	3.35	157	2.51	40.12	.000*
Although many languages exist, concepts such as family, health, and environment are universally understood.	170	2.31	156	2.03	5.92	.015**
The purpose of helping culturally diverse customers is to successfully bring them into the mainstream.	167	2.57	156	2.27	6.29	.013**
A person understands another culture if he or she knows the language, history, food and other visible aspects of that culture.	170	2.32	156	1.89	18.24	.000*
A person who is open to working with customers of different cultures is culturally competent.	170	2.38	156	2.08	8.85	.003*
Obtaining appropriate basic training and education assures cultural competence for the employee.	170	2.19	153	2.04	2.21	.138
An agency, which employs culturally diverse persons, is culturally competent.	170	2.12	156	1.95	3.44	.064
Cultural differences exist and impact the delivery of services.***	170	1.41	156	1.34	.912	.339
Each culture has its own way of thinking and some ways are better than others.	168	2.32	155	2.08	4.059	.045**
Cultural competence is something that can be incorporated into the work that I do.***	170	1.28	154	1.29	.059	.809
Learning about different cultures can just be done by reading a book.	170	1.52	156	1.42	1.90	.169
My culture and the culture of my customers do not affect the way in which we interact.	170	1.67	155	1.51	3.16	.076
Incorporating culture into services, programs, policies, and practices gives some people a more favorable status than others.	166	2.28	155	2.08	3.48	.063
Cultural competence is something that I can achieve.***	169	1.45	155	1.37	1.28	.259
As a result of this training, I plan to make changes in the way that I work with culturally diverse customers.***	166	1.57	156	1.45	2.67	.103
When culture and cultural competence are discussed, race and race relations are what is really meant.	169	1.89	153	1.54	16.32	.000*
Cultural competence is just being politically correct.	170	1.58	153	1.33	11.50	.001*
Cultural sensitivity and cultural awareness are the same as cultural competence.	168	2.39	152	1.91	5.089	.025**
There is not need to collect culture specific data for the use of targeting services.	169	1.43	153	1.36	1.22	.270
All people of a cultural group have the exact same culture.	170	1.42	153	1.26	7.30	.007*
It is important that organizations assess their own culture.***	169	1.62	153	1.31	15.81	.000*
As individuals, everyone should assess his or her own cultural beliefs and values.***	169	1.37	153	1.24	4.60	.033**

*Significant at $p \leq .01$ **Significant at $p \leq .05$

Table 3: Results of Section II of Pre/Post-Assessment

Section II of Pre/Post-Assessment	Pre-Assessment		Post-Assessment		F Statistic	P-Value
	N	Mean	N	Mean		
I can define culture and related terms.	151	1.21	134	1.88	150.885	.000*
I can discuss culture and its influence on health.	152	1.34	134	1.92	104.277	.000*
I can describe the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings.	151	.79	133	1.71	193.603	.000*
I can apply aspects of the Conceptual Framework for the Provision of Culturally Competent Services in Public Health Settings.	152	.91	133	1.74	151.599	.000*

*Significant at $p \leq .01$

culture, race, and ethnicity were defined. Participants indicated learning that "culture is very important in the provision of services and how they are received." Participants also realized that "there are many diverse points involved in cultural competence that must be taken into perspective in order to deliver services that are culturally appropriate," and that "cultural competence is more than just being aware of different cultures."

Increasing organizational awareness was a second of the most important points that participants learned through the training. Participants felt that "to increase organizational awareness of the hiring of personnel who are sensitive to and aware of cultural competence" would be beneficial in reducing health disparities in the state of Florida. Furthermore, participants felt that if their organization could learn "how to incorporate diverse cultures into our mission/values statements and make sure *all* employees have an *intent* to carry out the mission", it would help in the implementation of cultural competence among their employees.

In response to "when I return to my work unit, I plan to use this information in my daily activities to/by," numerous participants expressed that they would use the information learned at the training in their daily activities by educating other staff, listening to and communicating with the clients, focusing on issues specific to all cultures, incorporating cultural competence into their services, and improving their own knowledge. Almost half of the respondents felt that educating their organization as well as other staff members would aid in the development of skills in the area of cultural competence.

Many of the participants indicated that they plan to listen to and communicate with their clients. Participants also felt that being "more sensitive and using a focus group to find out what the target group wants" will add to the overall goal of assuring cultural competence. This information will also be used by "putting more attention on the individual and the different groups and learning" more about the clients' culture and by "asking more questions of clients about their culture, customs, beliefs, values, etc. rather than assuming I know" about the client based on their feedback.

For the next item, "to be more culturally competent, I need to develop more skills in the area of", participants identified a variety of skills and knowledge areas. These skills and knowledge areas included culture of clients, language, and listening/communication. Over half of the participants felt that finding out more information about the clients' culture is extremely beneficial to providing culturally competent services. As an example, one participant expressed, "I need to learn about other cultures and their beliefs. I want to learn their reasons behind those beliefs." Participants felt that "developing strategic plans to address cultural competence in the workplace and the community" will aid in good customer service. Participants also indicated that "working with those who have different cultures to help them adopt healthier habits in an appropriate and sensitive manner" is a skill needed to be more culturally competent.

Listening and communicating skills were also identified as aiding in the application of culturally competent services. For example, one participant indicated as a skill, "become a better listener". Many of the participants saw ways to improve their skills by "listening to others rather than forming an opinion" as well as "listening and allowing others to voice their opinions, even if I don't agree."

Lastly, participants responded to "I plan to further develop my cultural competence skills by…" Well over half of the participants felt that education, implementing cultural competence, and involving the community are ways for them to further develop their cultural competence skills.

For participants, education is the key to developing cultural competence skills. Some participants expressed desire to "attend more trainings and try to learn a different language in the near future" to develop skills. Other participants will "research the subject to better understand my need to learn more about cultural issues to better help those targeted." Lastly, some participants will "emphasize the importance of cultural competence to others and continue to educate myself."

Participants viewed community involvement as a necessity for the correct functioning of cultural competence. For example, one participant indicated his/her cultural competence skills would be developed through "increase out reach efforts in communities and group meeting in identified cultural groups and identifying groups to work with in the community of different cultures."

Conclusion and Recommendations

This project attempts to address the gap in the need for research on cultural competence training efforts (Chrisman, 1997). Individually, these results should be viewed skeptically because of the lack of a comparison group. When reviewing the results collectively, all results of the evaluation of this training project indicate that the training was an overwhelming success. Participants indicated on several independent measures that they learned about culture and cultural competence. Analysis of variance analyses were conducted to determine if

there were any differences in results based on training site. No differences were found.

Based on the results of the evaluation of this project, two major recommendations are made. The first is to expand trainings. This expansion could be making the trainings two full 8.0 hour days or to offer the training more frequently. This recommendation is based on the observation by the authors and representatives of the Florida Department of Health that participants seemed to have gotten a good understanding of culture, but not so much cultural competence. In reviewing the results of the pre/post-assessment, items related to cultural competence in *Section I* were not statistically different from pre-assessment to post-assessment. For example, from pre- to post- assessment, participants' responses to the item "obtaining appropriate training and education assures cultural competence for the employee" were not statistically different. This result is despite the training stressing to participants that cultural competence is more than just knowledge, but it also involves adapting the way one works to fit within the cultural context of the client. Training and education alone are not enough.

Based on the analysis of the "Contract with Myself," the key points that participants indicated that they learned most were about culture. The results seem to indicate that participants were so struck by the definition of race and ethnicity that they never moved to the next level of understanding cultural competence. A second full day would allow for further exploration of and skill development in cultural competence. Increased frequency of training would allow for broader participation and greater dissemination of knowledge.

The second recommendation is making this training mandatory and/or readily available for all public health professionals. In reviewing the session evaluation forms, about 30% of the respondents indicated that this type of training is needed in all levels of the agency. In addition, cultural competence is not something that individuals who attend the training can accomplish by themselves. Buy-in to the provision of culturally competent services by organizations is needed from all levels of the agency and not just those who participate in the training.

As public health agencies continue to address racial and ethnic health disparities, the need for cultural competence is becoming clearer. Based on the results presented here, these agencies should have some confidence that the provision of cultural competence training can result in staff beginning to learn the concepts of cultural competence that will enable them to develop appropriate knowledge and skills.

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Melva Thompson-Robinson is Assistant Professor, Institute of Public Health, College of Pharmacy, Florida A&M University, Tallahassee, FL (melva.robinson@famu.edu). She teaches in the Behavioral Science and Health Education track of the

Master of Public Health program. **Darrlyn Cornelius** is a Public Health Prevention Specialist at the Centers for Disease Control and Prevention in Atlanta, GA. She currently is assigned to the Alabama Department of Public Health in the Diabetes Branch. The project described herein was supported by the Florida Department of Health. This paper was submitted to the *FPHR* on December 3, 2003, reviewed and revised, and accepted for publication on February 25, 2004.