The Cultural Proficiency Capacity Building Model for Organizational and Systems Accountability

Ivan P. Eaton, DPA

A Dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Public Administration

School of Public Affairs

University of Baltimore
Baltimore, Maryland

April, 2011

***The Cultural Proficiency Capacity Building Model for
Organizational and Systems Accountability***

A Dissertation

Submitted to
Yale Gordon College of Liberal Arts
University of Baltimore
in partial fulfillment of the requirements for the degree of

Doctor of Public Administration

by

Ivan P. Eaton, DPA

_____
Dr. Lenneal Henderson

_____   _____
Dr. Heather Wyatt-Nichol   Dr. Jean Hyche Jackson

School of Public Affairs
University of Baltimore
Baltimore, Maryland
April, 2011

Dedication Page

 This body of knowledge is dedicated to all who dare to
envision a state of social justice, one worth fighting for,
within historical neighborhoods of racial oppression,
covert discrimination in the form of blocked employment
opportunities and disproportionate health disparities and
constraints of executive, legislative and judicial apathy
toward the spread of HIV disease.

Acknowledgment Page

Thank You!

The Almighty, for graciously sustaining and reviving me throughout the completion of this final project.

A loving and supportive family!

The most competent DPA Committee, for patience, scholarly guidance and knowledge of the most recent advances in respective areas of expertise.

Mitchell F. Rice, Ph.D., for granting permission to cite a notable work in public administration.

Robin and Ademola, and all the anonymous members of the *Black AIDS Action Movement!!!!!!!* for making a real difference!

Claudietta, for your mutual encouragement, camaraderie and shared experiences during *NVivo 8* training in D.C.

Sherita, for 'holons' and avant-garde discourse.

Those who continue to serve as my apathetic and adversarial muses; wouldn't have done it without you.

Abstract

Title: *The Cultural Proficiency Capacity Building Model for Organizational and Systems Accountability*

Author: Ivan P. Eaton, DPA

Overview: Reportedly, the Black Community represents over 80% of all HIV/AIDS cases in the State of Maryland, now ranking first (1st) in the nation for Blacks/African Americans living with AIDS. This two-phased project presents a capacity building model to incite community and public administration practitioner involvement to collectively ensure the delivery of equitable, accountable, ethical, effective, efficient, high-quality, responsive, and sustainable HIV prevention and treatment programs while striving toward an idealistic, milestone target of *cultural proficiency*[1] in order to achieve any resemblance of cultural competence.

Method: Phase I, a participatory action research approach, describes preliminary issue formulation, formation of a community action movement to hold accountable *stewards* of public funds and development of a model to incite ethical and culturally proficient decision making in the public administration of HIV prevention and health services. Phase II, evolution of the model, provides scholarly inquiry through qualitative data analysis of archival documents to determine *what* the State did, is doing, or proposes to do, to remedy the spread of HIV/AIDS in Maryland and ensure for equitable and culturally proficient responses to HIV/AIDS in Maryland.

Conclusion: Analysis of State archival documents on HIV prevention and health services does not evidence fulfillment of federally promulgated Culturally and Linguistically Appropriate Standards (CLAS). The researcher recommends adoption of a capacity building model to garner support and provide direction toward cultural proficiency in the delivery of HIV prevention and health services.

---

[1] Terry L. Cross et al. (1989) developed *The Cultural Competence Continuum*, which describes cultural competence through a range of cultural stages: *Destructiveness, Incapacity*, *Blindness, Pre-Competence*, *Competence,* and *Proficiency* (Cross et al. 1989, 13-18).

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

PREFACE

According to the most recent Henry J. Kaiser Family Foundation report on HIV/AIDS in Maryland (2010), Blacks/African Americans represented 81.8% (1,273) of the estimated number of AIDS diagnoses in Maryland (Kaiser 2010d, 1) and 78.5% (28,036) of all estimated Maryland cumulative AIDS diagnoses through 2008 (Kaiser 2010e, 1), ranking Maryland first (1st) in the nation for the estimated number of Blacks/African Americans living with AIDS (Kaiser 2010b, 1). The State of Maryland is in *grave danger*.

This final project/dissertation is an exposé to solicit national support to restore Maryland to a state of integrity in the public administration of HIV prevention and health services. The work also contains social commentary that challenges Maryland public administrators to understand what's happening through another lens and to act responsibly and expeditiously to meet the neglected needs of the Black Community.

Realistically, this restoration will not happen overnight since it took many years of complacency, stagnation and resignation to regress to the current state of affairs. However, something must be done differently and

timely response is crucial in order to slow the spread of HIV disease.

Technical Disclaimers

Technically, the researcher makes the following disclaimers to aid in the reading of the text.

In the tradition of localized critical theory, the researcher frames the issues and possibilities within a localized, historical context that is "grounded in the politics, circumstances, and economics of a particular moment, a particular time and place, a particular set of problems, struggles and desires" (Denzin, Lincoln and Smith 2008, 9).

The researcher presents components of *The Cultural Proficiency Capacity Building Model for Organizational and Systems Accountability to Redress the Collective Needs of the Disproportionately HIV-Impacted Black Community in Maryland*, hereinafter referred to as *The Capacity Building Model*, against a backdrop of race as a critically constructed social determinant of socioeconomic and health outcomes; a reality to be discussed merely because it was constructed to be existentially defined and perpetuated.

The researcher used Microsoft Professional Office 2007 software (Microsoft Corporation 2006) to develop the dissertation and visual schematics of the model.

Words designating racial categories, such as *Black*,
shall be used contextually to refer to "a historical
category, a political category, a cultural category" as
well as a racial category (Back and Solomos 2009, 204).

In other words, people identify as *Black* "in their
heads" and not solely due to "pigmentation" (Back and
Solomos 2009, 204). Because of this, the researcher does
not imply that all persons of African ancestry (e.g.
African Americans, African-born U.S. citizens, African and
Caribbean expatriates and immigrants, persons of more than
one race, ethnicity and/or heritage, and persons
identifying primarily with other nationalities of the
African Diaspora) necessarily identify as such.

On the other hand, discussion of demographic categories
and data on HIV/AIDS are historically consistent with U.S.
census definitions.

Closed brackets (University of Chicago 2003, 267, 463-
464) are technically used to signify interpolated text and
linguistic corrections made to direct quotes (e.g. syntax
and pragmatics), but not to change semantics. For instance,
throughout the text, the researcher capitalizes the first
letter of the words 'Black' and 'White' to refer to groups
of people so as not to linguistically diminish modifiers of
racial/ethnic groups. Thus, words and similar terms that

iii

refer to racial groups, when appearing as "black or white"
appear changed for in-text citations as "[B]lack or
[W]hite."

For stylized consistency, multiple references to one
source, which are cited in separate paragraphs, adhere to
the following format (author year, page) instead of
referencing only the page (University of Chicago 2003,
622).

The pragmatic, capacity building project contains
educational tools (presented as in-text figures) to
facilitate discussions and self-exploration on the need for
cultural proficiency and ethical decision making in HIV
prevention, health care and treatment. To this end, auto-
ethnographic and ethnographic narratives describe
collaborative insight and social commentary of members of
the action movement and the researcher.

The scholarly component of this project, the integral
dissertation, includes qualitative data analysis of
archival and electronic mailing list (*listserv*) documents,
between 2005 and 2009, to determine *what* the State of
Maryland claimed to be doing, or planned to do, during this
critical epidemiological period.

Primary documents, available in the public domain, were
crafted by the Maryland Department of Health and Mental

Hygiene (MD DHMH), AIDS Administration, primarily for
activities provided by the Center for HIV Health Services
and Center for HIV Prevention. Please note that this
administration has since been departmentally reorganized,
but, for the most part, not re-located, and is now known as
the Maryland Infectious Disease and Environmental Health
Administration (IDEHA), (MD DHMH, IDEHA 2009, 1).

The discussion section includes findings of data
qualitative analyses as well as social commentary to incite
continued dialogue on historical and contemporary issues
and social determinants that impact the spread of the HIV.

The audience of said discourse includes customers of HIV
services, other steward agency stakeholders, academicians,
public administrators, public health practitioners,
HIV/AIDS researchers, state legislators, executives and
judiciary bureaucrats, as well as the media.

The researcher uses the word *epidemiology* when
discussing Human Immunodeficiency Virus (HIV) and Acquired
Immune Deficiency Syndrome (AIDS) *incidence* and *prevalence*
in the United States, its states and localities, since
traditional use of the word *pandemic* describes epidemics on
an international, or global, scale.

The definite article *the*, as a noun marker, usually
precedes the acronym HIV. However, the researcher, most

often, will use the term *HIV disease* to reference a continuum ranging from initial HIV infection (acquisition), through asymptomatic and symptomatic phases, through progression to end-stage HIV disease with co-occurring opportunistic infections (OI) and clinical conditions (*sequelae*), otherwise known as AIDS.

The researcher refrains from the use of the misused terms *HIV virus*, to redundantly reiterate Human Immunodeficiency Virus virus, and *full-blown*, as a descriptor, since a person either meets the clinical definition for AIDS, or not.

Despite current activism to refrain from use of the term AIDS, the researcher employs the term to: 1) signify the far right of the continuum of HIV disease, thus underscoring the clinical progression of the disease; 2) highlight the stigma associated with the label; 3) be consistent with the widely accepted complexities in determining disability benefits; 4) recognize over 25 years of research since the virus was identified in early literature as Human T-Lymphocyte Virus (HTLV)III and the end-stage as AIDS Related Complex (ARC); 5) recognize well over 25 years of advocacy and activism for health care for marginalized groups and individuals in the name of the *fight* to cure AIDS; and 6) support the claim for continued

and demographic proportionate protections and services for those living with AIDS today, as the epidemic spreads throughout communities and becomes mainstreamed into a slowly reforming and complex health care system.

The researcher claims that most PLWH/A did not acquire the HIV of their free will as suggested by cynics and underscores the current disproportionate epidemiological state in the Black Community, where race and degree of poverty, or wealth, are presented as the primary attributes of *social determinism*.

Optimistically, the researcher agrees with the President's vision for the *National HIV/AIDS Strategy for the United States*, that "The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, race/ethnicity, sexual orientation, gender identity or socio-economic circumstances, will have unfettered access to high quality, life-extending care, free from stigma and discrimination" (Office of The President 2010, III).

It then becomes crucial that public stewards realize this ambition through an aim toward cultural proficiency in public administration involving practitioner, professional, organizational, and systematic accountability and performance measurement to ensure ethical, collaborative

and participative planning, development, implementation, evaluation, and appropriate revision of policies and practices to ensure that programs are effective, efficient, of optimal quality, responsive, sustainable, non-discriminatory, and universal, and/or specific, to the cultures of the customers for which services are being provided.

INTRODUCTION

Prior to becoming the 44th President of the United

States, Senator Barack Obama ended his March 18, 2008

speech entitled, "A More Perfect Union," by stating,

> It is not enough to give health care to the sick, or
> jobs to the jobless, or education to our children.
> But it is where we start. It is where our union grows
> stronger. And as so many generations have come to
> realize over the course of the two-hundred and twenty
> one years since a band of patriots signed that
> document in Philadelphia, that is where the
> perfection begins." (Obama 2008, 8)

The document the he refers to is the *United States*

Declaration of Independence, which states, "We hold these

truths to be self-evident, that all men are created equal,

that they are endowed by their Creator with certain

unalienable Rights, that among these are Life, Liberty and

the pursuit of Happiness" (Continental Congress 1776, 1).

Although the Declaration does not explicitly state that

health care is a "right," we, as public health

professionals, logically advocate, in most instances, that,

holistically, life, longevity and emancipation emanate from

physical, mental, emotional, and spiritual health and

wellness.

Additionally, Article 25 of the *Universal Declaration of Human Rights* of the United Nations states that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing[,] and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. (OHCHR 1996-2005, 1)

The Sullivan Commission declares, "The Commission unequivocally concurs with the fundamental principle that all of our nation's citizens have a human right to health care of equally high quality regardless of racial or ethnic background" (The Sullivan Commission 2004, 27).

This health imperative underscores the United States national *Emergency Medical Treatment and Active Labor Act*, enacted in 1986, which "ensures public access to emergency services" (Centers for Medicare & Medicaid Services 2006, 1) and Section 1867 of the *Social Security Act*, which requires Medicare-certified hospitals to provide emergency triage and appropriate referral services regardless of patient ability to pay (Social Security Administration 2008, 1)

According to Paul Farmer's ethnographic research entitled, *Pathologies of Power: Health, Human Rights, and*

the New War on the Poor (2005), "[T]he most basic right—the right to survive—is trampled in an age of great affluence." Moreover, "Human rights violations are not accidents; they are not random in distribution or effect. Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm" (Farmer 2005, xiii).

It is upon these fundamental humanistic premises that I have decided to critically examine a few of the social complexities relating to what has been coined *cultural competence* and what I shall advocate for, *cultural proficiency*, in the delivery of one essential dimension of health care: the delivery of HIV/AIDS services to citizens of Maryland.

Despite the globalization of the HIV/AIDS *pandemic*, and national declarations made by federal regulating agencies and national non-governmental organizations (NGO) to inspire response to the struggle, or what has been called a *fight* against HIV/AIDS, the focus of the project shall remain *close to home* in order to magnify issues that are most momentous in the State of Maryland, while spotlighting Baltimore City, the jurisdiction of highest prevalence and incidence.

Similarly mimicking inconsequential propaganda popularized in the 1990s, the Baltimore City Commission on HIV/AIDS Treatment and Prevention declared on the local level,

> When the City Council Commission on AIDS Report was issued in 2002, a "State of Emergency" was declared by the Mayor and City Council President. It was the expectation of the Commission that a "State of Emergency" would have generated a coordinated, expanded, and sustained response by City agencies to address the complex need of the citizens infected and affected by HIV" (Baltimore City Commission on HIV/AIDS 2006, 3).

Such an expectation has yet to be realized.

Statement of the Problem

What Was Lacking in Maryland?

According to 2000 U.S. Census Bureau estimates, the population of the United States was 281,424,602 and the population of Maryland was 5,296,544 (U.S. Census Bureau 2010c, 1).

According to U.S. Census Bureau 2000 summary data for Maryland, the population of Maryland was 5,296,486 with persons identified as Black or African American composing 27.9%. The population of Baltimore was 651,154, with Black persons composing 64.3% (U.S. Census Bureau 2010a, 1).

According to previous data from the Centers for Disease Control and Prevention (CDC), "Maryland reported 29,116 AIDS cases to CDC, cumulatively from the beginning of the

epidemic through December 2005. At the time, Maryland ranked 9th highest among the 50 states in number of reported AIDS cases." Of these cases, 78.4% were categorized as Black, non-Hispanic (CDC 2008, 1).

According to The Henry J. Kaiser Family Foundation *HIV/AIDS Policy Fact Sheet* (2008), Maryland ranked fifth (5th) in the nation for Black Americans estimated to be living with AIDS (The Henry J. Kaiser Family Foundation (Kaiser) 2008, 2).

The Kaiser report indicated that:

Black Americans have been disproportionately affected by HIV/AIDS since the epidemic's beginning, and that disparity has deepened over time. Blacks account for more HIV and AIDS cases, people estimated to be living with AIDS, and HIV-related deaths than any other racial/ethnic group in the U.S. The epidemic has also had a disproportionate impact on Black women, youth, and men who have sex with men, and its impact varies across the country. Moreover, Blacks with HIV/AIDS may face greater barriers to accessing care than their white counterparts. Today, there are approximately 1.2 million people living with HIV/AIDS in the U.S, including more than 500,000 who are Black. Analysis of national household survey data found that 2% of Blacks in the U.S. were HIV positive, higher than any other group. (Kaiser 2008, 1)

According to the *CDC HIV/AIDS Surveillance Report*, the CDC estimated that 185,988 persons categorized as Black were living with AIDS (nationwide) through December 2005 (CDC 2007, 21). The report also indicated that whereas there was a decline in AIDS case rates in many other

states, Maryland AIDS cases increased from 1,445 in 2004 to 1,595 in 2005 and the Maryland AIDS case rate (per 100,000 population) increased from 26.0 in 2004 to 28.5 in 2005 (CDC 2007, 28).

In addition, the report indicated that, in the Baltimore-Towson Metropolitan Statistical Area, AIDS cases increased from 863 in 2004 to 1,074 in 2005 and the AIDS case rate (per 100,000 population) increased from 32.6 in 2004 to 40.4 in 2005 (CDC 2007, 30).

According to the Maryland DHMH AIDS Administration statistical report entitled, *HIV/AIDS Epidemiological Profile, Fourth Quarter 2007-Data Reported through December 31, 2007*, African Americans accounted for 75.4% of HIV incidence (1,207 cases) and 81.8% of HIV prevalence (12,242 cases) and 81.5% of AIDS incidence (1,005 cases) and 80.6% of AIDS prevalence (11,638 cases), indicating a total HIV/AIDS prevalence of 81.2% (23,880 cases) in Maryland. The profile indicated that "cases with missing race or gender were excluded from percent distribution" (MD DHMH, AIDS Administration 2008, 4).

Through December 31, 2007, Maryland percentages of HIV data by CDC-defined risk categories are: *Heterosexual Transmission* (57%); *Injection Drug Use (IDU)*, (23%); *Men*

who have Sex with Men (MSM), (17%); *IDU/MSM* (1%); and *Other Risk* (2%), (MD DHMH, AIDS Administration 2008, 9).

New cases of HIV (incidence) by the 24 "jurisdictions" were as follows: Baltimore City (47.7%); Prince George's County (16.2%), Montgomery County (10.6%); Baltimore County (9.2%); Anne Arundel County (2.6%); Harford County (1.8%); Washington County (1.6%), Howard County (1.4%); Wicomico (1.2%); Frederick County (1.0%). In addition, a comparable 1.9% of cases are designated as correctional institutions, or "Corrections." The remaining Maryland counties, Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Garrett, Kent, Queen Anne's, Saint Mary's, Somerset, Talbot, and Worcester, are indicated with less than 1% incidence, with Talbot County indicated as having 0% HIV incidence (MD DHMH, AIDS Administration 2008, 3).

New cases of AIDS (incidence) by "jurisdictions" were as follows: Baltimore City (45.3%); Prince George's County (20.0%), Montgomery County (10.9%); Baltimore County (9.2%); Anne Arundel County (3.2%); Charles County (2.2%); Harford County (1.2%); and Howard County (1.0%). In addition, a comparable 1.9% of cases are designated as "Corrections." The remaining Maryland counties, Allegany, Calvert, Caroline, Carroll, Cecil, Dorchester, Frederick, Garrett, Kent, Queen Anne's, Saint Mary's, Somerset,

Talbot, Washington, Wicomico, and Worcester, are indicated
with less than 1% incidence, with Talbot County indicated
as having 0% AIDS incidence (MD DHMH, AIDS Administration
2008, 3).

Living cases of HIV (prevalence) by "jurisdictions" were
indicated as follows: Baltimore City (50.0%); Prince
George's County 14.5%, Montgomery County (7.6%); Baltimore
County (7.2%); Anne Arundel County (2.6%); Washington
(1.2%); Harford County (1.1%); Howard County (1.0%); and
Wicomico (1.0%). In addition, a significant 9.7% of cases
are designated as "Corrections." The remaining Maryland
counties are indicated with less than 1% prevalence, with
Garrett County indicated as having 0% AIDS prevalence (MD
DHMH, AIDS Administration 2008, 3).

Living cases of AIDS (prevalence) by "jurisdictions" were
indicated as follows: Baltimore City (47.1%); Prince
George's County 17.8%, Montgomery County (9.7%); Baltimore
County (7.4%); Anne Arundel County (3.3%); Harford County
(1.3%); and Howard County (1.1%). In addition, a
significant 6.2% of cases are designated as "Corrections."
The remaining Maryland counties are indicated with less
than 1% prevalence, with Garrett County indicated as having
0% HIV prevalence (MD DHMH, AIDS Administration 2008, 3).

Living cases of HIV/AIDS (prevalence) by "jurisdictions" were indicated as follows: Baltimore City (48.7%); Prince George's County 15.9%, Montgomery County (8.5%); Baltimore County (7.3%); Anne Arundel County (2.9%); Harford County (1.2%); and Howard County (1.0%). In addition, a significant 8.2% of cases are designated as "Corrections." The remaining Maryland counties are indicated with less than 1% prevalence, with Garrett County indicated as having 0% HIV/AIDS prevalence (MD DHMH, AIDS Administration 2008, 3).

In short, the jurisdictions where Blacks tend to reside in Maryland have been most impacted by HIV/AIDS incidence and prevalence in comparison to the other jurisdictions, less populated by Blacks.

According to the *Maryland Office of Minority Health Plan to Eliminate Health Disparities: A Healthier Future for all Marylanders 2006-2010*,

> Considering HIV/AIDS, the 2003 rate of new cases of HIV was 16 times higher for African Americans than for Whites, and the age-adjusted mortality from HIV/AIDS in 2004 was 13 times higher for African Americans. This is an example where the disparity in the adverse outcome, in this case mortality, is driven primarily by the disparity in the rate of new cases. Even if access, quality of care, and resultant treatment success were equal between African Americans and Whites, as long as double-digit disparity ratios in new cases exist, double-digit disparities in mortality will persist. Eliminating this mortality disparity will require finding a solution to the disparity in the rate of new

cases. (MD DHMH OMH 2007, 59)

Another problem has been historical suspicion of Maryland HIV estimates and data reports due to the use of an ineffective, code-based, HIV surveillance system.

Maryland has not stood alone with this challenge. Due to the use of inaccurate HIV surveillance systems, data from 13 states had not been included in national HIV data tables due to data inconsistencies despite repeated CDC recommendations that all states and U.S. dependent areas "adopt confidential name-based public health disease surveillance systems to report HIV infections." This recommendation was strongly encouraged "in order to achieve the goal of acquiring nationwide, high-quality HIV data" (CDC 2007, 47).

As of December 31, 2005, Maryland remained one of eight jurisdictions that had not yet followed the national recommendation to report HIV cases by name and remained irrationally wedded to its ineffective code-based system to conduct case surveillance of HIV infection (not AIDS). The other seven jurisdictions included California, Hawaii, Illinois, Massachusetts, Rhode Island, Vermont, and the District of Columbia. Likewise, five other states (Delaware, Maine, Montana, Oregon, and Washington) continued to implement HIV (non-AIDS) name-to-code

surveillance systems, whereby names were collected, and then, following field surveillance activities, converted to codes (CDC 2007, 47).

Today, most states are reporting HIV cases by name, but some data are still not *mature*. "An area's confidential name-based HIV infection reporting is considered mature after [four] years—long enough for the calculation of reporting delay estimates and the determination of reliable trends" (CDC 2010a, 12-13).

This *holdout* and slow transition to HIV name-based reporting by some states has caused many challenges in accurate HIV reporting as explained in the *Summary of Changes to the National HIV Surveillance Report*, in which the CDC explains:

> As of April 2008, all states had implemented confidential name-based HIV infection reporting. This is a tremendous change in the operation of our surveillance system and requires some changes to how we display our data. However, it should be noted that only 37 states have been reporting HIV infection data to CDC long enough (defined as being submitted to CDC by at least January 2005) to apply statistical adjustments to the data and be included in CDC's estimates in this report. The *HIV Surveillance Report* for 2012 (issued in 2014) will be the first time the data from all 50 states will be included in the estimates. (CDC 2010c, 1)

Nevertheless, after public inquiry, community outcry for accountability, transparency, honesty, and diligent efforts of federal programs to mandate accurate HIV surveillance

and reporting, it has been revealed that the spread of the HIV as well as the progression of HIV to AIDS in the state of Maryland has continued to dramatically increase, with Maryland now ranking *number one* for disproportionate AIDS cases among Blacks.

This contradicts insinuating, exaggerated claims by the Maryland DHMH, AIDS Administration, that state and local HIV prevention programs are successful and "HIV prevention is working," boasting that "427 people [were] not infected by HIV as a result of these prevention programs" (MD DHMH, AIDS Administration 2002, 1).

Aside from measured program outputs as a result of the Baltimore City Health Department Needle Exchange Program, at the time of that unsubstantiated declaration, there was little to no empirical evidence, or robust data, to show that HIV prevention interventions actually "worked."

What's Lacking in Maryland Today?

According to 2009 U.S. Census Bureau estimates, the population of the United States is 307,006,550 with persons who self-identified as Black composing 12.9%. The population of Maryland is 5,699,478 with Black persons composing 29.7% (U.S. Census Bureau 2010c, 1).

According to 2006 U.S. Census Bureau estimates, the population of Maryland was 5,615,727 with persons who self-identify as Black composing 27.9%. The population of Baltimore was 631,366, with Black persons composing 64.3% (U.S. Census Bureau 2010b, 1)

At the end of 2008, the estimated total number of Maryland residents was 5,534,500. Of this total, 5,081,700 were citizens, and 452,800 were not (Kaiser 2010g, 2010).

According to the most recent data from the CDC, an estimated 13,080 persons living with an AIDS diagnosis through December 2007 were categorized as Black/African American (CDC 2010a, 128). The number was increased from 12,681 to 13,080 to statistically account for "reporting delays" (CDC 2010a, 125) and ranked Maryland as 5th highest among states for AIDS diagnoses among Blacks/African Americans with a rate of 990.4, following the other U.S. jurisdictions heavily impacted by HIV/AIDS: District of Columbia with a respective rate of 2,709.9; New York (1,413.7); Florida (1,095.8); and New Jersey (1,091.5), (CDC 2010a, 128).

According to the same CDC surveillance report, Maryland reported 35,725 AIDS diagnoses, cumulatively from the beginning of the epidemic through December 2008 (CDC 2010a, 117).

According to The Henry J. Kaiser Family Foundation *HIV/AIDS Policy Fact Sheet* (2009), Maryland ranked fourth (4th) in the nation for Black Americans estimated to be living with AIDS (Kaiser 2009, 2).

However, according to the most recent Kaiser report on HIV/AIDS in Maryland (2010), Blacks/African Americans represented 81.8% (1,273) of the estimated number of AIDS diagnoses in Maryland (Kaiser 2010c, 1) and 78.5% (28,036) of all estimated Maryland cumulative AIDS diagnoses through 2008 (Kaiser 2010d, 1), ranking Maryland first (1st) in the nation for the estimated number of Blacks/African Americans living with AIDS (Kaiser 2010b, 1).

Through December 2007, a year earlier, Blacks represented 79.2% (13,108) of the estimated number of persons (of all ages) living with an AIDS diagnosis in comparison to a national percentage of 42.8% (Kaiser 2010c, 1).

The Kaiser report also indicates that the estimated rate of AIDS diagnoses for Black/African American adults and adolescents in Maryland through December 2008 was 95.5 in comparison to an estimated national rate of 61.3 (Kaiser 2010f, 1).

This ranks Maryland fourth highest in the U.S. "The AIDS diagnosis rate is calculated by dividing the number of AIDS

diagnoses in 2008 by the population in the same year, multiplied by 100,000." Other respective rates by jurisdictions are: District of Columbia (166.9); Florida (117.1); New Jersey (100.4); New York (94.9); and Montana (93.8), (Kaiser 2010f, 1).

According to the Maryland DHMH IDEHA statistical report entitled, *HIV/AIDS Epidemiological Profile, Fourth Quarter 2009-Data Reported through December 31, 2009*, Non-Hispanic Blacks in Maryland accounted for 78.8% (2,037 cases) of HIV diagnoses and 81.0% (841 cases) of AIDS diagnoses, reported between January 1, 2008, and December 31, 2008 (MD DHMH, IDEHA 2010, 11).

The latest Maryland data reveal that Non-Hispanic Blacks in Maryland account for 77.6% (9,861 cases) of living HIV cases without AIDS; 79.3% (12,924 cases) of living HIV cases with AIDS; and 78.5% (22,785 cases) of total living HIV cases (MD DHMH, IDEHA 2010, 12).

Baltimore City alone accounts for 46.3% (5,893 cases) of living HIV cases without AIDS; 44.5% (7,262 cases) of living HIV cases with AIDS; and 45.3% (13,155 cases) of total living HIV cases (MD DHMH, IDEHA 2010, 10).

For other Maryland jurisdictions, the total numbers and percentages of living cases of HIV are indicated as follows: Prince George's County with 18.8% (5,463 cases),

15

Montgomery County with 10.4% (3,008 cases); Baltimore
County with 7.6% (2,205 cases); Anne Arundel County with
3.4% (984 cases); Howard County with 1.4% (395 cases);
Harford County with 1.3% (371 cases); Washington County
with 1.0% (292); Frederick County with 1.0% (285 cases);
and Charles County with 1.0% (283 cases). In addition, a
significant 5.0% of cases are designated as "Corrections."
The remaining Maryland counties are indicated with less
than 1% prevalence, with Garrett County indicated as having
0% total living HIV cases (MD DHMH, AIDS Administration
2010, 10).

Moreover, to compound matters, despite the incline in
reported AIDS cases and trend data, which indicated
dramatic increases in HIV/AIDS among the Black Community,
through heterosexual transmission and HIV/AIDS incidence
increasing among Black women, the Maryland Department of
Health and Mental Hygiene, over the past ten years, has
repeatedly reduced funding to jurisdictions with large
populations of Black Americans (i.e. Baltimore City and
other urban and suburban areas in Maryland).

In addition, at the time this project was initiated, the
State had not made significant inroads to increase:
community participation in problem-solving, culturally
specific outreach efforts or culturally proficient

responses to meet the needs of the Black Community. Nor were sufficient efforts made to create new points of access to serve the Black Community or promote HIV/AIDS health and support services to reach PLWH/A, who are not in care and not receiving anti-viral treatment, those with *the greatest propensity* to spread the disease.

Despite historical increases in *formula* funding (based upon the number of reported AIDS cases) in addition to the award of *supplemental funds* and approval of unspent, *carry over* funds, only lackluster efforts had been attempted.

For Fiscal Year 2008, Maryland received a total of $90,037,710 in federal funding to provide services for persons living with HIV/AIDS, including funds from the CDC, HRSA, SAMHSA, OMH, and HUD (Kaiser 2010h, 1).

To detail the problem, over the past decade, only intermittent efforts to promote HIV health services (i.e. pharmaceutical and insurance programs) have been made. Additionally, HIV prevention and Health Education and Risk Reduction (HE/RR) programs to serve the Black Community, even in Baltimore City, the jurisdiction most impacted by HIV/AIDS, have been only diminutively funded, and sometimes de-funded or discontinued.

Questions for Inquiry

The prominence of the aforementioned problems in the Black Community has led community leaders to ponder, firstly, what could be done to heighten awareness of and to increase interest in the desperate need to align the State of Maryland with federal recommendations to include community-accepted, cultural approaches in the delivery of HIV prevention and treatment services?

Preliminary inquiry of Phase I revealed that there was no community-endorsed approach, guidance or model to specify what could be done to achieve such an undertaking in the catchment area of focus.

At that time, the researcher decided to conduct a qualitative review of government documents to determine whether or not culturally sound approaches were actually being implemented, since the inception of this project, in order to respond to a rapidly advancing disease that is considered, by many public health officials, to be "preventable."

Therefore, the research question for Phase II became what has the state actually done, is doing and plans to do to demonstrate equitable and culturally appropriate HIV prevention and treatment programs for the Black Community?

REVIEW OF THE LITERATURE

It is the aim of the literature review to introduce: 1) foundational social theories 2) nationally-promulgated cultural competence approaches to the delivery of HIV prevention and health services to slow the spread of HIV/AIDS and 3) foundational and emerging definitions and ideologies of the concept known as cultural competence and cultural competency.

It is also an objective to hone in on the common themes, inconsistencies and ambiguities that are evident among said cultural approaches in order to rationalize the development of a culturally proficient and specific approach to address the identified problems in Maryland.

Foundational Social Theories

According to Charles H. Powers (2010), author of *Making Sense of Social Theory*, "The entire idea behind science is to *make progress by improving our body of theoretical insights over time*" (Powers 2010, 4).

This *work in action*, which required active advocacy from inception to completion, provides insight and social commentary on issues of social justice, poses theoretical knowledge assumptions and claims, but does not include traditional social research hypothesis testing.

Foundational and emerging definitions of cultural competence have been reviewed in order to determine overarching, commonly used (and disputably misused) and dissimilar themes.

Social Theory: The Multicultural and Classic Readings (2010) is a compendium that contains several oppositional viewpoints of several social theorists and scholars, including Karl Marx, Max Weber, Frantz Fanon, Aimé Césaire, and Cornel West (Lemert 2010). Some of the works may be viewed today as "old-fashioned or insensitive." Nevertheless, they provide a foundation upon which future discourse must occur (Lemert 2010, xvii).

The editor, Charles Lemert states, "The social theories gathered here have not endured simply because professors assigned them. They are still read because they still matter. Their value is in the ways they serve as guides to understanding the times we live in now and how our realities came to be—even why, real though they are, they are as they are" (Lemert 2010, xvii).

Action Research

Action research, also referred to as "participatory research, collaborative inquiry, emancipatory research,

action learning, and contextual action research" is

"learning by doing" (O'Brien 2001, 1).

Other components include "co-learning" and pragmatic

problem-solving through social and systematic change by the

researcher, client and members a system (O'Brien 2001, 1).

> A primary reason for carrying out action research is the
> belief that one of the most important professional
> contributions one can make is to take part in creating
> something "new," a social innovation, not just testing
> or reformulating theoretical propositions or ideas. A
> great deal of learning in such projects will involve
> conditions for creating and disseminating innovations.
> Thus, in addition to being concerned with evaluation,
> the researcher will be interested in studying forces
> that lead to change. Methods suited to such an approach
> to the problem are of particular interest. (Whyte 1991,
> 150-151)

Participatory Action Research (PAR)

The researcher employed components of participatory

action research (PAR), rooted in social theory, to gain

preliminary public input, to incite publication, to select

the methodology used to evidence community need, reveal

evidence of the planning and governance process and, in the

future, to be used as "a method for generating planned

social reforms" (Whyte 1991, 151).

According to Whyte (1991),

> The [change] process involves three main steps:
> formulation of aims, development of new practices, and
> diffusion of results. The way an action is developed and
> implemented is just as important as the result of the
> action, in the sense that a reform is tried out with
> those who are affected, and is adjusted and appraised,

before being adopted and diffused. In other words, this
represents an alternative strategy for social change,
compared with traditional social reform policies that
are directed from above, whether based on laws or on
negotiated outcomes. In particular, this approach is
relevant when it comes to solving complex, problematic
situations whose development calls for teamwork and
mutual commitment among several interested parties.
(Whyte 1991, 151)

Alice McIntyre (2008), author of Participatory Action

Research, quotes Brown (1982), as stating, "Similarities

provide a foundation for communication and trust;

differences offer possibilities for mutual learning and

development" (p. 206). When explored, addressed, and

critiqued, both the similarities and differences, as well

as the gray areas in between, benefit the field of PAR,

assisting practitioners in developing authentic and

effective strategies for collaborating with people in

improving their lives, effecting social change, and

reconstituting the meaning and value of knowledge"

(McIntyre 2008, 5).

S. Kemmis and M. Wilkinson (1998), authors of

Participatory Action Research and the Study of Practice,

list fours tenets which are also evidenced throughout this

work. They are: change in practice, empowerment (from

constraints in language and the media), emancipation from

irrational and unjust constraints and structures, and

active collaboration with others rather than *on* or *to* others (Creswell 2003, 11).

The Caledonia Centre for Social Development presented 16 Tenets of Participatory Action Research at the *Third World Encounter on Participatory Research*, in Managua, Nicaragua, in September 1989, "as part of its on-going work in the field of participatory development... to make these tenets accessible to a new generation of social activists and to re-stimulate older practitioners" (McTaggart 1989, 1).

According to these tenets, PAR involves: 1) improvement of social practices by changing them; 2) authentic participation; 3) collaboration; 4) community-centeredness; 5) systematic learning; 6) rational integration of theory and practice; 7) application, testing and evidence for substantiation; 8) documentation and analysis of group "judgments, reactions and impressions about what is going on"; 9) "objectified" experiences through documentation; 10) political processes; 11) critical analyses; 12) incremental changes (starting *small*); 13) small cycles to plan and act, observe, and reflect upon issues; 14) small groups leading to a wider constituency of "collaborators"; 15) allowances for participants to record changes and developments (e.g. actions, practices and improvements);

16) allowances for participants to share their work with others (McTaggart 1989, 1-5).

The Global Development Research Center (GDRC) describes several alternative methods of PAR, which may include: critical review of secondary data; direct observation; inclusion of experts; probing or questioning regarding key issues; review of case studies and listening to anecdotes; use of different types of casual or structured groups; active participation and "do-it-yourself" involvement; mapping and modeling; analysis of secondary sources by members of the community; "transecting" or walking with "key informants" to find out more about the environment or to *canvass* an area; inclusion of chronologies, diagrams, matrices, and/or contracts; and collaborative, researcher-subject "brainstorming," analysis, documentation, and presentation (GDRC 2010, 1-2).

Critical Theory

One perspective assumed throughout this project, in the words of B. Fay, author of *Critical Social Science*, is the *Critical Theory* perspective, that is, "empowering human beings to transcend the constraints placed on them by race, class, and gender" (Creswell 2003, 10).

Box (2005) describes critical theory as a school of thought that encompasses writings from the 1920s to the 1970s, with several centralized themes and positions, not uniformly held by several authors such as Max Horkheimer, Theodor Adorno, Herbert Marcuse, Georg Luk[á]cs and Antonio Gramsci, and Jürgen Habermas (Box 2005, 16).

The school of thought, over time, encompasses, at least, three centralized themes.

Firstly, "social systems change over time because of built-in tension, or contradictions, between how they are and how they could be" (Box 2005, 16).

Secondly, the "dialectic" concept of *reason* is discussed as being a way to maintain existing systems "in support of systems of domination and control" while, on the other hand, serving as a means to shape "a different future"; that is, "to envision a better future" (Box 2005, 17).

Thirdly, Frankfort theorists such as Marcuse (1968) popularized Frankfurt critical theory, which underscored the perspective that "the concrete temporal and cultural specificity of the individual consciousness—values and perceptions are shaped by the time and society in which we live—but ultimately the measure of society is, as it has been since the Enlightenment, its effect on people, on

their happiness and sense of freedom to determine the future" (Box 2005, 20).

"The critical theory model envisions discourse as a technique of opening the public agenda to a broad group of citizens to counter governing elites' self-interested control" as well as a "more representative policy-making process" (Box 2005, 82-83).

Critical theorists do not describe the Marxist view of an overthrown government to establish equality in power and elimination of wealth and class, but rather a view that describes a "one-dimensional society, a capitalist system based on destruction of natural resources in pursuit of profit, supported by hostility toward supposed enemies who would threaten the consumer culture and its benefits for the controlling class" (Box 2005, 20).

Such theorists describe a reinforced national system that is, in the words of Marcuse, full of "sport, fun, and fad." These "meaningless" capitalist activities are "reinforced by corporate-delivered entertainment" in a nation that would discard and even "kill" anyone opposing such a system (Box 2005, 20).

Critical theory includes practitioner opportunities for conceptualizing (or re-conceptualizing) concepts and theories, and consequential application, within subjective,

value-laden constraints of public administration (Box 2005, 21).

Box also summarizes public administrator participation through a continuum, ranging from "uninvolvement" or "administrative neutrality" to active involvement, in which the administrator influences "the knowledge, opinions, and decisions of citizens, elected officials, and peers" (Box 2005, 21).

"The public professional who perceives contradiction between current public practices and a future with reduced inequity and oppression may use critical theory as a guide for taking action to create social change" (Box 2005, 21).

Critical Race Theory

Richard Delgado and Jean Stefancic (2001), authors of *Critical Race Theory: An Introduction* summarize in the section entitled *Legal Storytelling and Narrative Analysis*, an excerpt from the 1998 case, *State v. Buggs*, and write:

> Race may be America's single most confounding problem, but the confounding problem of race is that few people seem to know what race is…. In part, what makes race a confounding problem and what causes many people to not know what race is, is the view that the problems of race are the problems of the racial minority. They are not. The problems of race belong to all of us, no matter where our ancestors come from, no matter what the color of our skin. Thus, concluding that race is not an issue in this case because juror 32 is not a member of a racial

minority, misses the point. Race is an issue.
(Delgado and Stefancic 2001, 42)

The researcher agrees with this position, that race is,
indeed, an issue, particularly since the social
construction of race has been historically used to
marginalize Blacks within all U.S. social institutions,
consequently, hindering full potentialities and realization
of personal and communal aspirations and achievement for
many, if not the majority, of Blacks.

According to Philip Smith and Alexander Riley (2009),
authors of *Cultural Theory: An Introduction*, race is
socially "constructed and maintained" and is perpetuated to
"market social stratification" and identify and maintain a
"[B]lack underclass" (Smith and Riley 2009, 241).

Gloria Ladson-Billings and Jamel K. Donnor, authors of
the work entitled, *Waiting for the Call: The Moral Activist
Role of Critical Race Theory Scholarship*, describe the
"call" as "the moment where, regardless of one's stature
and/or accomplishments, race (and other categories of
otherness) is invoked to remind one that she or he still
remains locked in the racial construction" (Denzin, Lincoln
and Smith 2008, 61).

The authors believe that this "call" should "mobilize
scholars of color and others who share commitments to

equity, social justice, and human liberation" (Denzin,

Lincoln and Smith 2008, 61).

Historical Underpinnings: Colonialism and Oppression

According to John Frow and Meaghan Morris (1993),

authors of *Australian Cultural Studies: A Reader*,

> In short, 'culture' is a term that can designate, in
> Raymond Williams' [1959] phrase, the 'whole way of life'
> of a social group as it is structured by representation
> and by power. It is not a detached domain for playing
> games of social distinction and 'good' taste. It is a
> network of embedded practices and representations—texts,
> images, talk, codes of behaviour, and the narrative
> structures organising these—which shapes every aspect of
> social life. (Frow and Meaghan 1993, viii)

"Power is the ability to substantially influence someone

else's behaviour" through potential use of authority,

control and/or "force" (Wilson 2004, 147).

The power inequality in the United States is undeniably

rooted in occurrences summarized by the selection entitled

Between Colonizer and Colonized (1955) by social theorist,

Aimé Césaire. In the work, Césaire speaks of "societies

drained of their essence, cultures trampled underfoot,

institutions undermined, lands confiscated, religions

smashed, magnificent creations destroyed, extraordinary

possibilities wiped out" (Lemert 2010, 348).

Likewise, Herbert Marcuse (1964), in his work entitled

Repressive Desublimation, speaks of the "liquidation of

two-dimensional culture" through "flattening out of the antagonism between culture and social reality," which is achieved through "wholesale incorporation into the established order, through their reproduction and display on a massive scale." (Lemert 2010, 436-437).

In *Contested Knowledge: Social Theory Today* (2008), in the Chapter entitled, *Colonial Discourse Studies*, Steven Seidman refers to Frantz Fanon as "one of the originators of a theory of colonialism," and explains how colonists depicted those "colonized" as "inferior, a lesser human type" (Seidman 2008, 251-252).

Even more specifically, "In colonial discourse, Blacks are seen as thoroughly sexual and instinctual, and as lacking self-control and discipline. The very nature of the Black is said to impede social progress in Africa and the Caribbean" (Seidman 2008, 252).

Seidman explains how Fanon theorized that European colonists justified themselves as "superior," in the name of "humanism," and imagined it to be their "duty" to enlighten other civilizations. This attitude, adopted by people of the United States, became "the mission of the West, according to Western colonial ideas, to lift humanity out of the darkness of the reign of impulse, superstition,

and despotism into the light of reason, democracy and social progress" (Seidman 2008, 252).

In addition, Fanon considered violence as central to colonialism through physical "imprisonment, torture, beatings, rape, starvation, genocide, and the denial of decent housing and health care," and psychologically through "violence done to the hearts and minds of the colonized by being denied freedom, integrity, and self-respect" (Seidman 2008, 252).

According to Frantz Fanon:

> You do not disorganize a society, however primitive it may be, with such an agenda if you are not determined from the very start to smash every obstacle encountered. The colonized, who have made up their mind to make such an agenda into a driving force, have been prepared for violence from time immemorial. As soon as they are born, it is obvious to them that their cramped world, riddled with taboos, can only be challenged by out-and-out violence. (Lemert 2010, 365-366)

In the book entitled *Looking White People in the Eye: Gender, Race, and Culture in Courtrooms and Classrooms*, Frantz Fanon, referred to as "the founding father of modern colonial critique" continues this dialogue in his essay entitled *Black Skin, White Masks* (Razack 1998, 3-4).

Fanon speaks of the ideology of colonial depersonalization of "oppressed peoples" by describing how colonizers perceived themselves as "more civilized beings"

and perceived indigenous peoples as contemptible "objects,"
in order to justify imposing new cultures and saving them
"from their fates" (Razack 1998, 3).

Xenophobia

During the late 1800s and early 1900s, "Scientists,
scholarly and popular writers, and other people of letters
directly reflected general folk perceptions and fears of
Negroes, Chinese, Native Americans, and the southern
European types," those who immigrated to the U.S. (Smedley
2007, 278).

Audrey Smedley (2007), author of *Race in North America:
Origin and Evolution of a Worldview* explains how "The
social and intellectual currents of the time mandated
conformity to a racial worldview resolutely fixed in
American culture and consciousness. It was a cosmological
perspective that was compatible with European and American
industrial and commercial dominance and with the
accelerating exploitation of non-European land and peoples
(Smedley 2007, 278).

This "American culture and consciousness" (Smedley 2007,
278) and propaganda lead to an irrational yet escalated
hatred and fear of immigrant groups (i.e. Greeks, Italians,
Jews, Slavs, and others from eastern and southern Europe),

who began to outnumber immigrants of northern European descent. Such groups were often referred to as criminals, sexual perverts, and by other disparaging labels (Smedley 2007, 278).

At the time, the ultimate determinant seemed to be exclusion and marginalization of other groups, namely those with greater pigment. Thus *melanism* became even more important in the social construction of race based upon ethnocentrism, physical likeliness in appearance of those of the dominant and popular culture and group familiarity.

Cornel West writes of "escalating xenophobias" and concludes that:

> There can be no artistic breakthrough or social progress without some form of crisis in civilization— a crisis usually generated by organizations or collectivities that convince ordinary people to put their bodies and lives on the line. There is, of course, no guarantee that such pressure will yield the result one wants, but there is a guarantee that the status quo will remain or regress if no pressure is applied at all. (Lemert 2010, 512)

Social Constructs of Race

Racial components of *The Capacity Building Model* are predicated upon an underlying cultural theory proposed by Michael Omi and Howard Winant (1994) which postulate the following tenets.

Firstly, the construct of race is built on the enslavement and conquest of *indigenous* peoples (Smith and

Riley 2009, 244), (e.g. native Africans, North Americans, Latin Americans, South Americans, Caribbean Americans, etc.).

Secondly, domination through "racial formations" was the central motivation for "socio-historical processes" and events of U.S. colonialism and slavery. For example, slaves, captured from various nations in Africa, were monolithically categorized as "Black" and [t]hat racial designation literally did not exist prior to this historical period…" (Smith and Riley 2009, 244).

Thirdly, social stratification occurred to legitimize domination of other peoples and acquisition of the resources of other peoples (Smith and Riley 2009, 244).

Ethnicity

Watt S. Norton, author of *Culture, Ethnicity, Race: What's the Difference?* defines ethnicity as "a concept that refers to cultural practices and attitudes that characterize a given group of people and distinguish it from other groups. People within [the] group have certain background characteristics such as language, religion, ancestry, and other shared cultural practices which provide them with a distinctive identity" (Norton 2004, 38).

Social construction of race and ethnicity in the U.S. has always been of controversy. Historically, the category *White* once excluded those of Irish, Italian or Jewish ancestry, and others considered to be subjectively *ethnic*. Yet today, many in those groups are considered to be White.

Whiteness

Omi and Winant (1994) also discuss the logic underlying "[W]hiteness studies," explaining how White people benefit most in societies that are racially and hierarchically structured. Whiteness, or culture, which is just as diverse as non-white culture is viewed as "normative" or national or even covert "unmarked and unnamed" (Smith and Riley 2009, 245).

In the United States, *[W]hiteness* was enabled through colonialism and during the period of mass immigration of Europeans. However, it was not until the 1960s that the distinction of *[W]hite ethnicity* emerged to exclude Whites of non-English descent (e.g. Italian and Hungarians). Whiteness was promoted as being based on "historical accomplishment" and not on the color or "complexion" (Smith and Riley 2009, 245).

For many ethnic groups, this exclusion, created a sense of *racial inbetweenness*, not being "visibly" Black yet not being visibly *White* either (Smith and Riley 2009, 245).

During the time, thereafter, and today, exclusion of non-ethnic Whites (and non-Whites) was achieved and perpetuated through denigration and ridicule, as evidenced by discriminatory practices, construction of dissociative disadvantages and myths to identify the *outsiders*, and reproachful terms and pejoratives that shall not be avowed in the writing of this text.

However, over the years, and even more recently, as non-Whites increase in numbers (or are reported as such), then it becomes even more critical to increase or maintain White quotas through a more broad and flexible concept of *Whiteness* in order to maintain majority rule, that is, if Whites are to remain in domination and power. However, as the diversity and blending of cultures becomes even more obscure, concepts of race will become even more indistinguishable.

Piloting Whiteness

Paul Gilroy describes the *Diaspora* as the spread of people throughout the world, namely people of Jewish descent out of Israel and Egypt and people of African

descent primarily through the "European and American slave trade," which he refers to as the "black Atlantic." This Diaspora underscores the complexities in understanding the composition and diversity of those identified as Black people (Smith and Riley 2009, 246).

According to Sander L. Gilman, author of Chapter 19 of *Theories of Race and Racism* (2009), entitled *Are Jews White? Or, The History of the Nose Job*, "The Jews were quite literally seen as [B]lack," especially since they were believed to have historically procreated with Africans during the period following the *Exodus* from Egypt, as were other ethnicities with "color of skin" similar to "mulattos," Blacks of mixed-race heritage (Back and Solomos 2009, 297). And, physiologically, even though the skin color became [W]hiter, it "could never get [W]hite enough" (Back and Solomos 2009, 314).

According to Gilman, popular culture has shaped Jewish identify over the past two centuries in the United States. Gilman explores perceptions of physical attributes and body image, which "shape the sense of Jewish identity" (Back and Solomos 2009, 294).

Even though racial boundaries were strategically used to separate people socially and politically during the 1800s, (Back and Solomos 2009, 297), it was not until after the

atrocities of World War II that the concept of "the Jewish race" was characterized and used to depict "ethnicity" (Back and Solomos 2009, 314).

According to Chapter 20 of *Theories of Race and Racism* (2009), entitled *Looking Jewish, Seeing Jews*, by Matthew F. Jacobson, persons of Irish, Italian, Greek and Jewish descent were considered to be "probationary [W]hite[nesses]" during the mid-1800s through mid-1900s (Back and Solomos 2009, 304).

Jacobson maintains a position that these ethnic groups evolved into becoming White as a result of what he calls "a complex process of social value *become* perception" whereby race evolves over time to become attributable to social values instead of physical attributes, such as the color of one's skin, shape of one's nose, texture of one's hair, etc. (Back and Solomos 2009, 304).

Even more specifically in Maryland, according to Jacobson, Jews were not permitted to hold office due to religious ostracism (Back and Solomos 2009, 303) during this era of "anti-Jewish imagery" (Back and Solomos 2009, 304).

In short, Jacobson states that "race is social value become perception" In other words, "physiognomic[al] surveillance" and concepts of race and ethnicity (Back and

Solomos 2009, 304) over the years have evolved based upon

historical events and underpinnings as well as inclusion

based upon a subjective attribute of worthiness condoned by

the dominant culture of non-ethnic Whites.

Identity

According to Craig Calhoun (1995), author of *Twentieth-*

Century Social Theory: Critical Social Theory:

> Concerns with individual and collective identity,
> thus, are ubiquitous. We know of no people without
> names, no languages or cultures in which some manner
> of distinctions between self and others, we and they
> are not made. Though the concern may be universal,
> however, the identities themselves are not. Gender
> and age seem to distinguish people nearly everywhere,
> pedigree or parentage are of almost equally wide
> significance. Yet it is no accident that discourse
> about identity seems in some important sense
> distinctively modern – seems, indeed, intrinsic to
> and partially defining of the modern era. (Calhoun
> 1995, 192)

According to Calhoun, "self-knowledge," or *self-*

awareness, and self-identity are inseparable from how we

are perceived and interpreted by others, and therefore,

compose a "construction" (Calhoun 1995, 194-195).

In addition, "contrived" labels, usually by others, may

lead to the loss of cultural identity (Rogers-Adkinson,

Ochoa and Delgado 2003, 5). For instance, many people may,

or may not, construct their primary identity based upon a

combination of attributes, such as race, ethnicity, ancestry, etc.

Continuum of Blackness

Persons who settle in other countries usually continue to identify with the cultural identity and traditions of their countries of origin, or "homeland" (Rogers-Adkinson, Ochoa and Delgado 2003, 4).

However, the "collective memory" of African Americans was framed by the overwhelming "cultural trauma" of slavery in the U.S. Out of this collective experience, are African American assimilation into mainstream Euro-centric culture and Black nationalism (Smith and Riley 2009, 244). These perspectives are the two polarities on a continuum of a diverse, racial identity.

The "monolithic" category of *Black*, which "did not exist prior to this historical period," was first introduced in the U.S. to perpetuate exclusion and domination of diverse groups of people "from many different countries and cultural groups" (Smith and Riley 2009, 244).

During U.S. expansion of slavery, it was not until after 1680, after the enactment of "the major slave codes," that a "dichotomy emerged," which provided a visible means for differentiating denizens according to outward appearance

(i.e. melanism). This supplanted previously endorsed

methods, such as prejudice according to religious beliefs,

for example, being baptized, or not (Tehranian 2000, 830).

Despite the knowledge of many non-Blacks having

supported the advancement of "colored peoples" and that

racial prototypes and ethnicities are becoming blurred

beyond recognition, there still exists "interest

convergence," the idea that "people believe what benefits

them" (Delgado and Stefancic 2001, 41).

Stuart Hall, author of *Old and New Identities, Old and
New Ethnicities*, writes:

> I heard Black for the first time in the wake of the
> Civil Rights movement, in the wake of the de-
> colonization and nationalistic struggles. Black was
> created as a political category in a certain
> historical movement. It was created as a consequence
> of certain symbolic and ideological struggles. We
> said, "You have spent five, six, seven hundred years
> elaborating the symbolism through which Black is a
> negative factor. Now I don't want another term. I
> want that term, that negative one, that's the one I
> want. I want a piece of that action. I want to take
> it out of the way in which it has been articulated in
> religious discourse, in literary discourse, in visual
> discourse. I want to pluck it out [of] its
> articulation and rearticulate it in a new way." (Back
> and Solomos 2009, 204)

Likewise, any cultural proficiency model must allow for

a wide range of positions and perspectives on group and

individual identity within a community that is diverse and

consists of multicultural groups with many regional and local differences.

Assimilation: Cultural Quandary within Racial Identities

Watt S. Norton states, "Culture comprises the system of shared ideas, rules and meanings that inform us how to view the world, and tell us how to act (Norton 2004, 38).

Norton cites Andrews and Boyle (1995) as defining culture as an evolving process, which begins at birth, and through learning and "socialisation," becomes a shared identity based upon "beliefs and patterns that bind people together under one identity as a group" (Norton 2004, 38).

According to Richard Alba (2009), author of *Blurring the Color Line: The New Chance for a More Integrated America*, the social conceptualization of [W]hiteness is inadequate, in and of itself, since it is also riddled with "important ethnic and religious elements" and implications (Alba 2009, 14-15).

He continues and states, "This sort of assimilation has had an especially strong impact on some once-denigrated European groups, such as Irish Catholics and those from southern and eastern Europe" (Alba 2009, 7).

Assimilatory change caused racial/ethnic distinctions to become blurred over time, "to fade to the point of near

invisibility in much of social life." The author also states that our eyes have been "altered as a consequence" of assimilation (Alba 2009, 7).

Alba (2009) says that we need to consider the contextual dynamics of assimilation "anachronistically," that is, beyond modern and acceptable views of political correctness, and consider the "perceptions of witnesses of the time" (Alba 2009, 7-8).

Alba (2009) discusses concepts such as "mass assimilation" as a process, but not a precursor to racial prejudice and "[W]hite-ethnic assimilation" and "social boundary" to separate self-selected groups from those considered to be "less fortunate" (Alba 2009, 14-15).

In essence, Alba (2009) discusses that misconception of racial privilege as "[a] sociological commonplace" whereby groups "defend the boundaries that separate them from the less fortunate," only to allow non-threatening upward mobility of other groups according to the "non-zero-sum mobility." According to this idea, the gains of those moving upward come at no expense to those already in the "upper," or dominant group (Alba 2009, 15).

He continues, "Such mobility occurs when members of lower-situated groups can move upward without affecting the

life chances of the members of well-established ones" (Alba 2009, 15).

In contrast, "[a] zero-sum situation exists, by definition, when the gains of some must come at the expense of others" (Alba 2009, 15).

Alba postulates that this non-zero sum rule is the reason why White ethnic groups, "in between groups," were included in the definition of *Whiteness* and conjectures that it may serve as a premise upon which racial boundaries may become softened, or *blurred*, for Blacks (Alba 2009, 16).

Cross-Culturalism

Calhoun states that "thoroughgoing relativism" is critical to "overcoming ethnocentrism in social theory" and "involves not just appreciating differences but coming to terms with incommensurable practices." Cross-cultural understanding is a mechanism to combat ethnocentrism (Calhoun 1995, 80).

"There is always some overlap in the practical problems of life, in the conditions of social structure, and in the understanding of each of these that provides a starting point for cross-cultural discourse" (Calhoun 1995, 81).

On the other hand, Fanon describes the cultural differences model/approach in education and highlights its inadequacy due to the trivialization of diversity, reduced to superficial "sensitivity" and "a harmonious, empty pluralism" in an environment that reinforces dominant values and norms and denies the existence of true power imbalances (Razack 1998, 8-10).

Fanon continues to say that "the adoption of 'cross-cultural' strategies does little to ensure that [W]hite teachers will view their Asian and Black pupils as capable of the same level of achievement and range of desires as their [W]hite students (Razack 1998, 9).

Dula also explains how oppressed "minority groups" fall prey to "majoritarian presuppositions," which are assumed, yet oftentimes, disparaging beliefs, attitudes, philosophies, prescriptions held by those in power (Dula and Goering 1994, 23).

Racing Toward Cultural Blindness

Smedley says that because of the advancement of scientific knowledge, the evolution of worldviews, acceptance of cultural diversity, and expansion of ideas on culture "the disintegration of the ideological components

of race may well become a reality by the end of the twenty-first century" (Smedley 2007, 351).

The cost of not mending the gap of alienation leads to more distrust and crystallized/re-crystallized attitudes and beliefs that move society away from the acceptance of a diversified, blurred, or *colorblind*, society where people are judged by the "content of their character," a society in which if one suffers, then we all suffer.

The researcher maintains the position that, until the time when current definitions of race become "blurred," advocates shall continue to refer to current irrationally-defined categories of race, that is, what people have been historically conditioned to believe, in order to launch appropriate sociopolitical agendas for change.

Such action shall be predicated upon disparate circumstances, both evidenced in the past and present, and founded upon crystallized attitudes, beliefs and discriminatory practices, overt and covert, and motivated by existing social constructs of race and ethnicity as well as perceptions of racial superiority, privilege, social class, and expatriate caste.

Marginalization in the Media

"In truth, the changes involved in assimilation can be more radical than most Americans now appreciate, for assimilation ultimately affects the way that group differences are perceived" (Alba 2009, 7).

Iconography and visual representations in the U.S. have been historically used to disparagingly distinguish and depict racial differences. Such depictions have been used to perpetuate stereotypes of inferiority and undesirability (Alba 2009, 8).

More specifically, images or icons were used to disparagingly depict immigrant Whites and Blacks in printed media (Alba 2009, 15).

Dula cautions us to "be suspicious of" certain "psychological mechanisms," coined by Shelby Steele, a renowned literary critic. These descriptions were and are used by practitioners to explain behaviors of Black people as portrayed through characters in literary works. The "Token Black Syndrome" is depicted as first generation Black people who "endorse negative stereotypes" of "most Black people." They also "minimize similarities" with other Black people. The "bleaching syndrome" is characterized by Black people repudiating other Black people and identifying with White people instead of other Black people. In short,

Dula summarizes that race and ethnicity can shape personal perspectives and worldviews in both positive and negative ways (Dula and Goering 1994, 22).

Many non-Black persons continue to view Blacks in terms of disparaging, deriding and over-generalized labels and misrepresentations in order to maintain the *status quo* despite evidence of other possibilities. Doing so: 1) tempers any cognitive dissonance (that require self-exploration and social familiarity to overcome), 2) waivers re-construction that requires mental mapping and 3) perpetuates racial propaganda and prophetic fallacies directed at Blacks.

Today, this is evidenced in the media (and throughout other institutions) through solidified images of acceptable appearance and beauty, negative stereotypical images and reinforced, progressive notions of success, achievement, pleasure, happiness, sexual freedom, status, and family.

Marcuse continues to explain that *desublimation* spreads because the benefit of assimilating outweighs the "refusal to behave" or to not accept the norms of the dominant culture, which is promoted as *popular culture* (Lemert 2010, 437).

Societal norms such as immediate gratification within a "material culture" are promoted. Marcuse explains how this

is achieved through what he refers to as perverted propaganda and "materialization of ideals" by political leaders and incumbents as well as other industries (i.e. business and hospitality), (Lemert 2010, 437-438).

Social Equity Theory

H. George Frederickson theorized that public administration must include "re-distribution of wealth and power in society" (Box 2005, 22) based upon a "legitimized public administration" that increases one that is "democratic, equalitarian and humane" (Box 2005, 71).

Several arguments have surfaced to challenge this theory.

For example, authors of *The Bell Curve* (1994) argued that Blacks and other "minorities" were disparately represented in education and employment due to biological inferiority to Whites. This claim and accompanying propaganda was based upon "discredited 1920s-era pseudoscience" (Delgado and Stefancic 2001, 104-105).

Furthermore, legislation, based upon racial disadvantage and oppression, has been evidenced throughout the 20th and 21st centuries in cases such as *Plessy v. Ferguson* (separate-but-equal) and *Brown v. Board of Education* (racial integration) as well as affirmative action policy

(equal opportunity and anti-discrimination), enacted through "Executive Order 11246 in 1965" (Delgado and Stefancic 2001, 103-104).

The latter was challenged as "unconstitutional" in terms of "race conscious admissions" (Delgado and Stefancic 2001, 104). However, "most educators" maintained that supplanting affirmative action policy based upon race with that based upon "socioeconomic disadvantage or class" would benefit the numerous Whites who outnumbered Blacks (Delgado and Stefancic 2001, 106).

Additionally, the following have historically served as cornerstones of covert discrimination: 1) globalization to include outsourcing of work and job opportunities via sweatshops; 2) a "decontextualized free market ideology," which provided a deceptive façade as reparation for colonialism; and 3) revised laws that eliminated quotas (in 1965) and facilitated the immigration of cheap labor (peoples working for less and in less desirable conditions). All of which heightened denial of employment opportunities in the U.S. for those who would rightfully fight for equal protections, namely Blacks born in the U.S. (Delgado and Stefancic 2001, 112-113).

The political platform of the Black Community has traditionally been predicated upon reparation for social

injustice caused through centuries of barbarism (murder, torture, maiming, rape, pillaging, and other injuries), generalized mistreatment, discrimination (overt and covert), and social disenfranchisement, exclusion and isolation.

Such reparations have never occurred, and probably never will, since current and future generations are not obligated to pay for the transgressions and debts of the "forefathers."

Maryland Apologizes for Slavery

In 2007, Maryland legislators approved a bill to apologize on behalf of the State of Maryland for a system of slavery that "fostered a climate of oppression not only for slaves and their descendants but also for people of color who moved to Maryland subsequent to slavery's abolition" (Exum et al. 2007, 2).

According to Senator Nathaniel Exum, "Once we come to that recognition, maybe we will also recognize steps we need to do to get rid of the lingering effects of it on the people" (Associated Press 2007, 1).

One such step could begin with holding State officials accountable in the expeditious and culturally proficient response to the spread of HIV disease in Maryland.

Health Disparities

"Indeed, cultural competence seems to be evolving, from a marginal to a mainstream health care policy issue and as a potential strategy to improve quality and address disparities" (Betancourt et al. 2005, 503).

Thomas and Quinn cite DesJarlais et al. (1991) and state, "In addition to acknowledging differences in values and priorities, health care workers must anticipate and address expectations of racial prejudice" (Dula and Goering 1994, 95).

Norton (2004) states that race, "a social and political construct," has "a burden of historical and prejudicial connotations," and alone, is inadequate in explaining vast human differences or disease prevalence (Norton 2004, 39).

It Just Ain't Fair: The Ethics of Health Care for African Americans (1994), edited by Annette Dula and Sara Goering, is a compilation of writings, which provide:

> The practical knowledge of those working with particular underserved groups (mostly African American) with the more distant knowledge of policymakers, philosophers, ethicists, and others involved in ethical debate. The chapters display a diverse array of moral perspectives. Some refer to traditional medical experiences and communities; but all work toward a different, more inclusive vision of justice and ethics in medicine. (Dula and Goering 1994, 7)

The content of this diverse composition ranges from philosophical and ethical discussion in medicine to sociopolitical and economic inquiry and debate to community empowerment on resolving critical issues relating to the effective delivery of health care for underserved individuals and groups. It serves as a testament of practitioner experiences and commitment to work toward a "more inclusive vision of justice and ethics in medicine" (Dula and Goering 1994, 7).

In Chapter 1, entitled, *Bioethics: The Need for a Dialogue with African Americans*, the author Dr. Annette Dula, states that "ethnic perspectives in ethics seem to presuppose that certain intellectual positions can be identified with this or that ethnic group. Such an idea, however, is deeply problematic." She says that there is a danger in assuming that people of a group will share similar worldviews since "there will be as many perspectives as there are people" since members of groups do not share the same views on all things. (Dula and Goering 1994, 21-22).

Dula, citing Jones and Rice (1987), states, "Health disparities are the result of at least three forces: institutional racism, economic inequality, and attitudinal barriers to access" (Dula and Goering 1994, 12). More

emphatically, "institutional racism" is rooted in "unequal power relations" between Black people and "the medical profession" and society-at-large (Dula and Goering 1994, 12-13).

In addition, children and families receive disparate services from the allied human services, resulting in higher rate of infant mortality, disabilities (cognitive, emotive and physical), truancy, and teen pregnancy (Cohen 2003, 144-145).

According to Stephen B. Thomas and Sandra Crouse Quinn, authors of Chapter 7, entitled *The AIDS Epidemic and the African-American Community: Toward an Ethical Framework for Service Delivery*, regarding social and medical research, "We must also be mindful that race is not an independent risk factor. In other words, compared to [W]hites, [B]lacks do not have higher morbidity and mortality rates simply because they are [B]lack" (Dula and Goering 1994, 86).

The authors continue, "History reminds us that science is subject to racism, classism, and sexism; we must be cognizant of those influences on research, policy, and prevention" (Dula and Goering 1994, 86).

More specifically focused on the aforementioned conversation, they reiterate:

AIDS policy decisions in the first decade of this epidemic were greatly influenced by strong gay advocacy groups that sought adequate protection for those seeking HIV testing services.... As the focus of public health concern continues to shift away from white homosexual men to poor [B]lack drug users and their sexual partners, the influence of those who have spoken on behalf of the gay community has begun to wane. (Dula and Goering 1994, 86)

Social Determinants

The Commission on Social Determinants of Health acknowledges the ethical and political implications of equality in health care and state, "Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity"(Blas and Kurup 2010, 5).

The Commission designates a five-level of analysis framework consisting of the following aspects (Blas and Kurup 2010, 6).

Socioeconomic context and position (societal-level) influence the societal distribution of health, and include factors such as power and control, allocation of resources, social stratification, gender, ethnicity, governance, social policies, and culture (Blas and Kurup 2010, 6).

Differential exposure (environmental-level) includes factors such as psychosocial distress, environmental conditions, unhealthy housing, dangerous working

conditions, limited food choices and quality of foodstuffs, social exclusion, and obstacles to changing behaviors (Blas and Kurup 2010, 6).

Differential vulnerability (population-level), that is, different outcomes for different groups, is based on "cumulative life course factors," and include factors such as co-morbidities, poor availability and access to health care, low or insufficient income, and malnutrition (Blas and Kurup 2010, 6).

Differential health care outcomes (individual-level) are the results of the previously discussed levels (above). The underlying premise is that health care equity, or universal health care, should ensure that "everyone in health care receive it in a form that is beneficial to them." Disparate health care outcomes reveal that interventions may not have been appropriate or effective for certain groups. (Blas and Kurup 2010, 7).

Therefore, it is critical that the development of interventions include considerations for "cultural differences, nuances and values" (Dévieux 2004, 108).

Differential consequences (individual-level) include implications of the previous levels to include poor health care outcomes. Such negative results include exacerbated socioeconomic conditions such as decreases in: daily

activity, overall physical health and mental well-being, employability and income, leading to "social isolation and exclusion" (Blas and Kurup 2010, 7).

The researcher comprehensively discusses some of these social determinant implications, which magnify the cultural competence issues relating to the spread of HIV disease in Maryland.

Poor Health Expectations and Outcomes

Although there are correlations between poor health outcomes and income level and ethnicity, in general, those who rely on public health are more likely to experience poor health outcomes due to a complexity of variables, compounded by lacking, or limited, resources.

According to Jean J. Schensul and Barbara H. Guest, authors of Chapter 3, entitled, *Ethics, Ethnicity, and Health Care Reform*:

> Members of ethnic minority groups are more likely to be exposed to the hazards of inner-city and urban environments (including air and environmental pollution such as dust, roach and rat remains, poor housing, and traffic), occupational hazards (including pesticides, toxic substances, and accidents), and stress associated with poverty (including abuse and violence, homicides, and suicides). These circumstances are associated with higher rates of infectious diseases, chronic diseases, accidents, and premature deaths (Heckler 1985; Manton et al. 1987; Robinson 1987). (Dula and Goering 1994, 27)

Schensul and Guest continue to explain that poor people are "forced" to utilize less than optimal health care, and are therefore, even more likely to receive delayed diagnoses, treatment, care, and prognoses due to inadequate physician to patient ratios and/or physician refusal to accept reimbursements through Medicaid (Dula and Goering 1994, 29).

In addition, nursing and other clinical staffing shortages have exacerbated organizational operations and plans to achieve optimal patient treatment and care. In turn, it appears as if standards have been lowered in desperate efforts to maintain a workforce, but, at what cost? And, for whose benefit?

Additionally, "health education and primary care for inner-city families are not promoted in a weakened and underfunded public health system that has reached the limits of its ability to serve." (Dula and Goering 1994, 27-28).

Oftentimes, more than naught, public agencies and their sub-grantees do not encumber the total amount of funds awarded through formulary and competitive processes. Such unspent funds are seldom returned to the federal government for redistribution, may go unreported, and sometimes, are

not reconciled and disappear in suspected *soft money laundering*.

Such funds could very easily be jurisdictionally re-allocated through supplemental or appropriate *one-time* awards for desperately needed public education and promotional campaigns, and co-sponsored by: proceeds from fundraising events, program income, in-kind contributions; and corporate and celebrity donations, which may be used as *tax write-offs*.

Moreover, due to the availability of private funds and public funds for HIV/AIDs programs in the United States, incrementally increasing over the years, the lack of funding is less likely the reason for poor public awareness and health outcomes; but mismanagement, misuse and abuse of public funds and poor stewardship are likely contributory.

To magnify such suspicion, for Fiscal Year 2008, Maryland received $90,037,710 in federal funds for HIV/AIDS programs (Kaiser 2010h, 1).

Socioeconomics

Paul Farmer, anthropologist and infectious disease specialist, states, "Among those already infected, poverty hastens the development of AIDS" (Farmer 1992, 15).

Thomas and Quinn support the literature that finds health outcomes to be directly correlated with socioeconomic status (poverty), lack of education, inadequate residential environment, and low job esteem and confer that "Within this context, disease prevention policies that place responsibility solely on individual Black men and women are simply unjust" (Dula and Goering 1994, 86).

The authors cite Jaynes and Williams (1989), who claim that "the relationship between poor health and socioeconomic status has been well documented" (Dula and Goering 1994, 86).

Thomas and Quinn support remedying AIDS along with other health disparities to de-stigmatize HIV disease and minimize fear within the Black Community. They also condone using public health as a means to achieve social justice (Dula and Goering 1994, 86).

According to Dalton Conley, recipient of the American Sociological Association 1997 Dissertation Award for his work entitled, *Being Black, Living in The Red: Race, Wealth and Social Policy in America*, "In contemporary America, race and property are intimately linked and form the nexus for the persistence of [B]lack-[W]hite inequality" (Conley 2003, 86). He explains that such corollaries result from

other socioeconomic factors such as "income, education and occupation" and "accumulated wealth," which synonymously includes "property, assets or net worth" (86).

Fernando De Maio (2010) writes in *Health and Social Theory*, "…[T]he emerging literature on the health effects of inequality sees inequality itself as a source of poor health" (De Maio 2010, 60).

Paul Farmer (2005) conceptualizes *structural violence* as "a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are un-contestedly human rights abuses, some of them punishment for efforts to escape structural violence…" (Farmer 2005, 8).

Farmer (1992), in his work entitled *AIDS & Accusation: Haiti and the Geography of Blame*, states, "Throughout the world, but particularly in what is termed the 'Third World,' much of human suffering is caused or aggravated by social forces, and social forces should be studied by medical anthropologists" (Farmer 1992, 259).

In addition, Farmer (1992) refers to his work as "a protest against the social forces that pattern inequalities in health and a call for recognizing the primacy to the right to health" (De Maio 2010, 89).

The way that crime was defined also created and maintained an unequal power dynamic. Crimes committed by non-Whites (e.g. loitering on public corners, graffiti, use of *crack* cocaine vs. powder cocaine) were more often, or heavily policed, whereas "figures show that white-collar crime, including embezzlement, consumer fraud, bribery, insider trading, and price fixing, causes more deaths and property loss, even on a per capita basis, than all street crime combined" (Delgado and Stefancic 2001, 114.

The authors also write:

> One premise of the new legal storytellers is that members of this country's dominant racial group cannot easily grasp what it is like to be nonwhite. Few have what W.E.B. Du Bois described as "double consciousness." History books, Sunday sermons, and even case law contribute to a cultural hegemony that makes it difficult for reformers to make race an issue. How to bridge the gap in thinking between persons of goodwill whose experiences, perspectives, and backgrounds are radically different is a great challenge.(Delgado and Stefancic 2001, 39-40)

This is another prospective outcome of *The Capacity Building Model,* that public health practitioners will rise to meet this challenge of attaining double consciousness or a semblance thereof, considering racial and ethnic tensions in the quest to make public service effective and fair despite cultural differences.

Are Resources Limited?

According to Thomas and Quinn, "The AIDS epidemic has exposed the harsh reality of diminished economic resources, limits of medical technology, and confusion over how best to attribute responsibility for prevention of HIV infection" (Dula and Goering 1994, 87).

They also emphasize the importance of responding to HIV/AIDS and the complexities associated with the disease in a comprehensive manner, treating them "as a social catastrophe brought on by years of economic deprivation, and benign neglect, and to meet it as other disasters are met, with adequate resources" (Dula and Goering 1994, 87).

The authors state that a major challenge of providing an appropriate public health response in the Black Community, consisted of understanding "how attitudes and beliefs influence the Black response to HIV education programs" (Dula and Goering 1994, 82).

Nevertheless, resources for HIV prevention and treatment must be provided for non-Whites as were previously for other racial groups.

Distrust of Public Health due to Myths and Deception

According to Arthur and others (2005), "The 1999 U.S. Surgeon General Report on Mental Health validated the need for cultural competency" and "indicated that people of

color feared or felt ill at ease with the mental health system" (Arthur et al. 2005, 244).

People of color are also less likely to advocate for themselves due to the lack of familiarity and trust of the health care system and its medical providers (Fowler 2004, 43).

Thomas and Quinn state that "several" research studies of the time concluded that Blacks also: "mistrust government reports on AIDS, believe that AIDS is a man-made virus, respond negatively to people who say AIDS came to America from Africa, and believe AIDS is a form of genocide" (Dula and Goering 1994, 82).

For this reason, the authors state that "Public health professionals must recognize that the belief in AIDS as a form of genocide is a legitimate attitudinal barrier rooted in the history of the Tuskegee Syphilis Study" (Dula and Goering 1994, 83).

In addition, many Blacks hold onto the re-telling of the Tuskegee Syphilis Study from 1932-1972, in which 399 participants were denied treatment by the U.S. Public Health Service, and instead, were administered a placebo (Reynolds 2004, 240-241); undeniable and unconscionable patient deception, with long-lasting social effects.

Moreover, Black administrators reported a common heresy that "AIDS is a genocidal plot developed by the government to destroy Black people" (Stevenson 1994, 71).

Even in 2010, many Blacks adamantly maintain the same or similar skeptical positions on the spread of HIV disease. But, who is to determine whether or not they are wrong? And what is the significance of the etiology on the epidemic and well-being of those living with the disease?

Academic Responsibility

In England, during the Industrial Revolution, William Cobbett, became known as "the first great tribune of the industrial proletariat" (Williams 1959, 3). He "insisted that learning could not be separated from doing; and that good education arose from a whole way of life, and was a preparation for participation in it, rather than an isolated, 'book-learning' abstraction" (Williams 1959, 18).

Osman Galal and Michele Yehieli (1995), authors of chapter 15 entitled, *The Role of Public Health Schools in Meeting the Needs of Rapidly Diversifying Communities*, state that when "shaping diversity's future," (Thomas 1995, 211), academic institutions should "reform curricula" (211-212); "serve as centers for continuing education opportunities" (212-213); "supplement academics with

practical field training" (213); "include language and area studies in degree requirements" (213-214); "increase minority student bodies" and "recruit minority and faculty administrators" (214); "encourage academic exchanges" (214-215); "focus health research on cultural diversity issues" (215); and "integrate education with heath care and social reforms" (Thomas 1995, 215-216).

The editor also states that because "traditional curative medicine" is preferred over "community and prevention health" the sustainability of public health schools "is in doubt" (Thomas 1995, 216).

The authors conclude that academic institutions should serves as "catalysts for change and vanguards of multicultural knowledge" and that the individuals and funding agencies are responsible for ensuring improvement through training to meet "the needs of the country's increasingly diverse population" (Thomas 1995, 216).

Robert T. Carter developed the Racial-Cultural Counseling Competence (RCCC) Laboratory in 1995 and explains that practitioners can only appreciate the importance and impact of "racial-cultural factors" of customers after they appreciate their own (Carter 2003, 21).

The "integrative approach to cultural competence training" (20) requires several pre-requisite counseling courses prior to the laboratory, which is "didactic (knowing that), experiential (knowing self), and skill-based... (knowing how)" (Carter 2003, 23).

The didactic component includes lectures on "reference groups," perceptions, history, power, sociopolitical dynamics, etc. (23-24). The "small group" includes peer-led self-exploration and written assignments, such as development of autobiographies to increase self-awareness, *genograms* of social networks (24-25) and questionnaires on attitudes and feelings regarding various reference groups and stereotypes associated with them (25).

Many students expressed that the lab was "one of their most valuable experiences in the program" (Carter 2003, 30).

Margo J. Heydt and Nancy E. Sherman, authors of *Conscious Use of Self: Tuning the Instrument of Social Work Practice with Cultural Competence*, propose several pragmatic teaching techniques and strategies for increasing cultural competence (Heydt and Sherman 2005, 32-37).

One method involves "Early Recollection of Identity," in which participants remember the construction of their self-

identities "in terms of gender, race, ethnicity, class, religion," etc. (33).

Another method involves the use of audio and videotaping for practitioner self-observation (30) and peer evaluation of "unconscious mannerisms" that hinder rapport building (36-37).

The *Greeting Card Identity* exercise involves participant exploration of situations scenarios for appropriate selection of greeting cards for others, based upon cultural differences and appropriateness. In addition, feelings that surface are explored when no cards are found to be consistent with the cultural identities of the participants (33).

It is important that practitioner education and training be presented in different ways that lead to personal value, vested interest, practical utility, and decreased placation of customers. Making the content personal creates a sense of personal commitment, involvement and worth.

Moreover, practitioners, who believe that they have been "adequately prepared" may be shocked by customers who challenge their assumptive beliefs and practices (Wilson, 2004, 145.

Dean E. Sidelinger et al. recommends a method of teaching cultural competent care to medical residents of

pediatrics. It prescribes collaboration with "community partners to act as teachers and experts of their own cultures," thereby learning from the "strengths of their communities" (Sidelinger et al. 2005, 1160).

Over-Generalized Research

Pathogenesis of the later identified or *discovered* disease known as (HTLV)III or ARC had been initially popularized (circa 1981) as "Gay-Related Immunodeficiency Syndrome (GRIDS)" (Quinn 2001, 1) and "Gay-Related Immune Deficiency (GRID)" or "gay cancer" (Wright 2006, 22).

Michelle Murrain, author of Chapter 11 entitled, *Women of Color and AIDS: Gender, Race, Class, and Science*, infers that because AIDS was sensationalized and "constructed" as a disease prevalent among White, gay men and persons who injected drugs, groups that were already stigmatized by the general population, the impact on women was not appropriately studied, if not "ignored" (Thomas 1995, 150).

Murrain also writes "the biomedical establishment had been largely unable to look at and deal with the ethnic disproportionality of AIDS among people of color since the beginning of the epidemic" despite the fact that "reports of the ethnic disproportionality of AIDS were published as early as 1986" (Thomas 1995, 149-150).

Sara Goering, author of *Women and Underserved Populations: Access to Clinical Trials*, explains in the section entitled, *Problems with the White Male Model*, how clinical research is based on the research data, treatment techniques, health outcomes for middle-aged, White men. According to Goering, research reveals: 1) under-representation of Blacks in clinical trials, 2) lack of "race-related response differences," 3) generalizability to the population-at-large despite "insufficient data" and findings that provide "misrepresentation" of disease diagnosis, manifestation, prognosis, and treatment alternatives for populations differing in sex and ethnicity (Dula and Goering 1994, 183-185).

According to Thomas and Quinn, "Cultural barriers prevent open discussion of homosexual behavior, and Black men who have engaged in same sex activity in the past or who currently engage in same sex "may not self-identify as gay or bisexual" (Dula and Goering 1994, 79).

According to Murrain, another limitation became reinforced. The *risk* dichotomy, or *all or nothing* rule, that, there were only two perspectives on contracting HIV, or risk. The first, being that "everyone is at risk" and second, that "only *those* people get it." The author reiterates, "Neither perspective is correct; and we need to

understand in a much more sophisticated fashion what social and economic forces help to put people at greater risk for HIV infection" (Thomas 1995, 150).

According to the Thomas E. Arthur and others (2005), authors of *Developing a Cultural Competence Assessment Tool for People in Recovery from Racial, Ethnic and Cultural Backgrounds: The Journey, Challenges and Lessons Learned*, there is a research-practice divide, which is "worse for people of color." They also state that some researchers claim that within the mental health system, and there is "no empirical data available to indicate what the key ingredients of cultural competency are and what influence, if any, they have on clinical outcomes for racial and ethnic groups" (Arthur et al. 2005, 244).

Stigma and Exclusion

Gerhard Faulk (2001), author of *Stigma: How We Treat Outsiders*, stigma is used to "establish boundaries" between people, those considered to be "insiders" and those excluded and considered to be outsiders, who are stigmatized (Faulk 2001, 11).

Stigma may be "existential," a state where the person may have little control over the condition (e.g. persons with same sex orientation, persons with cognitive/mood

disability, those with disease-related conditions (i.e. obesity), older persons (ageism), groups such as "Native Americans," identified by race/ethnicity, etc.), (Faulk 2001, 11).

Stigma may be also "achieved," or based upon personal conduct or contribution to the state (e.g. immigration, some cases of homelessness, engaging in sex for money, addictions, crime, etc.) (Faulk 2001, 11).

Gerhard Faulk (2001), says that negative labels are used to discredit people and exclude them from social groups and hinder attainment of "full social acceptance" so that "the stigmatized person will then suffer the consequences of the label in a manner similar to that which has been attributed to someone who is indeed engaged in unpopular behavior," thereby leading to rejection, scorn and contempt (Faulk 2001, 20).

When used as a sociopolitical strategy, stigmatization comes with a cost. Demonstrative indifference, dishonesty, untrustworthiness, and remorse, or lack thereof, may reveal to others the underlying motives, which may also be indicative of: irrational fears and/or the lack of understanding, empathy and/or self-confidence.

In addition, *anti-social* and or *narcissistic* (self-centered) behaviors may serve to undermine, disregard

and/or separate others to feel admired, validated or vindicated or to achieve personal gain or satisfaction. (DSM IV 2000, 701-703, 714-715)

For example, Faulk (2001) defines ageism as "scorn and contempt" toward the elderly (Faulk 2001, 20) and *gerontophobia* as the overriding fear, or "unreasonable fear and/or irrational hatred of older people by society and themselves (Faulk 2001, 21).

Smedley (2007) also says that "Science writers synthesized and articulated the hatred, fears, and frustrations emanating from explosive and unprecedented experiences, such as race riots, labor conflicts, and the like" (Smedley 2007, 278).

In summary, Blacks and other non-Whites were dehumanized and depicted as "inferior" through sociopolitical propaganda and unsubstantiated academic claims (considered to be scholarly) in order to align masses of Whites to perpetuate social exclusion, marginalization, discrimination, and violence.

Modern remnants of such principles and practices of dominance and misinformation of European colonialism and oppression are manifested in power-control dynamics and usurpation of Blacks or other groups of the African Diaspora.

Blaming the Customer

Schensul and Guest also discuss "cultural barriers," such as "beliefs, behaviors, expectations for wellness, disease and disease management, and language between the patient/community culture and that of the service provider/institution," which impede communication and achievement of optimal health care and outcomes (Dula and Goering 1994, 32).

In addition, there are other *obstacles* such as attitudes, rules of engagement, differing ideations of respect and appropriate conduct, inability to bridge cultural conflicts, which contribute to limited access, retention and re-entry into health care. These may occur in addition to obstacles relating to considerations of age, gender and sexual orientation within cultures.

One example of such a conflict in attitudes is that people living with HIV/AIDS are at fault for acquiring the disease.

In Tavis Smiley's New York Times Bestseller, *The Covenant with Black America*, David M. Satcher, M.D., in his essay entitled, *Securing the Right to Healthcare and Well-Being*, criticizes what the researcher refers to as *patient blaming*, a position held by some public health practitioners and administrators.

He writes:

> A common approach to health emphasizes the individual's role in her/his own health status: people get sick because they are not taking care of themselves. This perspective puts the responsibility of health entirely on the individual and fails to consider how the community in which people live has an impact—positive or negative—on health.(Smiley 2006, 11)

Even more pointedly, he continues:

> Overall, ethnic and racial minorities, and specifically African Americans in the United States, face a social and an economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty—all of which result in lower health status. Addressing health disparities means understanding how socioeconomic status and racism result in social and economic inequities that determine where we live, what we eat, where we work, how we exercise, what we breathe, what we drink, what we perceive as our life options, and how well informed we are about our health. (Smiley 2006, 11)

Farmer, referring to North American racism and xenophobia (including references to *Voodoo*, monkeys and HIV origins in Haiti), states, "Of all these types of accusation, only one blames the victims--AIDS-related discrimination. In the United States, an invidious distinction between 'innocent' and 'guilty' AIDS sufferers has become entrenched" (Farmer 1992, 247).

According to Thomas and Quinn, "Black Americans are being killed by a disease that is almost totally preventable" (Dula and Goering 1994, 76). This statement

has been misquoted over the years with public health officials and physicians alike stating that HIV is now a "totally preventable disease."

The latter statement is founded upon the following assumption discussed by Thomas and Quinn:

> AIDS risk-reduction policy is based on the assumption that we as individuals can control our health destinies in significant ways. The emphasis on changing personal behavior assumes equality of access to health care, education, income, and quality of life. It assumes that all individuals have comparable control of their lives, and therefore fails to recognize the structural and social factors that minimize that control for some minority groups.(Dula and Goering 1994, 86)

The authors continue and say, "To expect individual blacks to overcome the multiple barriers that contribute to their persistent health disadvantage is to ensure that a large segment of the [B]lack [C]ommunity will not benefit from advances in AIDS treatment and preventive research" (Dula and Goering 1994, 86).

According to Jean-Louis Jouve, Jens Aagaard-Hansen and Awa Aidara-Kane, authors of Chapter 6 entitled, *Food Safety: Equity and Social Determinants*, "External pressures, such as prolonged stress, are plausibly linked to immune responses and increased vulnerability to infectious diseases. The population of patients with AIDS is still alarmingly high. An estimated 33.2 million people

are living with HIV, and 2.1 million people died of AIDS in 2007" (Blas and Kurup 2010, 101).

Despite this evidence, HIV disease appears to be the only communicable disease of pandemic proportion in which persons living with it are stigmatized and blamed for acquiring it.

John D. Lantos, in Chapter 6, entitled *Race, Prenatal Care, and Infant Mortality*, criticizes "political rhetoric" that *writes off* infant mortality as "unavoidable" due to "genetic or racial factors." He claims that "We do have the ability to greatly reduce the racial differences in infant mortality rates through social, medical, and political changes" (Dula and Goering 1994, 71).

In the words of John D. Lantos, in Chapter 6, entitled *Race, Prenatal Care, and Infant Mortality*, similarly when addressing HIV/AIDS issues in the Black Community, "doing little to ameliorate the social conditions associated with it reveals a deeply rooted racism. That attitude must not be tolerated." (Dula and Goering 1994, 74).

This leads to the need to further refine culturally appropriate recommendations, standards, and performance measures, to regulate (and monitor) culturally competent and proficient delivery of services, funded on federal and jurisdictional levels.

Generalized Stigma in the Community

During the earlier years of the HIV epidemic in the United States, during the time when researchers began to ponder the social complexities of the spread of the HIV, authors began to publish articles and survey findings on the attitudes and beliefs of people impacted by HIV/AIDS.

According to Thomas and Quinn, "Thirty-five percent of respondents of a survey conducted at the Southern Christian Leadership Conference in 1990 believed that AIDS was a form of genocide" (Dula and Goering 1994, 83).

More recently, according to the *POZ: Health, Life and HIV* magazine article entitled, "Homophobia, the Church and AIDS," 95 percent of 1,200 survey participants reported that "they believe that Americans, in general, consider HIV to be a *gay disease*" (Straube 2010, 35).

Particularly within the religious community, the existent of same sex orientation has always been recognized, but not necessarily accepted or promoted as behavior of which to be *proud*, where "pride" precedes "the fall."

In the private sector, some Black-operated businesses and organizations have not responded to HIV/AIDS because of homophobia and the stigma associated with HIV/AIDS being a "gay disease" (Dula and Goering 1994, 79).

Consequences of Stigma

According to Thomas and Quinn, "Today, institutional racism in healthcare is manifested in the way African American and poor people are treated" (Dula and Goering 1994, 13.

Moreover, several years of lost opportunities for HIV/AIDS prevention, health care and treatment for non-White communities have been lost due to the focused racial-ethnocentric transgression of forerunner advocacy, designed to establish privileges in health care for White men and to further advance a sociopolitical gay rights agenda for White men and women.

Consequently, the Black Community has definitely taken a back seat due to the continued stigma associated with the promotion of HIV as a White, gay man's disease, which supposedly originated in Africa.

In direct contrast to theories that dissuade imposition of cultural values on customers, is demonstration of a genuine lack of respect or "force-fit" (Johannes and Erwin 2004, 332). This is also referred to as *one size fits all* or *one size fits most*.

Today, as the propaganda continues, few organize, proportionately respond, propose alternative theories to

countermand the myths, or ensure equal provision of HIV prevention interventions and health care for Blacks.

The misrepresentation of the disease lead to not only increased stigma, but also a consensual *opting out* by Blacks and other non-White groups, particularly women and persons, who solely or primarily engaged in sex with persons of the opposite sex.

Moreover, only miniscule efforts have been made to target Black, non-IDU, heterosexual men despite the rampant increase in heterosexual HIV/AIDS cases in Maryland even though Maryland data revealed that heterosexual exposure "surpassed injection drug use" in Baltimore as early as 2002 (Baltimore City Commission on HIV/AIDS 2006, 3).

Such continued bureaucratic apathy and disregard of cultural needs and values have resulted in disparate health outcomes for Blacks and constitutes infringement on the civil rights of many Black Marylanders through a predictable yet covert infraction, a "banality of evil" (Arendt 2006, 252).

Sociopolitical Change

The "Face of America" is truly changing. Overall, the American population is steadily increasing. However, the U.S. census projects that, by the year 2050, Black

Americans will represent 61 million of the population, an increase of 83% since 1995. Hispanics/Latinos will increase by 258% and Asian and Pacific Islanders by 267% (Fowler 2004, 42-43).

According to Alba, the two largest and disadvantaged ethno-racial populations are Black and Hispanic/Latino Americans (Alba 2009, 14).

As evidenced by the political attacks on the President Obama, even today many Whites still see the advancement of non-Whites, and Blacks in particular, as a threat, or an inevitable and pending doom, as a result of the instilled perceptions, beliefs and attitudes of yesterday.

Another fear is that, with the change in national demographics, one-day Whites may become the *minority* in North American as once before. Hence, the tables will have turned full circle, but at what cost to society-at-large? Will Eurocentric racism strengthen as illustrated through *Tea Party* propaganda or will equality prevail?

Tommie Shelby (2005), author of *Race and Ethnicity in America: Meeting the Challenge in the 21ˢᵗ Century*, contends, "I defend a conception of solidarity based strictly on the shared experience of racial oppression and a joint commitment to resist it. The practicality and scope of black solidarity depends on a diagnosis of the complex

forces that constitute black oppression and on the extent to which blacks suffer specifically because of anti[-B]lack racism, past and present" (Shelby 2005, 11-12).

Molefi Kete Asante, referred to as "perhaps the leading theorist of Afro-centrism," discusses "identity-based political movements," which invoked "a shared social identity as the basis of community and politics" (Seidman 2008, 222-223). He continues to explain how such Black movements for social justice were "attacked," or obstructed through a "resurgence of public racism in cities and campuses across the country" in the latter years of the 1970s (Seidman 2008, 223).

Alba (2009) states, "Social movements are likely to be most effective when conditions are favorable, when concessions can be made without much apparent effect on the life chances of the members of more privileged groups, and when, therefore, the countermobilization is weaker than it might otherwise be" (Alba 2009, 238).

Alba (2009) says that not taking advantage of the possibilities for "ethno-racial change" through non-zero sum mobility may lead to "recrystalization" of "ethno-racial inequities." If that were to occur, then old and newly developed attitudes, beliefs and social constructions of race would become "locked in" (Alba 2009, 240).

In short, the time is nigh for "substantial ethno-racial" change. Failure to act will result in a costly and missed prospect. "A wise society will seek to take advantage of such a chance" (Alba 2009, 240).

Cultural Competence Ambiguously Defined

Paul A. Sabatier (1999), author of *Theories of the Policy Process: Theoretical Lenses on Public Policy*, quoting Feldman (1989), defines ambiguity as "a state of having many ways about the same circumstances or phenomena." He emphasizes that ambiguity "may create vagueness, confusion, and stress." In this aspect, ambiguity may be used synonymously with ambivalence and not with "uncertainty," which is defined as "the inability to accurately predict an event" (Sabatier 1999, 74).

Culture "is an adaptation to specific activities related to environmental and technical factors and to the availability of these" and "ethnicity involves a system of shared meanings developed in a social and economic context with a particular historical and political background" (Norton 2004, 38).

In essence, the term *cultural competence* has been used ambiguously, both semantically and connotatively. This has lead to misunderstanding, misinterpretation and different

implications in the use of the term in practice, and particularly, in the field of public health.

As the literature review reveals, the definition of cultural competence has not been uniformly and scientifically operationalized since it is subjective and can be defined differently by individuals practicing within systems, agencies, professions, cliques within agencies as well as the diverse populations being served.

"*Cultural diversity* is a term used to identify differences," including "differences in behaviors," differences in their associated meanings, and "the risk associated with changing them" (Barrera and Corso 2002, 104).

Some of the recurrent issues that underscore the literature review include the emphasis, or overemphasis, on diversity as a predictor of cultural competence and repetition of the unfavorable or despicable 'isms' to be removed from our psyches.

It is the position of the researcher, however, that public administrators are obligated to ensure appropriate, equitable and non-discriminatory delivery of service in response to the needs of our public customers, realistically acknowledge that some attitudes and challenges may continue to exist despite all optimism and

eradication efforts and pledge to hold accountable all, who infrequently or oftentimes, operate out of integrity when serving the interests of the public.

"The term *cultural competence* or *cultural competency* is typically used in reference to the knowledge and skill necessary for facilitating communication and skill acquisition across cultures (e.g. Lynch & Hanson, 1992)" (Barrera and Corso 2002, 105).

The concept of *cultural competence* is also ambiguous in consideration of the flawed design of bureaucratic structures, systems and accountability mechanisms, ever changing political environments, and negative forces which compete against the achievement of positive, beneficial outputs and outcomes.

Nevertheless, public administration practitioners and community stakeholders must collaboratively: 1) strive toward an idealistic, milestone target of *cultural proficiency* [1] in order to achieve any resemblance of cultural competence, 2) collectively ensure the delivery of accountable, ethical, effective, efficient, optimal quality, and responsive HIV prevention and treatment programs by culturally proficient practitioners and 3) continue to take action and hold all federally-funded

agencies and sub-grantees accountable until ethical and culturally proficient services are provided.

Therefore, this work provides a working definition, framework and tools to advance cultural proficiency in public administration. The visual templates may be used as is or tailored for implementation by the public administration practitioner, who leads agencies toward fulfilling ethical, civil and legal requirements on behalf of the public being served.

The Capacity Building Model was developed in consideration of social constructs and concepts such as race, health disparities, dominant and popular culture, as well as measurable tenets of public administration: accountability, effectiveness, efficiency, quality, and responsiveness.

Nationally Accepted Cultural Competence Approaches

Mental Health

Most promulgated definitions of cultural competence originate from the work of Terry L. Cross, Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs (1989), entitled, *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed: Volume 1.* This Monograph was published by the National Technical

Assistance Center for Children's Mental Health, Georgetown
University Child Development Center.

Cross et al. (1989) developed the Cross Model of
Cultural Competency and discuss cultural competence on a
continuum with the following cultural stages: *cultural
destructiveness*, *cultural incapacity*, *cultural blindness*,
cultural pre-competence, *cultural competence*, and *cultural
proficiency*, or *advanced cultural competence* (Cross et al.
1989, 13-18).

In 1998, the Maryland Mental Hygiene Administration
(MHA) and Maryland Health Partners (MHP) Cultural
Competency Advisory Group (CCAG), composed of
administrators, practitioners, advocates, and "persons in
recovery," in consideration of the advances of the Center
for Mental Health Services (1997) and researchers such as
Cross et al. (1989) and Davis (1997), defined "cultural
competence as the willingness, commitment, effort and
ability to recognize, understand and appreciate cultural
differences and effectively using this knowledge to design
and provide services to address the mental health needs of
people from various cultures" (Arthur et al. 2005, 245).

Based upon this definition, from 1998-2001, using a
Participatory Action Research (PAR) methodology, the CCAG
developed a 52-item survey (Likert scale) to measure the

perceptions of clients of mental health services in

Maryland (Arthur et al. 2005, 245-249).

Four practitioner competencies were revealed through

analysis of the results: 1) ability to assess

"psychosocial, medical and spiritual" needs of customers;

2) access to services and negotiable service priorities; 3)

outreach to racially diverse communities; and 4)

"willingness to listen to and respect" a diverse customer

base (Arthur et al. 2005, 248).

Examples of standardized measures that are of particular interest to the researcher are listed below.

Table 1: Cultural Competency Measures (Arthur et al.)	
Question Number	Measure Description
Q22	Some of the mental health providers are from my racial or ethnic group.
Q30	The staff here treat me with respect.
Q31	The staff here think less of me because of the way I talk.
Q33	The staff here respect my religious or spiritual beliefs.
Q35	The staff here hold it against me if I complain about things that I am not happy with.
Q36	If I show anger about something the staff here thinks the worst right away.
Q37	The staff here understand some of the different ideas that I, my family and others from my racial or ethnic group may have about mental illness.
Q42	Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.
Q43	The staff who work directly with me on my mental health needs respect my belief in God, a Supreme Being or Higher Power.
Q47	The staff who work here *do not* talk to other people about my problems or treatment without asking me first.
Q55	Some of the staff here understand the difference between their culture and mine.
Q56	Staff here acknowledge the importance of my cultural beliefs in my treatment process.
Q57	Staff here understand that people of my racial or ethnic group are *not* all alike.
Q59	I *do not* see staff here taking time to understand a person's culture.
Q64	Staff from this program come to my community to let people like me and others know about the services they offer and how to get them.

(Arthur et al. 2005, 247-248).

The Substance Abuse and Mental Health Services

Administration (SAMHSA) Center for Mental Health Services

(CMHS) definition of cultural competence includes the

following tenets.

> Attaining the knowledge, skills, and attitudes to enable
> administrators and practitioners within system[s] of
> care to provide effective care for diverse populations,
> i.e., to work within the person's values and reality
> conditions. Recovery and rehabilitation are more likely
> to occur where managed care systems, services, and
> providers have and utilize knowledge and skills that are
> culturally competent and compatible with the backgrounds
> of consumers. Cultural competence acknowledges and
> incorporates variance in normative acceptable behaviors,
> beliefs and values in determining an individual's mental
> wellness/illness, and incorporating those variables into
> assessment and treatment. (HRSA 2008a, 1)

Social Work

According to the National Association of Social Workers

(NASW), "Social workers shall have and continue to develop

specialized knowledge and understanding about the history,

traditions, values, family systems, and artistic

expressions of major client groups that they serve" and

"[s]ocial workers shall use appropriate methodological

approaches, skills, and techniques that reflect the

worker's understanding of the role of culture in the

helping process" (NASW 2007, 5).

The NASW defines the word 'culture' as:

> [T]he integrated pattern of human behavior that
> includes thoughts, communications, actions, customs,
> beliefs, values, and institutions of a racial,

> ethnic, religious, or social group… [and] as the
> totality of ways being passed on from generation to
> generation. The term culture includes ways in which
> people with disabilities or people from various
> religious backgrounds or people who are gay, lesbian,
> or transgender experience the world around them.
> (NASW 2007, 11)

The NASW uses the word 'competence,' "because it implies having the capacity to function effectively within the context of culturally integrated patterns of human behavior defined by the group" (NASW 2007, 11).

The NASW defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations" (NASW 2007, 13).

The NASW cites Davis and Donald (1997) when operationally defining cultural competence as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (NASW 2007, 13).

The NASW later prescribes "[c]ompetence in cross-cultural functioning" to mean "learning new patterns of behavior and effectively applying them in appropriate settings" (NASW 2007, 13).

The NASW alleges that Gallegos (1982):

[P]rovided one of the first conceptualizations of ethnic competence as "a set of procedures and activities to be used in acquiring culturally relevant insights into the problems of minority clients and the means of applying such insights to the development of intervention strategies that are culturally appropriate for these clients." (p. 4). This kind of sophisticated cultural competence does not come naturally to any social worker and requires a high level of professionalism and knowledge. There are five essential elements that contribute to a system's ability to become more culturally competent. The system should (1) value diversity, (2) have the capacity for cultural self-assessment, (3) be conscious of the dynamics inherent when cultures interact, (4) institutionalize cultural knowledge, and (5) develop programs and services that reflect an understanding of diversity between and within cultures. These five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies, and services. (NASW 2007, 13-14)

Under the section entitled, *Standards for Cultural Competence in Social Work Practice, Ethics and Values*, the NASW cites Reamer (1998) as stating, "A major characteristic of a profession is its ability to establish ethical standards to help professionals identify ethical issues in practice and to guide them in determining what is ethically acceptable and unacceptable behavior" (NASW 2007, 17).

The NASW also states, "The personal attributes of a culturally competent social worker include qualities that reflect genuineness, empathy, and warmth; the capacity to respond flexibly to a range of possible solutions; an

acceptance of and openness to differences among people; a willingness to learn to work with clients of different backgrounds; an articulation and clarification of stereotypes and biases and how these may accommodate or conflict with the needs of diverse client groups; and personal commitment to alleviate racism, sexism, homophobia, ageism, and poverty. These attributes are important to the direct practitioner and to the agency administrator" (NASW 2007, 25).

Health Care

The President's Initiative on Race and Health Town Hall Meeting (July 10, 1998) defined cultural competence as "the ability to deliver effective medical care to people from different cultures. By understanding, valuing and incorporating the cultural differences of America's diverse populations and examining one's own health-related values and beliefs, health providers deliver more effective and cost-efficient care" (HRSA 2008a, 1).

Workgroups of the U.S. Department of Health and Human Services defined cultural competence as "behaviors, attitudes, and policies that can come together on a continuum: that will ensure that a system, agency, program, or individual can function effectively and appropriately in

diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency program or individual continually aspires to achieve" (HRSA 2008a, 1).

The U. S. Department of Health and Human Services (DHHS) Health Administration and Resources Administration (HRSA) promulgates the *Cross Model of Cultural Competence*, which is located on the HRSA website entitled, *Cultural Competence Resources for Health Care Providers*, under Chapter 3, entitled, *Strategies for Success in Implementing Cultural and Linguistic Competence Education* (HRSA 2007, 1).

The HRSA promulgate the *Cross Model of Cultural Competence*, ranging from cultural destructiveness to cultural proficiency, and including the following cultural stages: *cultural destructiveness*, *cultural incapacity*, *cultural blindness*, *cultural pre-competence*, *cultural competence*, and *cultural proficiency*, or *advanced cultural competence* (Cross et al. 1989, 13-18).

The Cross model "describes the various stages of competence at the organizational level" and defines cultural competence as "a set of congruent behaviors,

attitudes, and policies that come together in a system, agency, or amongst professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (HRSA 2007, 1).

The Cross definition is fundamentally useful and has already served as the foundation for the development of other definitions as well as the backdrop for many professional inquiries.

The HRSA Bureau of Health Professions (BHPr) defines cultural competence as "The level of knowledge[-]based skills required to provide effective clinical care to patients from a particular ethnic or racial group" (HRSA 2008b, 1). In addition, the HRSA BHPr consolidated a "representation [list] of definitions of cultural competence" (HRSA 2008a, 1).

The HRSA BHPr Nursing Division defines cultural competence as "a set of academic and interpersonal skills that allow an individual to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons [both of] and from the community in developing

targeted interventions, communications, and other supports"

(HRSA 2008a, 1).

Ultimately, the HRSA BHPr states,

No single definition of cultural competence is yet
universally accepted, either in practice or in health
professions education. Most have a common element, which
requires the adjustment or recognition of one's own
culture in order to understand the culture of the
patient. Neither is there consensus about how best to
provide the necessary knowledge, skills, experience, and
attitudes to effectively serve diverse populations. Some
individuals even doubt the legitimacy of teaching
cultural competence at all. (HRSA 2008a, 1)

Despite recent interest in cultural competence,

according to the HRSA BHPr, there is still no one

definition of cultural competence that has been accepted

universally in professional practice or education. Most

have common elements such as understanding one's own

culture in order to understand the culture of others,

appreciation for diversity and cross-cultural

communication. In addition, there are no widely accepted

prescriptions or evidence-based best practices regarding

how to motivate providers to put cultural competency

education, new insights, attitudes and skills, experience,

etc. into practice (HRSA 2008a, 1).

The American Medical Association (AMA), defines

'culture' as "[a]ny group of people who share experiences,

languages, and values that permit them to communicate

knowledge not shared by those outside the culture. Culturally competent physicians are able to provide patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social and psychological issues on the main biomedical ailment" (HRSA 2008a, 1).

In addition, according to the AMA cultural competence includes, "The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences: self-awareness; knowledge of patient's culture; and adaptation of skills" (HRSA 2008a, 1).

According to the HRSA Bureau of Primary Health Care (BPHC),

> Cultural competence is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competence also focuses its attention on population-specific issues including health-related beliefs and cultural values (the socioeconomic perspective), disease prevalence (the epidemiologic), and treatment efficacy (the outcome perspective). (HRSA 2008a, 1)

According to the HRSA BPHC Office of Women and Minority Health,

> Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities. (HRSA 2008a, 1)

In a similar vein in the private sector, Aetna collaborates on a national level with an independent consulting group to provide information and training on cultural competence for physicians and clinicians to increase "knowledge on cultural variations in the context of health and health care" (Hassett 2005, 419).

Culturally and Linguistically Appropriate Standards (CLAS)

The National Center of Cultural Competence adopted the fundamental definition developed by Terry L. Cross and others (1989) and states that "Cultural Competence is a set of congruent behaviors, attitudes, and practices 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" (HRSA 2008a, 1).

The U.S. Department of Health and Human Services, Office of Minority Health developed Culturally and Linguistically Appropriate Standards (CLAS), which "briefly summarizes the process of developing national standards for CLAS in health care (Office of Minority Health 2001a, V).

Table 2 below lists the CLAS according to organizational responsibility.

Table 2: Summary of CLAS	
Number	Standard
1	**Culturally Competent Health Care(Guideline)** Provision of effective, understandable and respectful care
2	**Staff Diversity (Guideline)** Recruitment, retention and promotion of diverse staff and leadership
3	**Staff Education and Training (Guideline)** Ongoing training and education in CLAS delivery
4	**Qualified Language Assistance Services (Mandate)** Free language assistance
5	**Notices to Patients/Consumers of the Right to Language Assistance Services (Mandate)** Promotion of free language assistance
6	**Qualifications for Bilingual and Interpreter Services (Mandate)** Assurance of competent language assistance
7	**Translated Materials (Mandate)** Availability of literacy appropriate materials and signs
8	**Organizational Framework for Cultural Competence (Guideline)** Inclusion of cultural competence in strategic plans, goals, policies, operational plans and monitoring to assure for CLAS
9	**Organizational Self-Assessment (Guideline and Recommendation)** Organization assessment of CLAS-related activities, which include competence-related performance measures in formative and summative evaluation activities (e.g. patient satisfaction surveys, process and outcome program evaluation, quality

Table 2: Summary of CLAS	
	assurance/improvement).
10	**Collection of Data on Individual Patients/Consumers (Guideline)** Collection of client demographic data and update of data in MIS
11	**Collection of Data on Communities (Guideline)** Assessment of community needs to include demographic, epidemiological and cultural data for accurate planning and response
12	**Community Partnerships for CLAS (Guideline)** Participatory and collaborative community partnerships to design and implement CLAS-related activities
13	**Complaint and Grievance Resolution (Guideline)** Establishment of cross-cultural conflict resolution processes
14	**Information for the Public (Recommendation)** Public disclosure of CLAS-related activities to include information on organizational progress, accomplishments, innovations, etc.

(IQ Solutions 2001b, 7-20, 48-111).

Use of Frameworks/Models

According to Sabatier (1999), frameworks provide the foundation for organizing inquiry and showing relationships among variables, but they do not explain or prescribe outcomes. "They attempt to identify the universal elements that any theory relevant to the same kind of phenomena would need to include" (Sabatier 1999, 234).

Additionally, "Frameworks must specify who motivates action, or change. They must do so if they are to provide the basis for theory development" (Sabatier 1999, 234).

Sabatier (1999), citing Ostrom in Chapter 3 of his text, states, "Models make precise assumptions about a limited set of parameters and variables. Analysts use models to fix variables at specific settings and to explore the outcomes produced. Models allow analysts to test specific parts of theories" (Sabatier 1999, 255).

He also states, "Occasionally, models may be developed from frameworks, with little theory development occurring in between. This is the case with the policy innovations framework" (Sabatier 1999, 255).

According to Fernando Barros, Cesar G. Victora, Robert W. Scherpbier, and Davidson Gwatkin, authors of Chapter 4, entitled, *Health and Nutrition of Children: Equity and Social Determinants* (2010), "To properly understand socioeconomic inequities and to design interventions to reduce them, a conceptual model is required" (Blas and Kurup 2010, 51).

Public Administration

Following a much appreciated recommendation of the prospectus defense committee, the researcher became aware of the recent contribution to the arena of cultural competency by Mitchell F. Rice, Ph.D., Professor of

Political Science, Texas A&M University and National

Academy of Public Administration Fellow.

Therefore, in this section, the researcher honors the

quintessential work of Rice, particularly since the work

provides the sought after interim agreement to corroborate

many of the foundational and applicable concepts of public

administration.

A Missing Framework

In his work entitled, *Cultural Competency: A Missing*

Framework for Contemporary Public Administration and Public

Service Delivery (2006), Rice demonstrated the need for

advancement of cultural competency in public administration

due to the growing and diverse U.S. population of

"consumers, customers, clients and communities," to be

recognized as a "core part of the landscape of the U.S."

(Rice 2006, 2).

He statistically reveals that many states, California,

Hawaii, New Mexico, and Texas as well as the District of

Columbia, are comprised of "majority-minority" populations;

that is, non-Whites comprise more than one-half of the

total population (Rice 2006, 2).

Non-Whites comprise over 40% of the total population in

some states such as Arizona, Georgia, Maryland,

Mississippi, and New York. Such demographic estimates substantiate Rice's recommendation to further advance cultural competency (Rice 2006, 2).

Rice, citing the Anne E. Casey Foundation, defines culture as "the structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices of a particular group of people that provides them with a general design for living and patterns for interpreting behavior" (Rice 2006, 4).

Rice expounds, "Culture is the totality of ways that shape how individuals see and respond to the world and community around them" and cultural competence is the ability to effectively apply "new patterns of behavior" in "appropriate settings" (Rice 2006, 4).

Rice declares that "consideration of cultural competency" in the field of public administration (in the U.S.) is undervalued, not clearly understood nor widely accepted (Rice 2006, 3), and citing Adler (1991), is perceived as "invisible, illegitimate and negative" (Rice 2006, 3).

Rice also states that cultural differences and variations do not fit the "neutrality/equality principles" of treating "all clients the same with neutral feelings," (Rice 2006, 3).

Cultural competency is achieved through applying knowledge into practice to transform organizational culture, leading to improved organizational processes and results (Rice 2006, 5-6).

Rice concurs with Tervalon and Garcia (1998), authors of the editorial article entitled, *Cultural Humility Versus Cultural Competence: A Critical Discussion in Defining Physicians Training in Outcomes Education*, on the necessity of "cultural humility," to correct provider-customer power imbalances (Rice 2006, 6).

Rice also states that cultural competency includes two levels or "dimensions" of the target population. The *surface* dimension includes "apparent and superficial" attributes (Rice 2006, 6).

Examples of surface structure activities include matching program "intervention materials and messages" with "observable characteristics of a target population" and "people, places and language familiar to and preferred by the target population" (Rice 2006, 6).

The *deep* structure deals with demographic and more comprehensive social issues of "relevancy" (Rice 2006, 6-7).

From the literature, Rice identifies four components of cultural competency, which are critical to organizational

and systematic *buy-in* and adaptation. They include prospective increases in: 1) understanding of the value of the cultural context of interactions, or "public service encounters" (e.g. within the organizational culture or in the community); 2) opportunities to redress inaccuracies, revise and improve service delivery and outcomes of public programs targeting diverse populations; 3) importance, or "relevance" of services, and consequent utilization, by the target population, and lastly, 4) overall competence for professionals/practitioners due to increased "knowledge, awareness, and skills" (Rice 2006, 7).

Betancourt and others (2005) recommend "standardized and evidenced-based" education and training to promote buy-in (Betancourt et al. 2005, 500).

Reynolds states that improved client satisfaction could induce organizational buy-in (Reynolds 2004, 240).

Rice condones academic cultural competency requirements in public administration through "teaching and practice" (Rice 2006, 7).

Rice also recommends assessment of cultural competency in Public Administration, primarily by conducting agency "self-assessments," which focus on the organizational culture as well as human resource and personnel management processes that ensure "utilization and engagement of

individuals from undervalued and underrepresented groups"
and cultural diversity training (Rice 2006, 9-10).

In the words of Taylor Cox, Jr. author of *Creating the
Multicultural Organization: A Strategy for Capturing the
Power of Diversity* (2001), diversity is "the variation of
social and cultural identities among people existing
together in a defined employment or market setting" (Cox
2001, 3).

Whereas diversity and multiculturalism have their
attributes, they also present many challenges (i.e. lowered
commitment, social distraction, communication barriers,
conflict among workers, "identity harassment," and maybe,
discrimination leading to increased organizational costs)
(Cox 2001, 4-5).

In addition to language barriers, other barriers exist
such as: health care access, discrimination (overt and
covert), "overdependence" on public health programs, the
lack of adequate health insurance, and lack of supportive
services including transportation (Fowler 2004, 43).

Rice developed eight self-assessment questions to
capture the key areas of organizational cultural competence
to include: 1) understanding and respect of cultures by
leaders and personnel; 2) appropriateness of programs and
services to meet unique needs of customers; 3) reflection

of cultural competence in mission and associated documents;
4) Representativeness of organizational leadership and
staff; 5) provision of language assistance; 6)
"collaboration with community groups to provide 'culturally
diverse' services and programs"; 7) processes to minimize
barriers of cultural competence; and 8) "dedicated"
budgeting for promotion of cultural competency (Rice 2006,
10).

In general, the questions are congruent with the
assessment indicators, recommended by Patricia Vinh-Thomas,
Megan M. Bunch and Josefina J. Card (2003), developers of *A
Research-Based Tool for Identifying and Strengthening
Culturally Competent and Evaluation-Ready HIV/AIDS
Prevention Programs*, to include, but not be limited to, the
following indicators (paraphrased): community and customer
assessment of specific socio-economic and obstacles and
barriers; organizational capacity to "tailor" programs to
meet the needs of diverse target populations; intrapersonal
development for practitioners; recruitment of staff and
leadership that reflect racial-ethnic composition of target
populations; and outreach as a "cost of doing business"
(Vinh-Thomas, Bunch and Card 2003, 484)

In June 2009, Rice made a lecture presentation entitled,
Changing Demographics, Diversity, Cultural Competency, and

107

Public Administration in the United States, at the Fudan University, School of International Relations and Public Affairs, in Shanghai, China.

In his 2009 presentation handouts, Rice reiterates developing a "culturally competent public administration and public service delivery system," which includes considerations of culture in order "to meet culturally unique needs" (Rice 2009, 10).

In addition, Rice distinguishes "cultural competence interventions strategies," *clinical*, *organizational* and *structural*, to be used by public agencies, including: knowledge enhancement (clinical); leadership and staffing representativeness (organizational); and service delivery processes (structural), (Rice 2009, 14).

Reaction to Literature Review

The researcher lauds many of the components of the aforementioned definitions as commendable. However, areas of challenge include overemphasis on diversity (as a surrogate for cultural competence) and references of cross-cultural situations and functioning.

The researcher neither overemphasizes nor undervalues multiculturalism, diversity or cross-cultural functions in responding to public health epidemics, but does not condone

promotion of diversity and cross-cultural communication as proxies for cultural proficiency in responding to public health issues, in desperate need of culturally-specific approaches (i.e. HIV/AIDS). Such mega-problems require targeted and culturally specific interventions in addition to universal approaches.

In addition, some literature includes use of the term *cultural sensitivity*, which may be interpreted as a condescending perspective since the connotation of the word 'sensitivity' may imply sympathy from an *ethnocentric point of view*, instead of empathy or authentic understanding and caring as promoted in the Allied Human Services. Because of this, the researcher promotes use of the term *cultural understanding*.

Corroboration with Rice

Rice's model presents many of the complexities that exist in the realm of public administration. To this end, the researcher supports pre-requisite review of Rice's work to advance cultural competence in public administration and beyond.

Aside from basic nomenclature, the researcher is in agreement with most of the content, general concepts,

overall organizational assessment criteria; and that which could be implemented and improved upon.

However, a more fundamental approach may be needed outside of academia, where little progress has been made. For this reason, the researcher has focused attention on the development of a *basic* model, as an introductory device, to be adapted and used to complement what is being done, or not, to slow the spread of HIV/AIDS in Maryland, in consideration of existing issues and challenges, which have been overlooked or neglected.

The researcher expounds upon the established themes, concepts and definitions of cultural competence through the following suppositions, with slight variation in conceptual and connotative contrasts; many included in components of *The Capacity Building Model*.

After all, connotative nuances in language, oftentimes, converge on a thin line between cultural and linguistic competence and cultural offensiveness.

Assessment Questions versus Requirements

Expounding upon Rice's *questions*, the researcher more specifically recommends applying a directive approach, which *requires* compliance with the following propositions.

The researcher proposes that organizations develop and monitor achievement of performance indicators, which are congruent with elements of a comprehensive strategic plan (mission, vision, results frameworks/models, *SMART* goals and objectives, strategies, action steps, etc.) and monitor adherence to the overall plan.

Organizations shall also ensure internal collaboration and external partnering with communities to increase customer satisfaction and *choice* and to ensure that interventions and activities are culturally specific (needed and accepted by the target population).

Socioeconomic and political obstacles and barriers to the delivery of services for customers being served shall be minimized, remedied or removed prior to receipt of governmental funding.

All human resource and personnel functions (recruitment, hire, selection, promotion, incentive-based retention, etc.) shall include considerations for cultural proficiency (i.e. competence in communication, interpersonal interaction, philosophy of helping, representativeness of the ethno-cultural composition of target populations, etc.).

In addition, ethical processes for executive appointments shall also include such provisions to ensure

consideration of candidates who are *bona fide*, culturally-proficient leaders (and not merely generous campaign donors, relatives, neighbors, friends of friends, etc.).

Implementation of a *structured*, cultural proficiency training program shall include employee inducements, tracking of courses, workshops, and other activities for all leaders, key personnel and staff, including and beginning with leadership (top-down).

Budgets shall reflect appropriate line item allocations for structured activities related to cultural proficiency. Funding applications, or proposals, shall be reviewed for appropriate budgetary earmarks. After award, expenditures shall be monitored to ensure appropriate spending.

Organizations must also ensure culturally equitable practices in all recruitment, selection, retention, and promotional practices, and not, under the guise of diversity, simply hire someone who is prototypically identified as a member of any particular group with the expectation that the person will be competent to work within that respective community.

Interview guides shall include assessment criteria of cultural proficiency (e.g. personal attitudes, philosophy of helping, experience in working with populations to be served, knowledge and understanding of cultural beliefs,

traditions, values, regional and local norms of target communities, etc.).

This task may be difficult for *unseasoned* human resource managers. However, because diversity may be superimposed with *tokenism*, whereby agencies hire prototypically representative employees for the sole purpose of saying, "We have one (or two) like that in our agency," public administrators must minimize such insincere pacification of communities and ensure for equitable selection processes in order to acquire the best qualified *and* culturally proficient candidates.

Self-Assessment versus External Assessment

In order to increase objectivity, organizational and practice assessments shall include "self-assessments," conducted by the agencies, and more importantly, assessment, evaluation and/or audits conducted by unaffiliated or *third* parties.

Unless prescribed by sound methods to ensure for genuine honesty, such unreliable processes of "self-assessment," sometimes, lend themselves to arbitrariness, exaggeration and deception.

The Professional/Practitioner

Many professionals and practitioners have already paved the way in the movement toward the delivery of culturally appropriate services, including those providing social work, mental health and health services. They are commended.

However, since practitioners of these professions are, oftentimes, supervised, managed or contracted by public administrators, the advocacy imperative of the researcher is that said administrators, managers and other public administration practitioners shall become more knowledgeable of professional perspective on cultural competence as well as the views of cultures being served.

This shall advance the field of public administration toward a much needed paradigm shift, toward culturally proficient delivery of services and care, especially in areas where all other *traditional* approaches and practices have failed.

The researcher prescribes, in *The Capacity Building Model*, that in order to actualize the definition provided by the HRSA BHPr Nursing Division, practitioners, on the individual level, must conduct continuous self-exploration and enrichment exercises before, during and after academic matriculation in order to define, crystallize and

understand themselves (beliefs, attitudes, values, adopted cognitive social constructs, worldviews, etc.) and their own customary, behavioral practices (leadership efficacy, management styles, supervisory skills, ways of being, etc.) prior to delivering or administering public services as well as throughout their professional careers.

In addition, since value congruence will not always occur across, and even within, cultures, professional and collegial mechanisms should be developed and established within organizations to ensure minimally-accepted accountability standards and best practices among practitioners across systems and professions as well as within organizations and programs.

While there may be some mutually agreed upon attitudes and behaviors, many are not widely accepted on the individual customer level.

There is still insufficient detail in public policies, procedures and practices relating to the assurance of culturally proficient services that are specific to the cultures and experiences of some groups (i.e. the lack of evidence, research studies and HIV clinical trials targeting certain gender and racial groups).

Additionally, the components of *congruence* (listed in the definition provided by the HRSA BPHC Office of Women

and Minority Health) must be adaptive, not only across cultures, but flexible and considerate of groups and individuals within those cultures.

For example, it is imperative that practitioners modify their cross-cutting yet over-generalized responses and practices and adapt themselves and their programs to meet the needs and acceptable norms and values of customer populations to ensure effective service delivery.

Practitioner willingness to adapt would inevitably help to demonstrate organizational cultural proficiency in responding to disparate, social determinants of health.

Academic Requirements versus Field Assignment

The researcher, instead of a core course requirement, advocates for an experiential field work assignment, or practicum, to demonstrate committed work with several socioeconomically diverse populations, that is, if such experience could not be demonstrated in students' work histories (i.e. professional employment, paraprofessional experience and volunteerism).

Social equity theory, critical race theory, multiculturalism, and other social concepts and constructs should be required and included in interdisciplinary, undergraduate studies in sociology in addition to

satisfying general entrance requirements into Public

Administration programs.

In essence, introductory scholarship should be

foundational during undergraduate studies and not remedial,

or cursory, on the graduate or post-graduate levels in

Public Administration, no more than are other introductory

yet necessary curricula (i.e. writing, literature,

mathematics, physical sciences, general psychology, etc.).

According to admission criteria for the University at

Albany, "applications for admission to the M.P.A. program

are reviewed by a department committee. Students are

expected to have at least minimal competence in mathematics

and good writing skills. Incoming students are tested for

competence in these areas, and remedial courses are

strongly encouraged for students without these skills"

(University at Albany, 2011, 1).

Paco Martorell and Isaac McFarlin, Jr., co-authors of a

manuscript and *forthcoming* journal publication entitled,

Help or Hindrance? The Effects of College Remediation on

Academic and Labor Market Outcomes, "College remediation is

an umbrella term that describes services provided by

postsecondary institutions to help academically

underprepared students succeed in college" (Martorell &

McFarlin 2011, 2).

117

Underscoring this definition, academic cornerstones of such *tertiary* education should also be precursory of doctoral level preparedness, particularly for students who have not yet demonstrated pragmatic application of crucial tenets of public administration. Moreover, foundational coursework, that is, introductory studies in research methods, management concepts, seminars, fieldwork, capstone projects, etc., should be completed prior to entrance into doctoral programs in Public Administration and not serve as obstacles of matriculation and conferring of the terminal degree.

In addition, introductory coursework (theory, research methods, management concepts, seminars, fieldwork, etc.) should be completed prior to entrance into doctorate programs and not serve as impediments to matriculation and conferring of terminal degrees. Such academic necessities should be required for doctoral level students who have not completed foundational coursework in Public Administration and have not demonstrated application of crucial tenets of public administration.

In contrast to current standards in Public Administration, it would be unheard of to support entrance into advanced level programs of psychology, social work or the allied human services without having ensured for

118

completion of foundational coursework and field placement in respective disciplines.

Diversity versus Cultural Specificity

The U.S. DHHS Workgroup definition reiterates diversity and presents cultural competence as the goal.

From another perspective, the researcher advocates for cultural proficiency and specificity in ethical and congruent practices and direction of administrative leadership to be operationalized in program management through clearly-defined and measurable performance indicators, which are evidenced: throughout agency operations; within intra-governmental systems, between intergovernmental systems, and within/across professions, in order to move toward the polar right end of the Cross continuum (1989), toward proficiency (advanced cultural competence).

Organizations and staff must also be able to work effectively *in specificity* with cultures according to mutually accepted norms (in consideration of national, statewide, regional, local, and *intra-cultural* similarities and contrasts).

The researcher substitutes the term intra-cultural for the traditionally used term *sub-culture(al).* More simply

defined, an intra-culture is a culture within or inside of another culture.

The researcher refers to neutrality and equality as *generalized* or *universal* service delivery and differentiates it from *culturally specific* service delivery, contextually provided within the cultural values, norms, rules, and constraints of the targeted community, according to mutually accepted practices of communities, and customarily provided by those of the same, or closely similar, value systems.

The researcher frames the concept in this way so as to underscore inclusion and representativeness of target populations in the quest toward cultural proficiency.

For example, as a marketing strategy, the researcher condones universal, or generalized, public service announcements (PSA), which target general audiences, but only in addition to, and not in lieu of, culturally specific PSA. The researcher highlights *cultural specificity* instead of cultural diversity when addressing many of the ignored issues of target populations, particularly on behalf of those communities that have been underserved.

The researcher distinguishes cultural specificity from the altruism of those who genuinely and vehemently stand in

the possibility of human equality regardless of culture; even though this is critical to the humanitarian advancement of all peoples.

Similarly, the researcher supports cultural diversity for the provision of programs that do not target specific groups, that is, for generalized programs to reach the community-at-large.

Culturally diverse approaches may be appropriate for the general population according to national demographics of the U.S. However, as with much of the literature on cultural competence, the researcher questions the appropriateness of a focus on diversity in the historical context of meeting the needs of any community that has been historically disenfranchised.

It is not appropriate to serve a more diverse clientele when, those within a particular group have reportedly been disproportionately impacted, with community requests for redress ignored, or marginalized to the extent where PLWH/A, and those with other chronic and communicable diseases, refuse to access services due to past mistreatment, unfair treatment and/or humiliation.

Cultural Expectations and Health Care Disparities

Focusing on the disproportionate spread of HIV in the State of Maryland, the researcher pondered: In what ways do Black Americans obviously differ culturally from other target populations in regard to health care access, retention in heath care, and return to health care after separation?

Moreover, what is needed to effectively convey health care messages to the Black communities? What are the expectations of Blacks in the delivery of health care?

Has mediocrity in service delivery become a normalized expectation for Blacks? Is the hope for improvement in health care delivery realistic?

The researcher is a proponent of financial consequence for organizational non-compliance and concurs with Reynolds, that organizations that do not adopt cultural approaches will, in the future, "suffer penalties from Medicare and Medicaid," and ultimately, "a strong, proactive approach to increasing cultural competence will prove beneficial" (Reynolds 2004, 240).

These are intrinsic to the provision of services, particularly where Black Americans have reported having to wait longer than non-Blacks, being "passed over" before being served and even being totally ignored.

However, considering the inappropriateness of such unacceptable, prejudicial standards of service delivery, why do they continue?

One would also assume that Black Americans would like to receive favorable and improved customer service, and ideally, be treated with dignity and respect; see other Blacks providing and utilizing the services that they access; and be assisted by other Black persons, who are gainfully employed within the organization; and not just occupying menial positions.

CLAS

Many components of the CLAS are presented, in one form or another, in *The Capacity Building Model*, with a focus on practitioner commitment and involvement and community input, activism and mobilization, resulting in consequential sociopolitical outcomes and higher standards for the delivery of public programs and services.

Connotative nuances have been made to generally accepted yet ambiguous language in order to: 1) clarify meaning, 2) specify issues 3) redirect focus on the facilitating and impeding dynamics, the *push and pull*, necessary to effect organizational and systematic change.

In addition, the researcher recognizes many of the aforementioned CLAS as typical customer service activities

with relative costs of business. Considering this, government-funded organizations must abide by equitable and appropriate requirements in order to be effective and responsive to the communities being served.

Bilingualism versus Linguistic Empowerment

Moon S. Chen defines empowerment as "the right for people to determine their own destinies" (Chen 2000, 141).

He continues to explain how in the U.S., "racial minorities" have experienced a legacy of "legal or deliberate denial of authorization to determine [their own] destinies" (Chen 2000, 142).

Regarding bilingualism, the researcher agrees that reasonable accommodations may be prerequisite to increase communication for populations with Limited English Proficiency (LEP) or *No English Proficiency (NEP)*. This may entail the employment, or contracting, of interpreters and translators of written materials as appropriate.

However, doing so does not screen for intra-cultural dichotomies and illiteracy for person with LEP/NEP. So, in effect, linguistic accommodations shall also account for such cultural and linguistic limitations as well as dialectic and regional differences in language.

Since the model is a capacity building model, the researcher proposes consideration of, as a form of cultural empowerment, encouragement to learn the prominent vernacular and/or pidgins, of any country or region, excepting those persons with physiological and cognitive reasons for not doing so; in order to maximize opportunity.

Continuing to require providers to make *one-way* language accommodations to increase communication in health care increases: customer dependence, semantic filtering and practitioner strain, which may lead to practitioner-customer fatigue.

It also requires a *middle* person to bridge communication between the customer and the practitioner.

In actuality, this may not be an effective or economical way to continue to conduct business in health care.

The researcher suggests conducting a cost comparison assessment, and if feasible, subsequent allocation of resources to empower LEP/NEP customers in Maryland to become linguistically competent or proficient, decrease reliance upon interpreter/translator services, increase direct, two-way practitioner-customer communication, and consequently, become empowered to increase academic and employment opportunities.

Method

Reaction to Literature Review: Toward a Fundamental Local Model

The Cross definition (1989) leads the researcher, as public administrator, to ponder the following questions.

What are the presenting biases and shortcomings of the systems, organizations, professions, providers, or individuals that/who determine what is cultural and what is competent?

What is effectiveness? Who decides what is effective? How is effectiveness operationalized? What proxy variables are used in measuring effectiveness and cultural competence?

Why does the literature insinuate that serving a diverse, or cross-cultural, segment of the population is preferred rather than being able to provide services according to specific attitudes, norms, traditions, and values of smaller and historically underserved fractions of the general population, such as the Black Community, with needs that have not been met over the past ten years, leading to the disproportionate spread of HIV in what has been referred to by bureaucrats and legislators as the "Great State of Maryland," a declaration that has given

126

legitimacy to the continual yet inadequate response to the spread of the HIV and other communicable diseases in this state.

The researcher cites and builds upon the far right of the Cross continuum throughout the development of the capacity building model and supports Cross' fundamental approach of providing effective delivery of culturally appropriate health programs, in this case, the realm of HIV prevention and treatment in order to redress the devastating spread of HIV in Baltimore, Maryland.

In order to lead organizations and systems toward accountable, effective, efficient, responsive, and optimal quality public administration, especially in health care, public administrators and practitioners must strive to achieve proficiency and not applaud achievement of minimal requirements and expectations of what has been rhetorically labeled *competence*.

This conclusion was made after examining performance indicators of cultural competence, which do not demonstrate competence in measuring or tracking performance, let alone capturing the necessities of measuring practitioner knowledge, skill and ability to provide services for unfamiliar cultures.

This is not to be overly critical of the Cross monograph, which is an excellent document as a point of departure. However, written over 20 years ago, the time is nigh for some follow-up exhortation for professional development in the field to raise the bar and strive toward excellence and not signify a higher range as achievement of competence.

Are scholars, practitioners and customers alike settling for less at a critical time when *the bar of excellence* should be raised?

Phase I: Aiming for Cultural Proficiency

This work discusses the development and evolution of *The Capacity Building Model* and substantive knowledge claims based on constructivist and advocacy/participatory perspectives, using informal ethnography (including auto-ethnography) and case study strategies of inquiry.

The researcher implemented several methodologies presented by the Global Development Research Center's (GDRC) "A Menu of Methods" for PAR, which describes the use of: casual, representative, community, and structured groups; "local people as experts;" mapping and modeling, chronological timelines; relational diagrams; matrices; and "shared presentations and analyses" (GDRC 2010, 1-2).

Phases of "authentic participation" as illustrated in the "Lewinian action/reflection spiral" of "*planning*, *acting* (implementing plans), *observing* (systematically), *reflecting* and then re-planning" (McTaggart 1989, 2) and the "three main steps" of the change process: "formulation of aims, development of new practices and diffusion of results" (Whyte 1991, 151) are included in the timeline.

The preliminary *project* component of this work (Phase I) primarily focused on the first step, formulation of aims, including innovation of thought, means to attract attention to the challenges and need for change, as well as development of a preliminary model, with the intent to shift the gauge of cultural competency toward the far right polarity in an effort to raise standards of excellence.

The model, with accompanying case study scenarios, is presented in this paper to incite continued discussion and development of new and ethical practices in the field of public administration (Step 2). Those interested in participating, that is, being an active member, in this paradigm shift were called upon to participate in further research, and later, to diffuse results (Step 3).

Many factors have contributed to the malaise and complacency in addressing the aforementioned sociopolitical issues introduced in the literature review. Nevertheless,

in spite of such challenges, Phase I of the project introduced the preliminary model and remedies used by a collaborative advocacy network to ensure public steward accountability in appropriately responding to the devastating spread of the HIV in the State of Maryland.

The preliminary model itself was based upon ethnography and auto-ethnography, wherein experiences of subject matter experts who have worked in the field of HIV/AIDS for over 17 years and long-term survivors, living with HIV/AIDS for over 15 years, were incorporated through the sharing of knowledge and anecdotal information in order to provide historical perspectives and make recommendations on the need to address the problems identified over the course of this project.

A methodological timeline is presented to guide discussion and delineate phases, or *arms*, of this work in action.

Table 3: Phase I Methodological Timeline

Integration of Theory and Practice through Participatory Action Research (PAR)

Planning & Formulation of Aims (Step 1): Community Involvement, Collaboration and Partnership (2004-2005)

- Informal participative group discussions
- Preliminary literature search on HIV/AIDS (emerging populations and epidemiological trends and health disparities)
- Semi-structured, in-depth group discussions on epidemiological data and demographic HIV/AIDS health disparities
- Preliminary literature review conducted on cultural competence
- Preliminary models developed on advanced cultural competence (*cultural proficiency*) to address community needs

Acting, Observing & Development of New Practices (Step 2): Community Mobilization/Sociopolitical Strategy (2005-2006)

- Collaboration to provide *pro bono* ombudsman services for PLWH/A
- Formation of the Black AIDS <u>Advocacy</u> Movement (BAAM)
- Sharing of information with the public and media via the *BlackCAB* newsletter
- Increased presence at community events and training events
- Renaming of the BAAM to the Black AIDS <u>Action</u> Movement (BAAM!!!!!!!)
- Issue formulation, sociopolitical activism and lobbying in Maryland
- Education and support of Legislative Black Caucus of Maryland (LBCM)

Reflecting & Diffusion of Results (Step 3): Revision of Model, Additional Research and Community Solidarity (2006-2007)

- Updating of epidemiological data
- Development of capacity building and community mobilization logic models
- BAAM recommendation to introduce the model at the National HIV Prevention Conference in November 2007
- Structured roundtable discussions and national promotion of the model and networking in Atlanta

Likewise, committee members were selected based upon their combined knowledge and experience in public administration, research methods, diversity, social work, HIV/AIDS health education, and organizational capacity building.

Additional academics and practitioners were consulted in order to provide input on program monitoring and evaluation, clinical health outcomes, HIV surveillance as well as recent implementation of state and local programs/projects.

The researcher cites literature from the media, health policy and legislature to illustrate the sociopolitical landscape in Maryland, which ultimately, underscored the need to develop a culturally proficient approach to slow the progression of HIV/AIDS in Maryland.

Review of archival and HIV/AIDS data reports provided epidemiological snapshots, changes and trends in the spread of HIV/AIDS in Maryland as compared to the nation as a whole.

The preliminary literature review, which began in 2004, did not reveal much, in general, regarding cultural competence, particularly not much regarding cultural competence in public administration. This revelation piqued the interest of the researcher in developing a preliminary

framework and model (with practical tools) to advance consideration of culture in the public administration of HIV/AIDS programs (HIV/AIDS prevention and health services).

However, over the past several years, additional information has surfaced and now there are many ambiguous and incongruent definitions of cultural competency, each promulgated by different professions and fields. Despite the ambiguity, the term has been promoted by federal agencies and professional organizations.

Therefore, the definitions and concepts of *cultural competence* shall be further explored and expounded upon due to specific ambiguities, complexities and inconsistencies in the understanding of the concept in the delivery of HIV prevention and treatment programs.

In addition, a culturally-specific and culturally proficient approach to addressing the spread of the HIV in Maryland (with a focus on Baltimore City) was recommended by the action movement based upon fundamental knowledge claims, historical observances and experiences as well as review of literature and data on HIV/AIDS.

Moreover, input/feedback obtained from community discussions and meetings shall be presented in discussion narrative and case study scenarios to incite exploration in

133

the classroom and workplace and ethical decision-making in public administration practice.

Knowledge Claims

The first knowledge claim, the constructivist perspective, describes and provides meaning for: the individual views of the meeting participants, the case study scenario *vignettes* presented in this paper, and the collective voice of the "action movement" that was formed to address the lack of a strategic and culturally appropriate response to address the spread of HIV/AIDS in Maryland.

According to John W. Creswell (2003), author of *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*:

> Researchers recognize that their own background shapes
> their interpretation, and they "position themselves" in
> the research to acknowledge how their interpretation
> flows from their own personal, cultural and historical
> experiences. The researcher's intent, then, is to make
> sense of (or interpret) the meanings others have about
> the world. Rather than starting with a theory (as in
> postpos[i]tivism), inquirers generate or inductively
> develop a theory or pattern of meaning. (Creswell 2003,
> 8-9)

In short, this work serves to make sense of what is currently happening in Maryland, to "construct a picture," based on historical and social perspectives (of participants and observers), and to generate meaning based

on interaction with "a human community" or, in this project, through a collaborative and inductive process (Creswell 2003, 9-10).

These formative explanations are presented with attribution to the collaboration and perspectives of others, the advocates and members of the action movement, those with the overt and covert courage to incite change.

This leads to the second knowledge claim, the advocacy/participatory perspective, which served the purpose of "advocating for an action agenda to help marginalized peoples" since further "inquiry needs to be intertwined with politics and a political agenda," which ultimately leads to the collective "voice" of the participants becoming "a united voice for reform and change" (Creswell 2003, 9-10).

In this project, the marginalized people are members of the diverse, Black Community, various *intra-cultural* groups with the highest incidence and prevalence of HIV/AIDS in Maryland, Baltimore City in particular, who remain either *unserved* or *underserved* due to several reasons to be discussed in depth throughout the paper. The researcher coined *the bureaucratic culture of indifference and presumptuousness*, which describes culturally destructive practices such as discontinuance of outreach and promotion

135

of HIV health services despite the rampant and disproportionate spread of HIV disease.

And since many of said groups may be considered by some public stewards in Maryland to have little, or no, political valence, "[t]his advocacy may mean providing a voice for [the] participants, raising their consciousness, or advancing an agenda for change to improve the lives of the participants" (Creswell 2003, 10).

According to Creswell, "Stating a *knowledge claim* means that researchers start a project with certain assumptions about how they will learn and what they will learn during their inquiry. These claims might be called paradigms; philosophical assumptions, epistemology, and ontologies; or broadly conceived research methodologies (Creswell 2003, 6).

In this effect, throughout the work, the researcher makes theoretical assumptions and claims to be evidenced, or not; to be supported or challenged, and continues to advocate *for something else to be done* instead of maintaining the *status quo* through *quid pro quo* politics. Because of the marginally responsive state of affairs in Maryland, the researcher supports a paradigm shift in public administration practice toward a cultural *proficiency* approach to ensuring the delivery of

accountable, effective, efficient, responsive, and quality
HIV prevention programs and treatment services.

The researcher serendipitously adopted a Participatory
Action Research methodology due to its change-readiness,
collaborative, emancipating, empowering, and sociopolitical
orientations as well as personal *way of being* when facing
adversity or unrelenting injustice.

Another posture assumed is grounded in pragmatism.
Creswell cites Cherryholmes (1992) as defending this
theoretical point of view that pragmatists would rather
"stop asking questions about reality…" that pragmatists
"would simply like to change the subject" (Creswell 2003,
12) and do something rather than asking questions and
conducting hypothesis testing.

This statement serves as an exhortation to take action
to resolve issues instead of simply thinking about them and
continually testing null hypotheses. It is a call to action
and not an excuse to avoid overwhelming problems, such as
the spread of HIV disease, while diverting attention to
traditional scholarly conjecture or political *babble*.

For many forms of pragmatism, "[K]nowledge claims arise
out of actions, situations, and consequences rather than
antecedent conditions (as in postpositivism)" (Creswell
2003, 11).

The problem itself, holistic resolution and successful

applications become paramount instead of focusing on

methods. Therefore, researchers approach problem-solving

holistically and pluralistically to obtain additional

insight (Creswell 2003, 11-12).

During the earlier years of this work, as a *work in*

practice, the researcher inadvertently forged ahead with

this position due to the considerations presented by

Creswell: consequence of actions, problem-centeredness,

pluralism, and real-world practice orientation (Creswell

2003, 11-12). The outcome was the need for a conceptual

framework to present to the *naysayers*, who purported to

have no clue that things were not *right*.

Responding to such complacency, the researcher, in

collaboration of the action movement, strategized to

develop a tangible representation for academics,

legislators and stewards of public funds, to appeal to the

innermost humanness of those who remain oblivious to the

social and medical issues of those living with HIV disease

as well as the socioeconomic and political implications of

doing business as usual.

Yet hope remains that things will take a turn for the

better, as in culturally competent care (CCC), that

champions will surface in "commitment, vigilance,

diligence, and perseverance, elements without which no strategy, including CCC, can ever be achieved" (Matus 2004, 260).

The Black AIDS Action Movement!!!!!!

Many of the aforementioned issues and reasons underscore the formation of advocacy groups and social action movements such as The Black AIDS Action Movement!!!!!!

One premise of the movement was, despite the perpetual challenge of confronting obstructionism and passive opposition, to ensure that similar concessions were made to redress the needs of the Black Community as were formerly made for non-Black groups.

A second reason for the formation of the movement was the need to include communities "outside-the-academy" to collaborate with "in order to be more effective researchers on behalf of people who can make use of our skills and abilities" (Denzin, Lincoln and Smith 2008, 61).

In other words,

> We must learn to be at home on the street corners, barrios, churches, mosques, kitchen, porches, and stoops of people and communities so that our work more accurately reflects their concerns and interests. Our challenges is to renounce our paternalistic tendencies and sympathetic leanings to move toward an empathetic, ethical, moral scholarship that propels us to a place where we are prepared to force-fully and courageously answer "the call."
> (Denzin, Lincoln and Smith 2008, 80)

While serving as collaborators of this project, the BAAM!!!!!!! answered the "call" on health care and racial disparities in Maryland by submitting an abstract to be presented at the CDC sponsored at the *2007 National HIV Prevention Conference*, entitled *Promoting Synergy between Science and Programs*, on December 2-5, 2007, in Atlanta Georgia.

The abstract, entitled, *Restoration Maryland: A Community Mobilization Approach to Ensuring the Delivery of Culturally Proficient HIV Prevention and Treatment Programs*, was selected as a Roundtable Discussion for national advocates/activists to network, share experiences and community mobilization strategies to effect change on HIV/AIDS issues and policies related to disparities in HIV priorities and service delivery.

During the conference, in collaboration with members of the BAAM!!!!!!!, the researcher preliminarily introduced components of *The Capacity Building Model*.(See conference program, Figures 1.1 and 1.2 on pages 141-142).
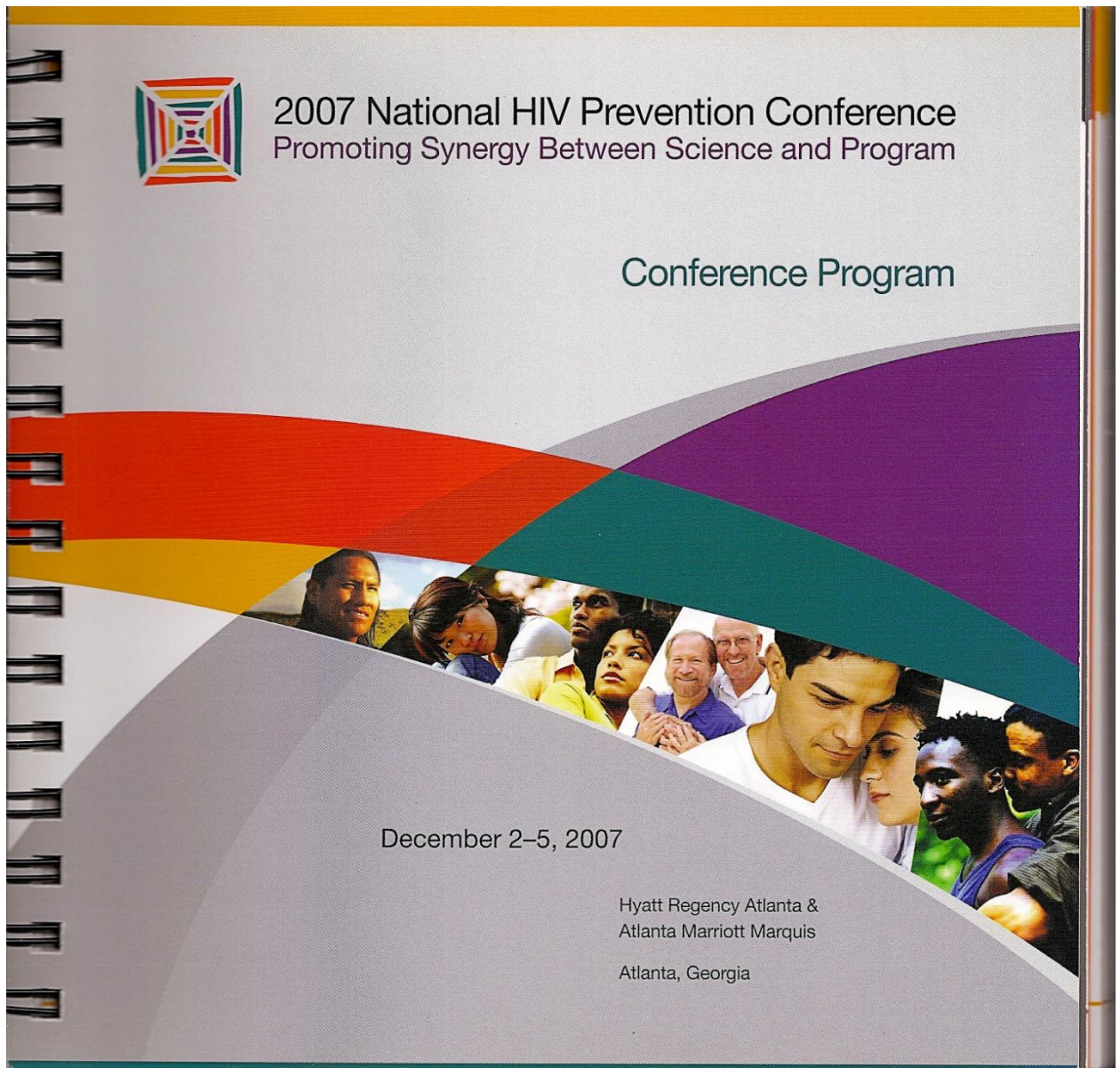
Figure 1.1: 2007 National HIV Prevention Conference Program

Roundtables | 5:30 PM - 6:15 PM (Continued)

Track E

ER04 – Restoration Maryland: A Community Mobilization Approach to Ensuring the Delivery of Culturally Proficient HIV Prevention and Treatment Programs

Room Location: A706 – (Marriott Hotel – Atrium level)

Presentation Number: ER04 – 1

Presentation Title: Restoration Maryland: A Community Mobilization Approach to Ensuring the Delivery of Culturally Proficient HIV Prevention and Treatment Programs

Author(s): Black AIDS Action Movement (BAAM!!!!!!! *Ivan P. Eaton, Master of Public Administration*
VanEaton Consultants, Baltimore, MD.

Presentation Number: ER04 – 2

Presentation Title: Stand Up - Speak Out!; Using Advocacy as a Tool for Change

Author(s): *Campbell, CM; Bryant, L*
Housing Works, Inc., Washington, DC

Track G

GR02 – Successful Strategies for Integrating HIV and Viral Hepatitis Prevention Programs

Room Location: HANOVER E – (Hyatt Hotel – Exhibit level)

Presentation Number: GR02

Presentation Title: Successful Strategies for Integrating HIV and Viral Hepatitis Prevention Programs

Author(s): *Taylor, C* - Chris Taylor, BA, National Alliance of State and Territorial AIDS Directors, Washington, DC.

Track G

GR04 – Integration of Prevention and Care: Future Directions

Room Location: A701 – (Marriott Hotel – Atrium level)

Presentation Number: GR04

Presentation Title: Integration of Prevention and Care: Future Directions

Author(s): *Foust, E;* North Carolina Department of Health

Figure 1.2: 2007 National HIV Prevention Conference Program

Preliminary Outcomes

After consideration of the many foundational definitions, the researcher built upon them to create the following working definition to be used by public administrators since many public administrators manage and work for, and laterally with, colleagues of different professions.

> *Cultural Proficiency* is the achievement of demonstrated adeptness in *Cultural Competence*, which has been historically defined by Terry L. Cross and others (1989) as "a set of congruent behaviors, attitudes, and practices that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural" [and intra-cultural] "situations" and "functioning." In addition, cultural proficiency in public administration involves practitioner, professional, organizational, and systematic accountability and performance measurement to ensure ethical, collaborative and participative planning, development, implementation, evaluation, and appropriate revision of policies, practices and programs that are effective, efficient, of optimal quality, responsive, non-discriminatory, and universal and/or specific to the cultures of the customers for which services are being provided.

This definition recognizes cross-cultural situations, but also includes the modifiers, intra-cultural, to emphasize the importance of addressing situations within cultures that are diverse in and of themselves. It also includes the tenets of public administration to ensure non-

discriminatory delivery of public services, provided in consideration of the specific cultural needs of customers.

Cultural Competence should not apply only across cultures as a generic, one-size-fits-all practice, but should apply within cultures as well since socially-constructed definitions of culture are not monolithic (such as categories defined by the U.S. Census Bureau).

In essence, it is not sufficient to overemphasize diversity without underscoring appreciation of similarities, differences, norms, mores, and other components within groups that are not customarily-defined as diverse, particularly when delivering public service and advocating for reform of public policy and practice in organizations and systems. In essence, many intra-cultural factors must also be acknowledged and affirmed.

The Capacity Building Model

Gery W. Ryan and Russell Bernard, authors of the Chapter 29, entitled *Data Management and Analysis Methods*, state that researchers may develop mental maps, which convey intangible social constructs and dimensions (Denzin and Lincoln 2000, 772).

For these reasons, development of *The Capacity Building Model* shall be presented in the form of a mental map

(Denzin and Lincoln 2000, 775), complete with visual constructs and tools to facilitate practitioner decision-making and implementation of effective programs and a list of activities to open dialog for further research and hypothesis testing in the realm of cultural proficiency in public administration.

David Jewitt, astronomer, University of California, states "We're visual animals and nothing seems wholly real to us until we have a nice picture of it" (Chang 2010, 2).

Another intent of the model is to provide visual diagrams to incite scholarly interest and increase practitioner and public awareness on the prospect of using a community-directed, regionally defined, and contextual-based, capacity building model to guide comprehensive and culturally-proficient planning efforts to strategically respond to the disparate HIV/AIDS epidemic in the Black Community in Maryland.

For example, on the following page, six integrative loci of control are illustrated as systemic domains, spheres, or *holons*, "from the Greek *holos* = whole, with the suffix *on* which, as in prot*on* or neut*ron*, suggests a particle or part" (Koestler 1967, 48).
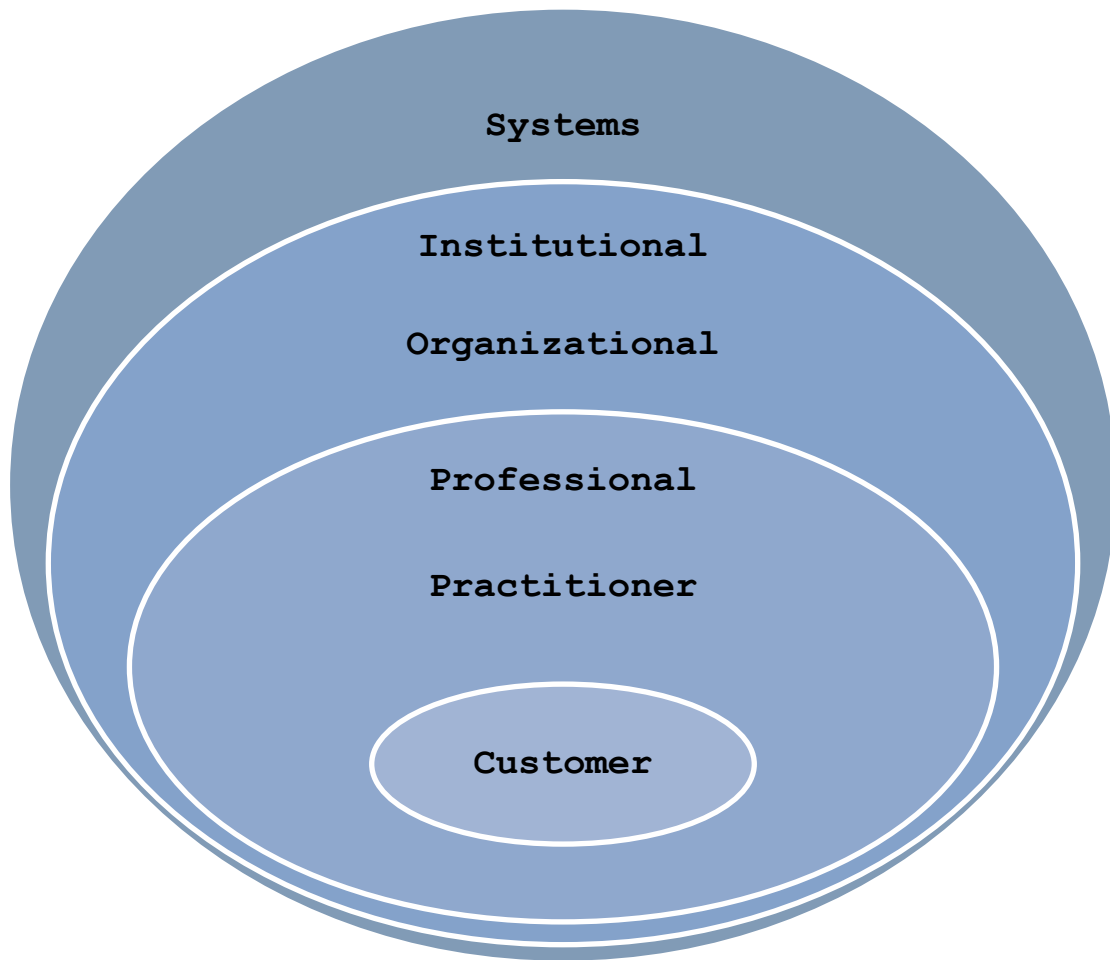
Figure 2: Holons/Spheres

Since approaches to cultural competence vary depending on several variables, one of which being the "sphere of influence," (Betancourt et al. 2005, 499), the researcher re-conceptualizes this concept to pertain to the viewpoint of any of the integral roles held by a person within a sphere of a system. In this respect, roles (and the respective holons) may be primary, secondary or tertiary, or other rank, depending upon the perspective or view.

Overlap of roles is likely. For example, a scenario may require that a practitioner operate within the holons of practice, profession, organization, and larger systems. In another role or holon, a practitioner may address personal concerns as a customer while maintaining professional codes of ethics within several social institutions and systems.

The *Systems Holon/Sphere* includes philosophies, activities, association implications, information, and the like, related to the *network* of socio-political institutions (i.e., religious, political, bureaucratic, non-governmental, economic, philanthropic, health care, educational, intellectual, community, cultural, domestic to include family and extended family), professional arena, academic school of thought, field of study (i.e. HIV/AIDS), external sociopolitical and socioeconomic environments, etc.

It emphasizes the interconnected dynamics of organizations within and across systems. It consists of the dynamics between executive, legislative and judicial bureaucracies, health care systems, sociopolitical and special interest *machines*, and other independent and interdependent *holons* that contribute to the complexities of addressing the spread of the HIV.

The *Institutional Holon/Sphere* includes philosophies, activities, association implications, information, and the like, related to actual institutions (i.e., religious and faith-based; bureaucracies, executive, legislative and judiciary branches of government; political/lobbying and special interest groups; non-governmental and quasi-governmental organizations; corporations, trade unions and businesses; philanthropic, non-profit organizations, community service organizations, and charities; health care, public health and medical organizations; universities, colleges and schools; unaffiliated communities; families/households and extended families; and racial/ethnic/cultural groups; and the media).

The *Organizational Holon/Sphere* includes philosophies, activities, association implications, information, and the like, related to the agency as well as issues related to (the) governance; ethical/legal sufficiency; organizational leadership, administration and management; strategic direction and planning; human resource management and personnel practices; organizational culture; infrastructure, location and facilities; agency sustainability and stability of funding; fiscal and accounting soundness; service delivery and programmatic development, implementation, performance, evaluation, and

148

revision; collaborative efforts; and other issues related to the internal and external business environments.

Structural, organizational and leadership attributes discussed by Rice are included in this holon.

The *Professional Holon/Sphere* includes philosophies, activities, association implications, regulation, information, and the like, related to the expertise, proficiency/competence, accreditation, licensure and certification, qualifications, required academic matriculation, continued development and education, skills building and training of the practitioner.

The *Practitioner Holon/Sphere* includes philosophies, activities, association implications, information, and the like, related to the actual practice and application of knowledge, skills and abilities (KSA) of the practitioner, provider or clinician. KSA may be acquired through academic matriculation, fieldwork, internship, fellowship, employment, civic responsibility, community service, and volunteerism in the private and non-profit sectors.

Practitioner activities will vary according to human resource classification and job responsibilities. This sphere may include activities of professional medical and specialty services providers and clinicians, mental health

therapist and counselors as well as paraprofessionals of the allied human services.

The *Customer Holon/Sphere* includes philosophies, activities, association implications, information, and the like, related to the comprehensive worldview, cultural perceptions, identity, and medical/physiological, mental (and spiritual as appropriate) and socioeconomic needs and reality of the customer. It is on this level that customer service and practitioner empathy is underscored since the researcher highlights the client as vital to, and in most case, *the* reason why practitioners are employed and remain committed to serve. This is why an inclusive and participative action research approach of community partnership was conducted to gauge the input, issues, concerns, and needs of those who receive services, those who provide services and those who refuse to access services. (Many of the reasons why persons refuse to access HIV health services shall be expounded upon in the discussion section).

The National HIV/AIDS Strategy for the United States promulgates establishment of pilot programs that utilize community models in order to reduce disparities between various groups affected by the epidemic (Office of the President 2010, 35).

In addition, "testing community-level approaches is needed to identify effective interventions that reduce the risk of infection in high prevalence communities" (Office of the President 2010, 35).

Such a pilot demonstration of the model is anticipated to occur after community-based organizations become familiar with, adopt and use the model.

The *Logic Model Framework for Community Mobilization* (starting on page 153) presents advocacy strategies for change.

Visual diagrams of the model (Figures 3.1-3.3 on pages 155-157) depict the *Competing Forces (Positive and Negative) of Cultural Proficiency*.

Some of the foundational theory was derived from the disciplines of sociology as well as social work and allied human services. This is also congruent with public administration theory development.

For example, according to Richard J. Stillman, III (1999) author of *Preface to Public Administration: A Search for Themes and Direction*, "Sociologists were equally influential in enriching postwar public administration literature in many areas. In its broadest sense, sociology concerns all the general problems of human existence: the causes and effects of social change, as well as the

narrower concerns of class, power, status, roles, caste, occupations, and community" (Stillman 1999, 133).

Concurrently with the development of the model, a goal of the movement was to incite continued dialogue to inspire personal, organizational and systematic change across academic disciplines and to provide a sociopolitical platform to support such a direction, or paradigm shift, in public administration in accordance with the following statement by William Foote Whyte, editor of *Participatory Action Research* (1991).

In an attempt to be less ambiguous, *Table 5* starting on page 158) distinguishes some of the many components of cultural proficiency from that which cultural competence clearly "*is not*," with modified language that is more specific to the ethno-racial and socioeconomic needs and issues of the Black Community in Maryland.

Table 4.1: Logic Model Framework: Value-Laden Community Mobilization

ACTIVITY	INPUTS	OUTPUTS	OUTCOMES	IMPACT
Community Mobilization	• Integrity • Reputation • Personal Sacrifice • Time • Energy • Resources	• Leadership • Increased Activism • Community Alliances • Community and Professional Networks • Socio-Political Recognition of Group/Community • Immediate Change in Bureau Leadership	• Change in Public Policies • Change in Bureau Practices • Recognized Stakeholder Status	• Increase in Influence • Decrease in Community Apathy, Complacency and Resignation • Community Empowerment to Confront Sociopolitical Ills
Information Sharing and Communication	• Integrity • Time • Energy • Resources • Informal and Formal Research and Investigations	• Widespread Knowledge of Issues • Increase in Public Knowledge • Increase in Public Support • Increase in Public Denial in Issues	• Informed Community • Increased Community Interest • Increased Public Support • Increased Alliances	• Actively Informed Constituency • Increased Desire to Advocate for Change • Increased Desire to Participate in Political Processes

Table 4.2: Logic Model Framework: Value-Laden Community Mobilization

ACTIVITY	INPUTS	OUTPUTS	OUTCOMES	IMPACT
Political Involvement	• Integrity • Time • Energy • Resources • Technical Information • Volunteerism • Humility	• Increased Political Alliances • Participation and Influence in Political Processes • Recognition of Community Leadership • Community Knowledge of Political Alliances • Immediate Changes in Bureau Leadership	• Continued Participation and Influence in Political Processes • Continued Systemic Influence • Clarity of Political Position on Issues • Short-Term Political Support • Increased Political Valence	• Sustained Participation and Influence Political Processes • Evolved Policy Formulation and Issue Framing • Responsiveness to Issues • Long-Term Political Support • Sustained Political Valence
Complaints and Litigation	• Integrity • Time • Energy • Resources • Detachment to Risks, Outcomes and Expectations	• Increased Knowledge of Legislation • Familiarity with Legal System • Changed Reputation • Increased Respect	• Bureaucratic Accountability • Public Challenge of Bureaucratic System • Executive and Legislative Accountability	• Continued Utilization of Legal System as a Mechanism for Accountability, Vindication and Retribution

Spirituality

Individual & Family Values

Spirituality, Morality & Ethics
Health (Physical, Mental & Emotional)
Financial Security (Income & Finance)
Intellectual Expression & Education
Recreation & Relaxation

Community Values

Relationships, Affirmation & Unity
Access to Health Care
Employment & Economic Opportunities
Creative & Educational Opportunities
Environmental Aesthetics & Safety

Spiritual Complacency
Moral Regression
Ethical Resignation
Community Acceptance of:
  * Media Misrepresentation
  * Disparaging Images
  * Stereotypes
Social (Judicial) Injustice
Targeted Marginalization
Political Placation
Political Discord
Institutional Racism
Blocked Opportunity
Bureaucratic Indifference
Bureaucratic Red Tape
Health Disparities
Environmental Decay

Figure 3.1: Competing Forces (Positive and Negative) of Cultural Proficiency

Affirmation

Relationships

Unity

Spirituality

Intellectual Expression & Education

Recreation & Relaxation

Access to Health Care

Health

Creative & Educational Opportunities

$$$

Safety

Financial Security (Income & Finance)

Employment & Economic Opportunities

Environmental Aesthetics
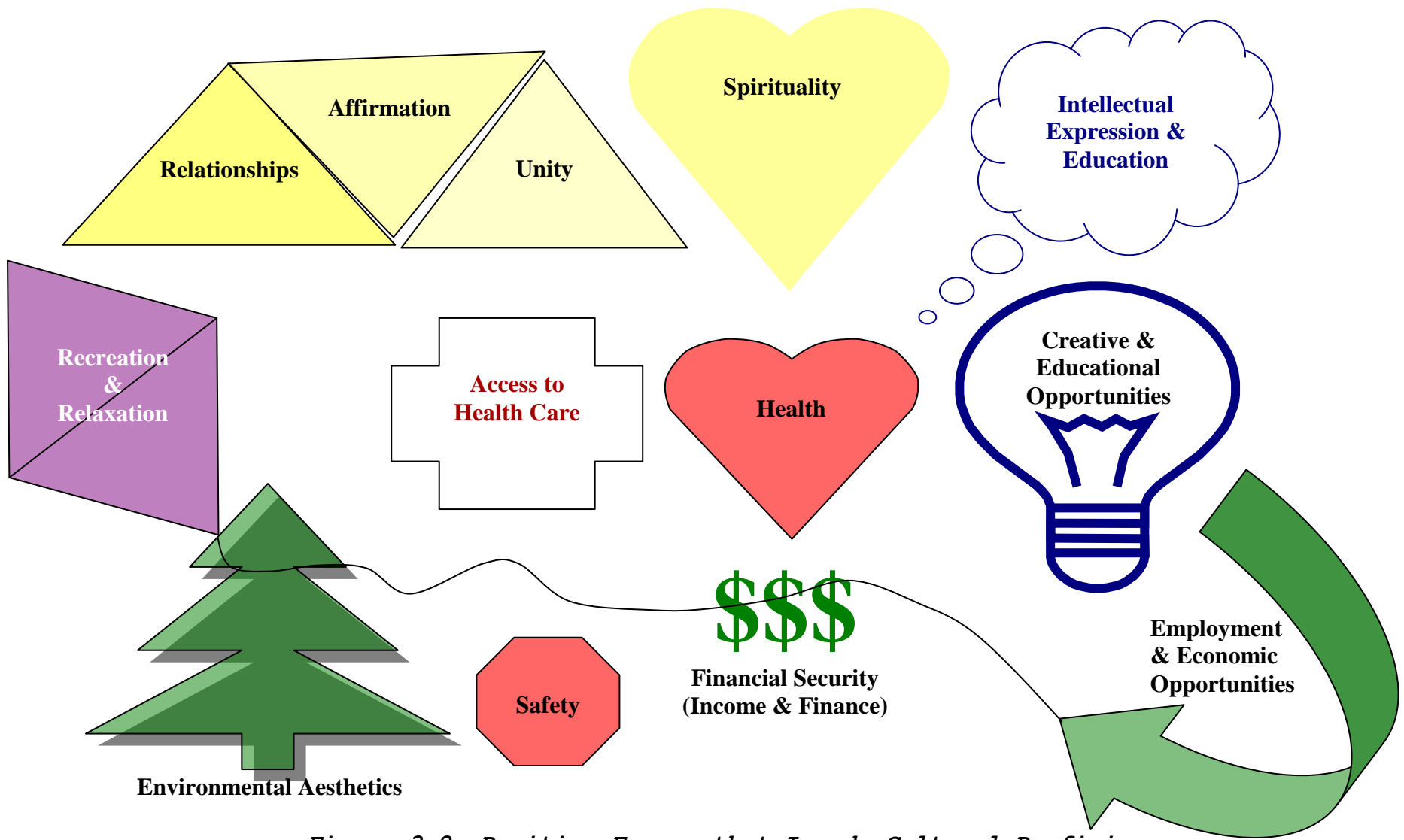
Figure 3.2: Positive Forces that Impede Cultural Proficiency

Misrepresentation
in the Media

Disparaging
Images

Stereotypes

Judicial
Injustice

Moral
Regression

Ethical
Resignation

Judiciary
(Courts)

Blocked
Opportunity

Unsafe
Communities

Targeted
Marginalization

Health
Disparities

Institutional
Racism in
Branches of
Government

Political
Placation

Political
Discord

Unhealthy
Living Conditions &
Environment

Executive
(Bureaucracy)

Bureaucratic
Indifference

Legislature
(Politics)

Figure 3.3: Negative Forces of Cultural Proficiency

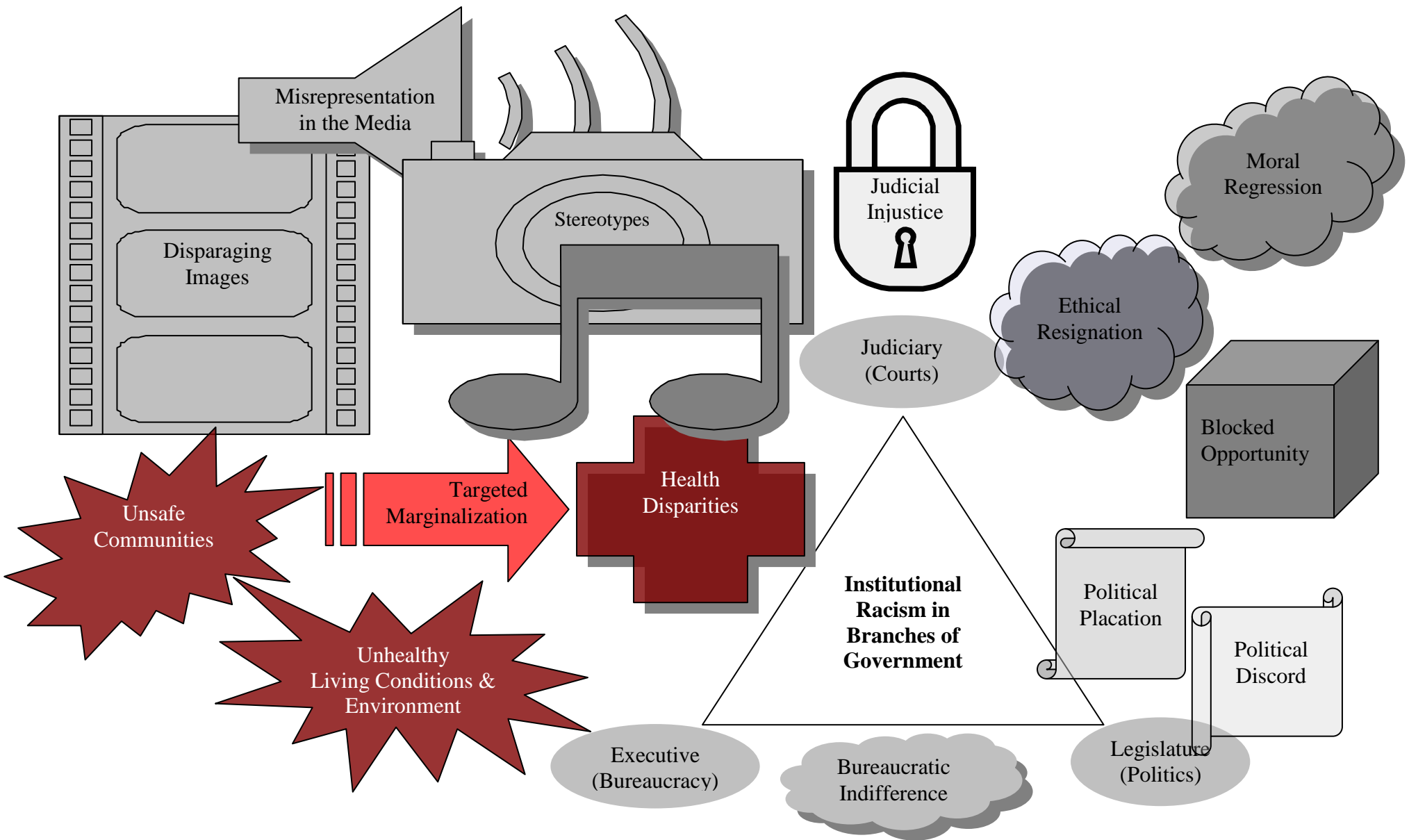| Table 5: Comparison Table, Definition of Cultural Proficiency: What It Includes and What It Is Not	
CULTURAL PROFICIENCY INCLUDES	**CULTURAL PROFICIENCY <u>IS NOT</u>**
Organizational Culture	
Cultural Proficiency Defined by the Community	*Cultural Appropriateness* Defined by the Organization
Congruence with Community Mission/Goals/Objectives	Organizational Incongruence with Community Mission/Goals/Objectives
Respect and Realization that Customers May Know their Needs and Desires	Assumption that Stewards of Public Funds Know Best and that Consumers May Not Know their Needs and Desires
Negotiable Offers made to the Community being Served	Coercion or Guidance of the Community
Organizational Transparency and Honesty	Organizational Opaqueness/Translucency and Deception
Factual Sharing of Information by Stewards of Public Funds and their Sub-Grantees	Sensational Sharing of Information by Stewards of Public Funds and their Sub-Grantees
Cultural Diplomacy in *Intra-Cultural* and Cross-Cultural Interaction	Cultural *Sensitivity* or *Tolerance* in Cross-Cultural Interaction
Appreciation of Cultural Diversity and *Cultural Specificity*	Over-Emphasis on Cultural Diversity and *Cultural Tokenism*
Cultural Affirmation and Respect of Cultural Values, Traditions and Norms	Cultural Imposition and Prescriptions
Linguistic Empowerment	Linguistic Placation
Organizational Adaptability to Make Appropriate Accommodations for Persons with Disabilities	Organizational *Pre*-Preparedness to Make Accommodations for Persons with Disabilities (*Just in Case….*)
Non-Discriminatory Practices	Discrimination in Practice based upon Perceptions of (Race, Ethnicity, Religion, Gender, Sexual Orientation, Disability, etc.)
Understanding of Human Sexuality as an "Ongoing Dynamic Process" (Klein 1993)	Promotion of Attitudes of *Hetero* and *Homosexism*
Program Planning, Design and Implementation	
Participative Community and Stakeholder Planning	Exclusive Stakeholder Planning
Focus on the Needs/Requests of *Customers/Consumers*	Focus on the Needs/Requests of *Political Stakeholders*
Active Involvement of *Unaligned* Customers in Governance	Prejudicial Selection of Consumers in Governance

Table 5: Comparison Table, Definition of Cultural Proficiency: What It Includes and What It Is Not	
CULTURAL PROFICIENCY INCLUDES	**CULTURAL PROFICIENCY <u>IS NOT</u>**
Active Involvement and Decision-Making Authority of *Unaligned* Customers and Other Community Members in All Phases of Program Design, Implementation, Revision, and Evaluation	Exclusion, Inducement or Biased Inclusion of Consumers and Other Community Members in All Phases of Program Design, Implementation, Revision, and Evaluation
Customer and Community Contribution	Consumer and Community Usurpation or *Usury*
Solicitation of Authentic Feedback from Customers and Other Community Members	Prescribed Solicitation of *Scripted* Feedback from Consumers and Other Community Members
Community-Based Program Designs/Interventions	Organizational/Political Stakeholder-Based Program Designs/Interventions
Programs Designed by Community Leaders who Represent the Impacted Community	Programs Designed by Individuals or Groups that do <u>not</u> Represent the Impacted Community
Program Developers with a Vested Interest in the Community being Served	Program Developers have a Feigned, Casual or Curious Interest in the Community being Served
Programs Designed, Implemented and Based Upon Customer Need, Service and Satisfaction	Programs Designed, Implemented and Based Upon Practitioner Philosophy and Client Non-Compliance
Programs Based Upon Empirical Research and Experiential Practice	Programs Based Only Upon Statistically Manipulated Social Research
Research and Evaluation	
Robust Research and Evaluation Methods	Research and Evaluation Methods that are <u>not</u> Robust
Research Methods that do <u>not</u> include Inducements to Impoverished Neighborhoods to Dock Results	Research Methods that include Inducements to Impoverished Neighborhoods to Dock Results
Research and Evaluation that include Qualitative or Mixed Methods to assess Quality	Research and Evaluation that include only Quantitative Methods that are Statistically Docked
Results that are Vigorously Achieved and Generalizable to Target Populations	Results that are <u>not</u> Vigorously Achieved and are <u>not</u> Generalizable to Target Populations
Results that are Directly Linked to Program Revision, Performance Measures and Quality Improvement	Results that are <u>not</u> Used or Directly Linked to Program Revision, Performance Measures and Quality Improvement
A Complement of Public Administration!	*A Public Administration Mismatch!*

Case studies are presented so that "we may be able to better understand social dynamics by carefully examining particular cases that are unusual in the sense that important factors or processes which are normally obscured from view can be brought into sharp and clarifying focus" (Powers 2010, 4).

They may be used for future qualitative inquiry, which "also uses strategies of inquiry such as narratives, phenomenologies, ethnographies, grounded theory studies, or case studies" (Creswell 2003, 18).

After all, "Everyone loves a story. The hope is that well-told stories describing the reality of [B]lack and [B]rown lives can help readers bridge the gap between their worlds and those of others. Engaging stories can help us understand what life is like for others, and invite the reader into a new and unfamiliar world" (Delgado and Stefancic 2001, 41).

The *Case Scenario Vignettes* (Figures 4.1-4.3 on pages 162-164) are intended to be read from an omniscient point of view to inspire: awareness of issues, in-depth, self-exploration, discussion of cognitive and emotive constructs that surface, scholarly debate in the classroom, translation of *anecdotal narrative* into simulated practice, future research, and increased ethical

decision-making on shared, or distinctive, issues facing customers, practitioners and public administrators.

Figures 5.1 and 5.2 on pages 165-166 are visual schematics to accompany the case scenario vignettes.

The accompanying templates are intended to facilitate practitioner assessment and contemplation of the overlapping issues, dynamics and possible complexities of intersecting holons, leading to increased understanding and capacity to better assist customers.

They are also intended to be adaptively used by practitioners, to put things into perspective, on a more professional level, and to magnify customary and exceptional challenges faced in the organizational, institutional and/or systems spheres.

Figure 4.1: Case Scenario Vignettes

Systems Holon/Sphere
Case #1
President Obama has declared several new health care reform policies to be implemented. This will require that more than 80% of clients in your health care provider network be transitioned to another federal program within the next few years. As a health systems coalition member in your jurisdiction, you have witnessed that several organizations have not fulfilled previous federal mandates and have never been audited. As a senior coalition representative, what do you do?

Institutional Holon/Sphere
Case #1
Several organizations within the statewide health system have been cited for environmental hazards with immediate improvement within three months including extermination and renovations. An employee, with an unknown respiratory condition, complains that she is concerned with contracting a disease after witnessing a co-worker disperse ferret excrement in the office to rid the building of mice. You remember that on three separate occasions, you noticed that three customers started to cough and wheeze. As an employee of the state health department, you are also aware that the state hosts an anonymous tip-line to report government abuse, waste and fraud. You happen to like all animals, including mice. What would you do?

Systems-Institutional-Organizational Holons/Spheres
Case #2
(Straw and Sutton 2001) describe an irrational "situation of escalating commitment" as refusal to abandon a position despite evidence that it is "dysfunctional" (171). Over the years, your organization has not transcended its commitment to change data collection and surveillance systems in order to accurately capture, analyze and report to Congress information on the agency's response to the spread of disease in your jurisdiction. Other peer jurisdictions, with waiting lists to serve clients, have complained on the federal level since *your* state has traditionally received more than the *lion's share* of funds based on data that cannot be verified. In your ethical opinion, what should occur?

Figure 4.2: Case Scenario Vignettes

Organizational Holon/Sphere
Case #1
Customers have to rely heavily upon services rendered through an agency with a mission to "provide leadership in the development of health policy." However, client satisfaction surveys and client complaints reveal that customers feel marginalized and "left out of" policy decisions. Instead of responding or revising the system of health care to appreciate clients and respect their dignity and diverse cultures and *intra-culture*, traditionally, non-customer stakeholders have collectively reinforced missionary philosophies to make decisions on behalf of the customers being served. You read that this socially reinforced position also perpetuates diminished customer value. In your view, what should occur? What would you do?

Organizational Holon/Sphere
Case #2
The staffing of your organization changes from being representative of the community being served to one that is disproportionately representative of the demographic characteristics of the recently hired executive (within 10 months). In your view, what should occur?

Professional-Practitioner Holons/Spheres
Case #1
After several clients filed grievances against an organization, a social work practitioner, who formerly expressed overt dislike of the client population during staff meetings has become more covert in exhibiting personal dislike and expresses opinions of disfavor of clients only during closed circles. On two separate occasions, you overhear your colleague make disparaging remarks regarding several clients. As a peer practitioner, do you address the issue? If so, how? If no, why not?

Professional Holon/Sphere
Case #2
Your colleague wears, tight fitting attire with revealing, plunging necklines and mid-thigh splits during traditional work hours. When asked about this, she jokingly responds that only "gay men" work in the field of HIV/AIDS? In your view, is HIV/AIDS still a *gay disease*? What are your views on the heterosexual transmission of the HIV?

163

Figure 4.3: Case Scenario Vignettes

Practitioner Holon/Sphere
Case #1

The manager of your bureau continuously makes self-deprecating remarks and also alludes to deriding epithets when referring to staff. More recently she forwards an e-mail that you perceive as sarcastic yet racially disparaging and copies several members within the organization. How do you respond? To whom do you respond? Why?

Practitioner/Customer Holon/Sphere
Case #1

You have just received an honorary award as employee of the month. You also have a client who persistently comes into your office with a foul, body odor. When discussing the matter previously, the client became offended and did not return for services until after several repeated attempts to re-engage her. Your supervisor tells you that her odor is "cultural." How do you handle the matter now?

Customer Holon/Sphere
Case #1

You come into receive services and overhear an agency support staff person refer to someone in the waiting room as a "Trick Baby." Being of bi-racial descent, (or not), you bring this to the attention of the triage clinician. After a 15 minute wait, the clinician returns and tells you that you need to bring in supportive documentation (e.g. Social Security card, proof of residence, proof of income) prior to being served. She never acknowledges your earlier concern. How would you interpret the care that you received? Would you return to this agency to receive care?

Customer/Practitioner/Organizational/Systems Holons/Spheres
Case #1

You find out that your medical provider has shared medical information with your employer, without your consent. What actions do you take?

Systems	Health Care Reform	New Antiviral Drugs	Changing Epi Trends
Institutional	Nursing Shortage	New Health Policy	Professional Competition
Organizational	Recent Burglary	High Staff Attrition	Budget Cuts
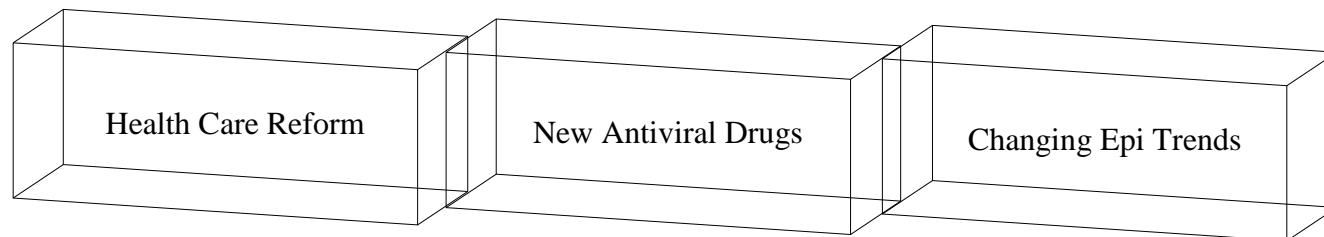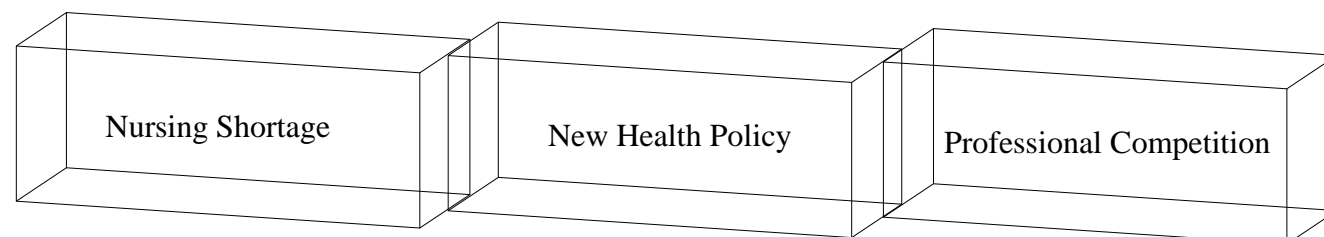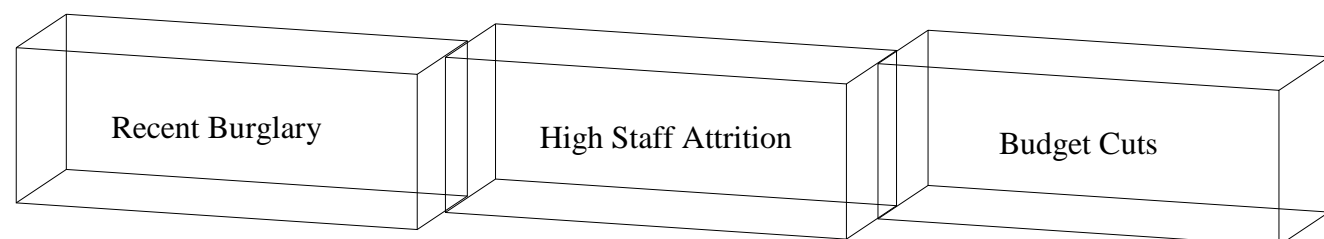
Figure 5.1: Template: Case Scenario Rubric

Professional (♀)

Ethics Charges

Re-Certification Costs

Preceptor of Student

Practitioner (♀)

Customer Complaints

Androphobic

Untreated Mental Illness

Customer (♂)

No Documentation

Mistrust of Caregivers

Homeless/Recidivist
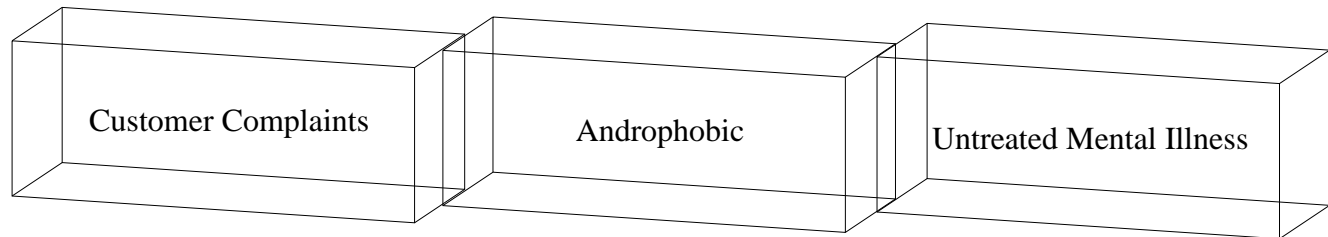
Figure 5.2: Template: Case Scenario Rubric

Phase II Method: Toward Scholarly Licensure

What began as a doctoral *final project* evolved into a much broader, scholarly and theoretical approach, founded upon social theory, in particular critical race theory and social equity theory, in consideration of the sociopolitical implications of the population most impacted by HIV/AIDS in Maryland, native-born Black Americans.

The researcher elected a qualitative research methodology to reveal evidence, or not, of adoption of culturally appropriate approaches in HIV prevention and health care in Maryland.

Lawrence Grossberg, Cary Nelson and Paula A. Treichler (1992) edited the international compilation entitled, *Cultural Studies*. From this work, Denzin and Lincoln (2000) derived the following succinctly paraphrased definition from Chapter 1 entitled, *Cultural Studies: An Introduction* by Nelson, Treichler and Grossberg,

> Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities and the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to 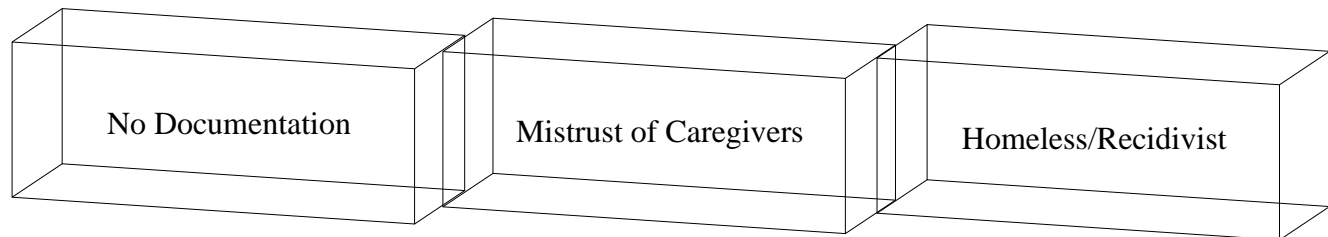the value of the multi[-]method approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions. (Denzin and Lincoln 2000, 7)

In the quest to construct a means to effect change and increase capacity (practitioner, organizational and systems) to provide culturally proficient health care and prevention programs in Maryland, the researcher used a qualitative approach to elucidate community need and substantiate the strong recommendations to develop the preliminary model since theories "are formed through interaction with others (hence social constructivism) and through historical and cultural norms that operate in individuals' lives" (Creswell 2003, 8).

Moreover, "constructivist researchers often address the *process* of interaction among individuals" and the "specific contexts in which people live and work in order to understand the historical and cultural settings of the participants" (Creswell 2003, 8).

Further development of *The Capacity Building Model*, will be based upon review of qualitative information obtained from local professionals of Social Work, Nursing, Public Administration, Medicine, and other disciplines, paraprofessionals of the Allied Human Services, and consideration of additional ethnographic experiences of community activists, PLWH/A, including long-term survivors, their families, friends, and care providers.

(The definition of family includes significant others, members of civil marriages, extended families, multiple households, etc.).

By presenting a foundation upon which future theories and models may arise, out of agreement or challenge, either way, this *work in action*, serves as a cornerstone to incite current and future practitioners to contemplate and explore what is (or is not) working now and advance the field of public administration in health care, more specifically, the arena of HIV/AIDS.

A Qualitative Method to Determine *What* the State Has Done, is Doing and Plans to Do

According to Creswell (2003), a researcher may use a qualitative approach to develop "advocacy/participatory perspectives (i.e., political, issue-oriented, collaborative, or change oriented) or both" (Creswell 2003, 18).

Ryan and Bernard explain that "qualitative data" may be found as "text" in narratives and other various forms of media (Denzin and Lincoln 2000, 769).

The researcher presents this body of work to reveal whether or not evidence exists to demonstrate cultural competence in the delivery of state-supported HIV/AIDS programs, using qualitative data analysis software to

examine language in: 1) historical and website documents, 2) current communications and 3) electronic information to promote HIV/AIDS interventions and activities.

Activities of Phase II are highlighted in the methodological timeline on page 171.

Table 6: Phase II Methodological Timeline Table

Demonstration of Scholarly License (2007-2009)

Planning, Acting, Observing & Development of New Practices (Step 2): Toward Qualitative Study (2007-2009)

- Crystallization of Phase II academic research question (*What has the State of Maryland done, is doing and plans to do…?*)
- Expansion of literature review on underlying theories
- Updating of epidemiological data
- Refinement of capacity building and community mobilization logic models
- Development of case scenario vignettes
- Collection and review of public documents
- Reconsideration of qualitative methodology
- Training on use of qualitative data analysis software

Reflecting & Diffusion of Results (Step 3): Qualitative Analysis and Presentation of Findings (2009-2011)

- Expansion of title, *Restoration Maryland: The Capacity Building Model for Organizational and Systems Accountability to Redress the Collective Needs of the Black Community in Maryland*
- Coding and content analysis of public documents on HIV/AIDS prevention and treatment
- Incorporation of committee recommendations
- Revising, editing and copywriting of dissertation and model
- BAAM Recommendation to premier the capacity building model at the National HIV Prevention Conference in August 2011
- Follow-up structured roundtable discussions in Atlanta in August 2011
- Diffusion of results of content analysis and revised model

Underlying Premises of Phase II Method

The underlying premise of the method is that substantive HIV prevention and health services activities shall be appropriately documented, maintained and archived in compliance with state and national programmatic and legislative requirements, standards and best practices.

States and sub-grantees have the duty to inform stakeholders, customers and the community-at-large of services to be provided.

Such activities are promoted, documented and reported to serve as evidence of grantee and sub-grantee performance and documentation is made available to the general public, maintained, and/or archived, for a number of specified years.

Providers of HIV prevention and health services also have the propensity to showcase activities that demonstrate achievement of organizational missions, visions, performance, competencies, and best practices in grant applications and promotional devices.

Recipients of HIV prevention funds traditionally promote activities via the Maryland AIDS Prevention Listserv by E-Mail (MAPLE). Providers of Ryan White (Part B), previously Title II, promote services via the Ryan White Listserv.

Data Analysis Using NVivo 8

Archival documents developed during the period between 2005-2008, and made available to the public shortly thereafter, were reviewed: to limit, or frame, the research period; to determine concurrent culturally competent prevention and health services practices in comprehensive Maryland State planning to address the spread of HIV/AIDS; and to determine overarching and recurring themes.

The following archival documents were collected and saved in Adobe Reader 8 (Version 8.1). The following, documents developed by the Maryland DHMH, AIDS Administration, served as the *primary sources* for data analysis:

- *Maryland's Comprehensive HIV Prevention Plan, 2004-2008*, hereinafter referred to as the *Maryland 2004-2008 HIV Prevention Plan*.
- *Ryan White Title II 2006-2008 Comprehensive HIV Services Plan*, hereinafter referred to as the *2006-2008 Ryan White HIV Health Services Plan*.
- *Ryan White Title II Statewide Coordinated Statement of Need (SCSN), January 5, 2009*, hereinafter referred to as the *Ryan White Title II (Part B) Statement of Need*.

Coding

Qualitative text data were catalogued, or *coded*, into *tree nodes* according to the CLAS (Table 2), using *NVivo 8* statistical software developed by Qualitative Solutions for Researchers (QSR) International. All entries were copied and included as they appeared in the original text, using

the *drag and drop* method (QSR 2008a, 58-59), to maximize coding concordance and minimize rater bias due to lack of memory of what had, or had not, been coded.

Johnny Saldaña, author of *The Coding Manual for Qualitative Researchers*, defines a code in qualitative inquiry as a "word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña 2009, 3).

A *broad-brush* coding approach, or *bucket* coding was conducted to group, or *chunk*, data in order to see what was present in the source text documents (Bazeley 2007, 67).

The Maryland sourced documents included qualitative data that could be considered positively correlated to the CLAS, and on occasion, those that could be negatively correlated, particularly in the SCSC, the statewide Ryan White Part B needs assessment.

Likewise, tree nodes were categorized either as a positive correlate to the concepts and themes of the CLAS, or as a negative correlate for ease of coding and to later facilitate corollary interpretation.

After a preliminary review, or read, it was decided to leniently include all surrounding content text when coding,

in consideration of the minimal referencing of CLAS in all source texts.

In addition, documents disseminated throughout the Maryland public domain via the Maryland AIDS Prevention Listserv by E-Mail (MAPLE) and/or Ryan White Listserv, for a four-year period ranging from 2006-2009, were analyzed through *stemmed Text Search (TS) queries* to determine existence of culturally appropriate programs provided in Maryland, including activities coordinated or implemented by the Maryland DHMH AIDS Administration as well as those that were sponsored with State funds.

State support was confirmed through any evidence of dissemination of communiqués (flyers and e-mail messages) via the two State-operated HIV/AIDS electronic mailing list mechanisms; informative *listserv* communication venues.

Data Analysis of Archival Documents

After coding, data were analyzed using NVivo8 and overall percentage coverage for concepts of cultural competency and CLAS were illustrated in a bar chart (histogram).

This was achieved by first individually *coding for a source*, that is, selecting the three Maryland source documents, and then, selecting the chart items, or nodes to

be shown; in this case, Tree Nodes consistent with the CLAS.

Charts were created individually for ease of interpretation, with data displayed according to the frequency of coding according to CLAS on the *X Axis* and percentage coverage on the *Y Axis*.

In addition, stemmed TS queries of the archival documents were also used as a basis for comparison between documents (Bazeley 2007, 184).

The Boolean operator 'OR' was used to search for the presence or lack of terms, concepts, synonyms, and related words for 'cultural' or 'cultural competence' or 'cultural competency' or 'cultural proficiency'. Using the NVivo8 stemmed search function reveals "any word with the 'stem'." For example a stemmed search for 'motive' would also return 'motivated' (QSR 2008, 38b).

Results of the stemmed TS queries were then reviewed by re-reading texts in order to eliminate, or *clean*, data and "unintended finds" (Richards 2005, 158).

Data Analysis of Listserv Documents

Data were analyzed using NVivo8 and overall percentage coverage for concepts of culture. Charts were created individually for ease of interpretation, with data

displayed according to the listserv documents with the highest percentage coverage on the *X Axis* and percentage coverage on the *Y Axis*.

The Boolean operator 'OR' was used to search for the presence or lack of terms, concepts, synonyms, and related words for 'cultural' or 'culturally sensitive' or 'cultural competence' or 'cultural competency' or 'cultural proficiency'.

Stemmed TS query source documents consisted of training announcements, e-mail messages relating to State-sponsored and community events and other attachments (i.e. flyers), disseminated to the general public via the Maryland AIDS Prevention Listserv by E-mail (MAPLE) and Ryan White listserv. Documents were de-duplicated prior to running searches in order to minimize redundancy.

Maryland HIV/AIDS surveillance data and plans to comply with federal recommendations and the following secondary source documents, transmitted via State listserv venues, were considered in issue formulation, response to action and model development.

- *Maryland Transition Plan to Name-Based HIV Reporting.*
- *Testimony, DHMH AIDS Administration.*
- *Infectious Disease and Environmental Health Administration (IDEHA) Memo to Community Partners.*

Additional information and data were obtained from state and federal sources, which are now also available in the public domain (e.g. informational websites and databases sponsored by the U.S. DHHS and Maryland DHMH).

Theoretically speaking, such information should qualitatively evidence: culturally appropriate interventions as recommended for all federally-funded programs; culturally competent interventions according to CLAS and/or Rice (2006); and/or culturally proficient services to heighten appropriate epidemiological response in Maryland according to components of the capacity building model of the researcher.

Finally, a *matrix* was developed in Microsoft Excel to appositionally compare the coding query results of primary source documents. (This software was preferred due to its visual features).

In addition, such comparison results were considered when developing or refining the dimensions and other aspects of *The Capacity Building Model*.

Results of Qualitative Data Review

Stemmed Text Search (TS) Results

The stemmed TS query revealed only .12% (less than 1%) coverage of the words "cultural OR culturally sensitive OR cultural competence OR cultural competency" for the *2006-*

2008 Ryan White HIV Health Services Plan. The query revealed that the document had 13 references that were positively framed. Moreover, the presence of such stemmed words/phrases were, oftentimes, described in the conditional tense of what *may,* or could, be done instead of what *is* actually being done.

The stemmed TS query of the same words/terms for the *Ryan White Title II (Part B) Statement of Need, or SCSN*, revealed .22% (less than 1%) coverage. On the other hand, this document contained 29 references that were negatively framed for the presence of culturally competent approaches, that is, the phrases/terms were used to describe the *need for*, or *lack of*, culturally appropriate responses in health care and supportive services.

Review of the SCSN queries results marked a significant, approximate ratio of 1:3 (the actual presence of cultural competency in the delivery of health care activities in proportion to client/community perceptions of the lack of culturally competent services and interventions).

The stemmed TS query for the *Maryland 2004-2008 HIV Prevention Plan* revealed .01% (less than 1%) for the same stemmed texts. Whereas there was only one reference to 'culture' in the text, the document had repeated language regarding the collection and use of data on special and

target populations and inclusion of members of various

groups of the community in the planning process.

Results of CLAS Coding Queries

The frequency and percentage coverage of positively

correlated text data that are consistent with CLAS include

the following for the *2006-2008 Ryan White HIV Health*

Services Plan.

CLAS	Description	Percentage
	Table 7: Coding Query Results for the 2006-2008 Ryan White HIV Health Services Plan	
#11	Collection of Data on Communities	23.42%
#1	Culturally Competent Health Care	9.78%
#10	Collection of Data on Individual Patients/Consumers	8.06%
#8	Organizational Framework for Cultural Competence	4.98%
#12	Community Partnerships for CLAS	2.60%
#3	Staff Education and Training	1.89%
#4	Qualified Language Assistance Services	0.84%
#9	Organizational Self-Assessment	0.55%
#6	Qualifications for Bilingual and Interpreter Services	0.38%
#2	Staff Diversity	0.24%
#7	Translated Materials	0.14%
#14	Information for the Public	0.00%
#13	Complaint and Grievance Resolution	0.00%
#5	Notices to Patients/Consumers of the Right to Language Assistance Services	0.00%

The frequency and percentage coverage of positively correlated text data that are consistent with CLAS include the following for the *Ryan White Title II (Part B) Statement of Need*.

CLAS	Description	Percentage
Table 8: Coding Query Results (Positive Correlates) for the Ryan White Title II (Part B) Statement of Need		
#11	Collection of Data on Communities	3.31%
#12	Community Partnerships for CLAS	1.00%
#8	Organizational Framework for Cultural Competence	0.97%
#10	Collection of Data on Individual Patients/Consumers	0.41%
#4	Qualified Language Assistance Services	0.00%
#5	Notices to Patients/Consumers of the Right to Language Assistance Services	0.00%
#3	Staff Education and Training	0.00%
#1	Culturally Competent Health Care	0.00%
#2	Staff Diversity	0.00%
#9	Organizational Self-Assessment	0.00%
#13	Complaint and Grievance Resolution	0.00%
#14	Information for the Public	0.00%
#6	Qualifications for Bilingual and Interpreter Services	0.00%
#7	Translated Materials	0.00%

The frequency and percentage coverage of negatively (or inversely) correlated text data that are inconsistent with CLAS, as prefaced by "lack of" in the source document include the following for the *Ryan White Title II (Part B) Statement of Need*.

Table 9: Coding Query Results (Negative Correlates) for the Ryan White Title II (Part B) Statement of Need		
CLAS	**Description (Lack of)**	**Percentage Coverage**
#1	Culturally Competent Health Care	21.32%
#3	Staff Education and Training	4.06%
#5	Notices to Patients/Consumers of the Right to Language Assistance Services	1.12%
#4	Qualified Language Assistance Services	1.08%
#8	Organizational Framework for Cultural Competence	0.73%
#11	Collection of Data on Communities	0.51%
#10	Collection of Data on Individual Patients/Consumers	0.51%
#6	Qualifications for Bilingual and Interpreter Services	0.35%
#12	Community Partnerships for CLAS	0.14%
#2	Staff Diversity	0.08%
#7	Translated Materials	0.00%
#13	Complaint and Grievance Resolution	0.00%
#9	Organizational Self-Assessment	0.00%
#14	Information for the Public	0.00%

The frequency and percentage coverage of positively correlated text data that are consistent with CLAS include the following for the *Maryland 2004-2008 HIV Prevention Plan*.

Table 10: Coding Query Results for the Maryland 2004-2008 HIV Prevention Plan		
CLAS	**Description**	**Percentage Coverage**
#11	Collection of Data on Communities	14.37%
#8	Organizational Framework for Cultural Competence	12.84%
#12	Community Partnerships for CLAS	10.07%
#10	Collection of Data on Individual Patients/Consumers	8.77%
#3	Staff Education and Training	2.65%
#13	Complaint and Grievance Resolution	0.75%
#14	Information for the Public	0.75%
#4	Qualified Language Assistance Services	0.39%
#2	Staff Diversity	0.00%
#7	Translated Materials	0.00%
#1	Culturally Competent Health Care	0.00%
#6	Qualifications for Bilingual and Interpreter Services	0.00%
#5	Notices to Patients/Consumers of the Right to Language Assistance Services	0.00%
#9	Organizational Self-Assessment	0.00%

Figures 6.1-6.4 illustrate histograms for the results

for the *2006-2008 Ryan White HIV Health Services Plan*, *Ryan*

White Title II (Part B) Statement of Need (positive and

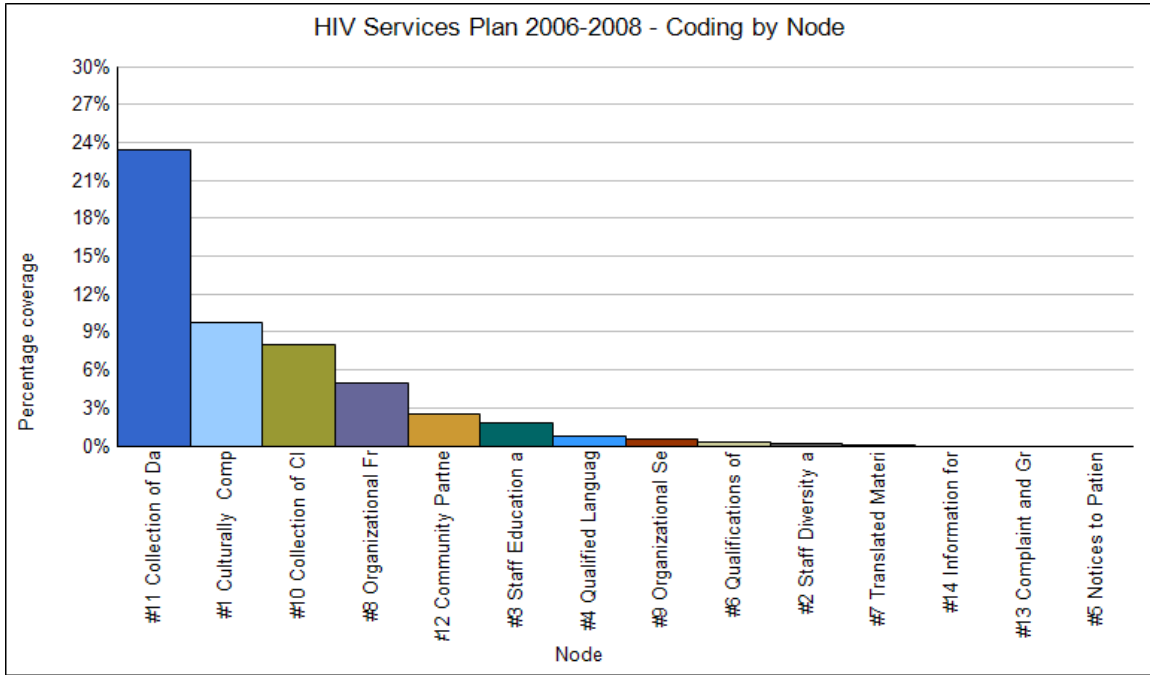negative) and *Maryland 2004-2008 HIV Prevention Plan*.

Figure 6.1: Coding Query Chart, 2006-2008 Ryan White HIV Health Services Plan (Positive Correlations to CLAS)
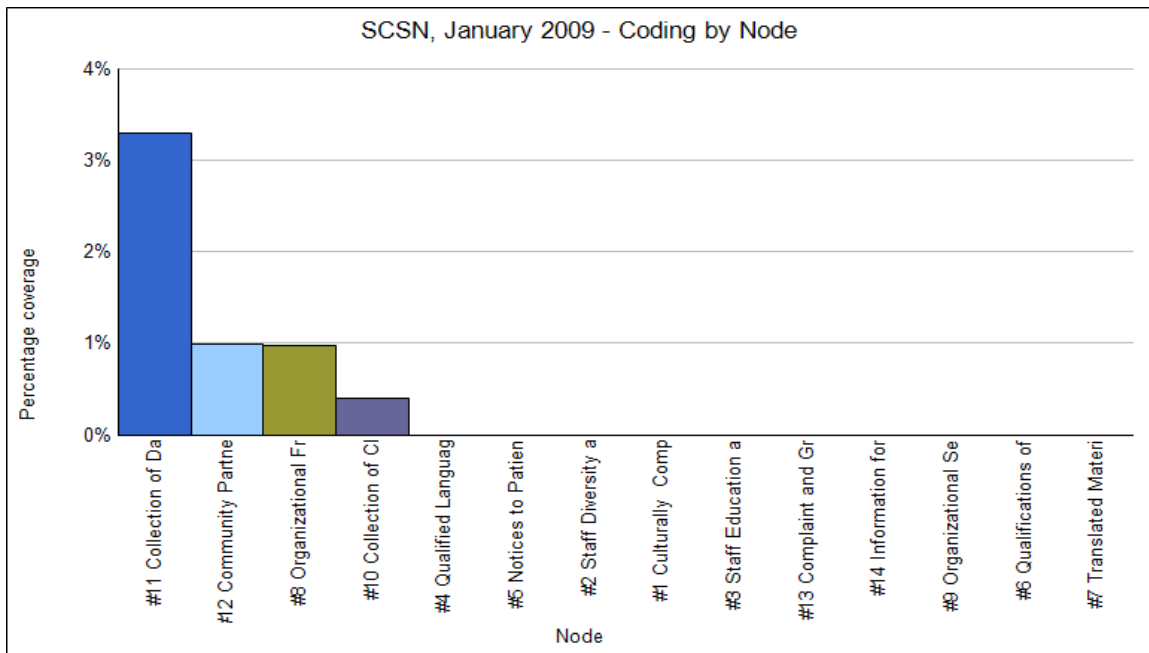
Figure 6.2: Coding Query Chart, Ryan White Title II SCSN (Positive Correlations to CLAS)
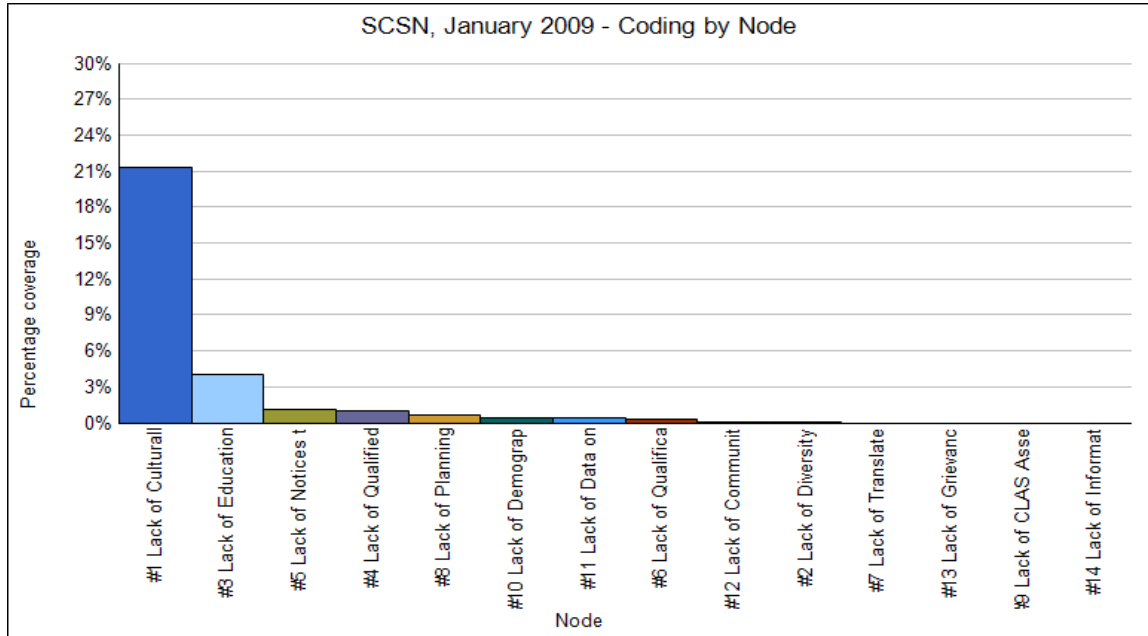
Figure 6.3: Coding Query Chart, Ryan White Title II SCSN (Negative Correlations to CLAS)
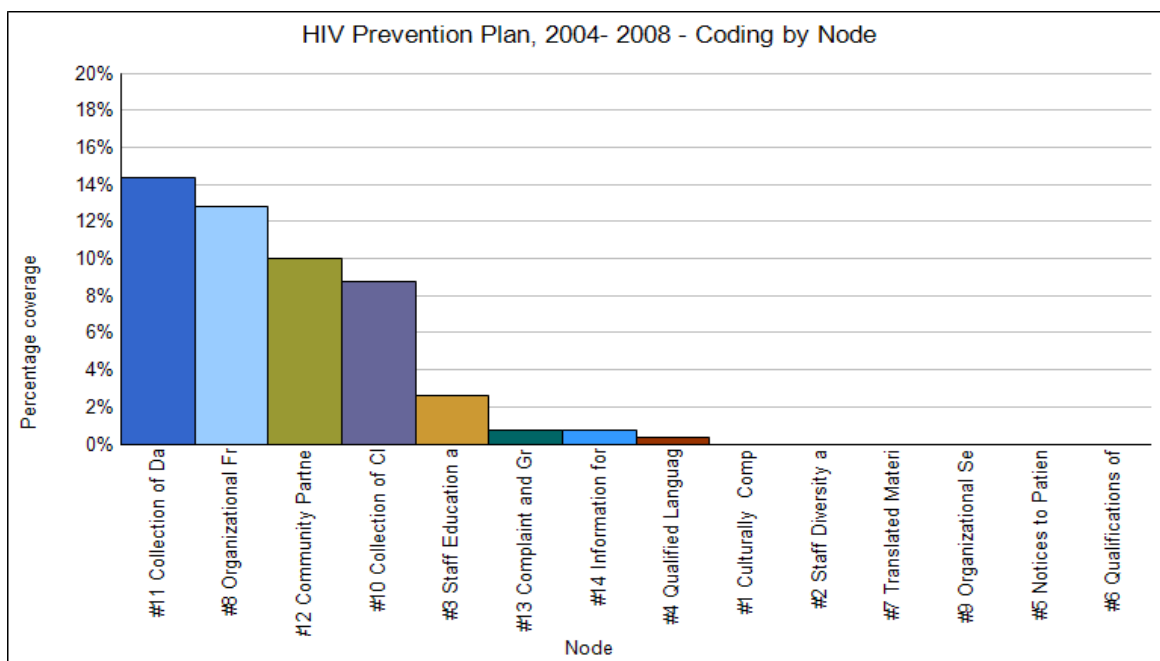
Figure 6.4: Coding Query Chart, Maryland 2004-2008 HIV Prevention Plan (Positive Correlations to CLAS)

Table 11 on page 188 reveals the results of the coding queries in a matrix, with percentage coverage of CLAS for all three primary source documents, prepared and approved for public view by managerial level administrators of the Maryland AIDS Administration.

The matrix reveals that the Maryland AIDS Administration self-reported the following in the *HIV Health Services Plan*: *Collection of Data on Communities* (23.42%), *Cultural Competent Health Care* (9.78%), *Collection of Demographic Data* (8.06%), and *Organizational Framework* (4.98%).

The SCSN columns of the matrix show both positive and negative correlations. Stakeholder participants positively

reported *Collection of Data on Communities* as 23.42% and *Community Partnerships for CLAS* as 1.00%. On the other hand, the SCSN participants negatively reported *Cultural Competent Health Care* as 21.32%, *Staff Education and Training* as 4.06%, *Right to Language Assistance* as 1.12%, and *Language Assistance* as 1.08%.

This demonstrates community discordance with agency self-reporting for CLAS #1, *Cultural Competent Health Care*.

Lastly, the matrix revealed that the Maryland AIDS Administration self-reported: *Collection of Data on Communities* as 14.37%, *Organizational Framework* as 12.84%, *Community Partnerships for CLAS* as 10.07%, and *Collection of Demographic Data* as 8.77%.

The most notable results were *Collection of Data on Communities* as 23.42% for the *HIV Health Services Plan* and the lack of *Culturally Competent Health Care* as 21.32% according to Maryland SCSN participants.

Further comparison of the *HIV Health Services Plan* with the *SCSN* marked significant discrepancies in agency perceptions of the presence of CLAS in the delivery of health care activities and client/stakeholder perceptions of the presence or lack of culturally competent services and interventions.

Table 11: Matrix: Coding Query Source Documents by CLAS

Culturally and Linguistically Appropriate Standards (CLAS)				
Maryland Sources Documents →	**HIV Health Services Plan**	**Statement of Need (SCSN)**		**HIV Prevention Plan**
		Positive	**Negative**	
	Presence of	*Presence of*	*Lack of*	*Presence of*
Standards	%	%	%	%
#1 Cultural Competent Health Care	9.78	0.00	21.32	0.00
#2 Staff Diversity	0.24	0.00	0.08	0.00
#3 Staff Education & Training	1.89	0.00	4.06	2.65
#4 Language Assistance	0.84	0.00	1.08	0.39
#5 Right to Language Assistance	0.00	0.00	1.12	0.00
#6 Qualified Bi-Lingual Services	0.38	0.00	0.35	0.00
#7 Translated Materials	0.14	0.00	0.00	0.00
#8 Organizational Framework	4.98	0.97	0.73	12.84
#9 Organizational Self-Assessment	0.55	0.00	0.00	0.00
#10 Collection of Demographic Data	8.06	0.41	0.51	8.77
#11 Collection of Data on Communities	23.42	3.31	0.51	14.37
#12 Community Partnerships for CLAS	2.60	1.00	0.14	10.07
#13 Complaint & Grievance Resolution	0.00	0.00	0.00	0.75
#14 Information for the Public	0.00	0.00	0.00	0.75

Percentage coverage equal to or greater than 1.00% are highlighted in **blue** for positive correlations for the *HIV Health Service Plan*, *Statewide Coordinated Statement of Need (SCSN)* and *HIV Prevention Plan* and **red** for negative correlations of the *SCSN*.

Listserv Stemmed Text Search (TS) Queries

Results of the MAPLE/Ryan White listserv stemmed text search (TS) queries are presented as *Tables 12-15* and histograms, *Figures 7.1-7.4.*

Out of a total of 171 heterogeneous documents distributed via the MAPLE and Ryan White electronic mailing lists in 2006, 38 documents (22.22%) were imported as unduplicated *NVivo 8* source documents. The stemmed TS query revealed that four of the 38 contained a range of 0.05%-4.76% coverage of the words "cultural OR culturally sensitive OR cultural competence OR cultural competency."

Table 12: 2006 MAPLE/Ryan White Listserv Stemmed Text Search Query Results		
Number of References	**Description**	**Percentage Coverage**
4	*Cultural Competency Training* (March 3, 2006), E-Mail	4.76%
4	*Cultural Competency Training* (October 6, 2006), E-Mail	4.76%
1	*HIV Men's Conference*, (June 16, 2006) (E-Mail)	1.30%
1	*HIV & Latinos Workshop*, (Flyer)	0.21%
3	*Maryland May Calendar*, 2006, Teen Pregnancy Prevention Month	0.05%

Out of a total of 209 heterogeneous documents distributed via the MAPLE and Ryan White electronic mailing lists in 2007, 94 documents (44.97%) were imported as unduplicated *NVivo 8* source documents. The stemmed TS query

revealed that 10 of the 94 contained a range of 0.06%-6.26%

coverage of the words "cultural OR culturally sensitive OR

cultural competence OR cultural competency."

Number of References	Description	Percentage Coverage
6	*Cultural Competency Training* (October 11, 2007), E-Mail	6.26%
3	*Culturally Appropriate Communication in HIV Prevention*, (March 2, 2007), E-Mail	3.60%
3	*HIV & Latinos Workshop*, Flyer	0.99%
3	*Culturally Appropriate Communication in HIV Prevention*, (March 2, 2007), Flyer	0.73%
4	*Youth Institute*, E-Mail and Registration Form	0.37%
1	*Psychosocial Adherence Workshop*, Flyer	0.29%
1	*Brother To Brother Workshop*, Flyer	0.27%
1	*Culture and Spirituality Workshop*, E-Mail	0.21%
1	*Maryland Respite Coalition Conference*	0.12%
1	*Dance for A Cure*, Flyer	0.06%

Table 13: 2007 MAPLE/Ryan White Listserv Stemmed Text Search Query Results

Out of a total of 56 heterogeneous documents distributed

via the MAPLE and Ryan White electronic mailing lists in

2008, 37 documents (66.07%) were imported as unduplicated

NVivo 8 source documents. The stemmed TS query revealed

that four of the 37 contained a range of 2.14%-11.17%

coverage of the words "cultural OR culturally sensitive OR

cultural competence OR cultural competency."

Table 14: 2008 MAPLE/Ryan White Listserv Stemmed Text Search Query Results		
Number of References	Description	Percentage Coverage
24	*Cultural Competency Training*, Flyer	11.17%
7	*Latino Cultural Competency Training*, sponsored by the National Minority AIDS Council (NMAC), Flyer	5.24%
6	*Ready, Set, Resources*, MSM Training Flyer	2.33%
1	*Ethics Training Announcement*, Flyer	2.14%

Out of a total of 86 heterogeneous documents distributed via the MAPLE and Ryan White electronic mailing lists in 2009, 54 documents (62.79%) were imported as unduplicated *NVivo 8* source documents. The stemmed TS query revealed that seven of the 54 contained a range of 0.04%-16.98% coverage of the words "cultural OR culturally sensitive OR cultural competence OR cultural competency."

Table 15: 2009 MAPLE/Ryan White Listserv Stemmed Text Search Query Results		
Number of References	Description	Percentage Coverage
12	*Cultural Competency Training*, Flyer	16.98%
6	*Race and Culture Training*, Flyer	3.05%
2	*Live Out Loud*, Transgender Training (Registration)	1.15%
1	*Transgender Training*, E-Mail	1.13%
2	*Transgender Education*, Flyer	0.23%
1	*HIV/AIDs Diversity Nomination*, Kaiser Permanente	0.19%
1	*A Woman's Journey*, Johns Hopkins, Workshop Flyer	0.04%
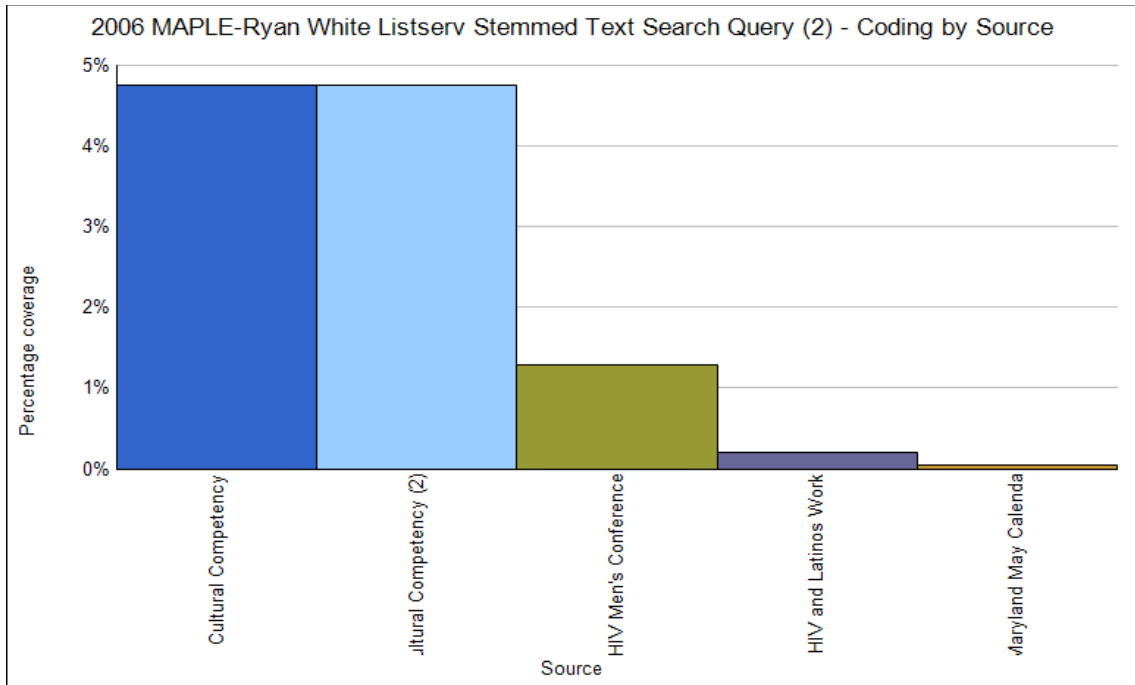
Figure 7.1: 2006 MAPLE/Ryan White Listserv Stemmed Text Search Query Results
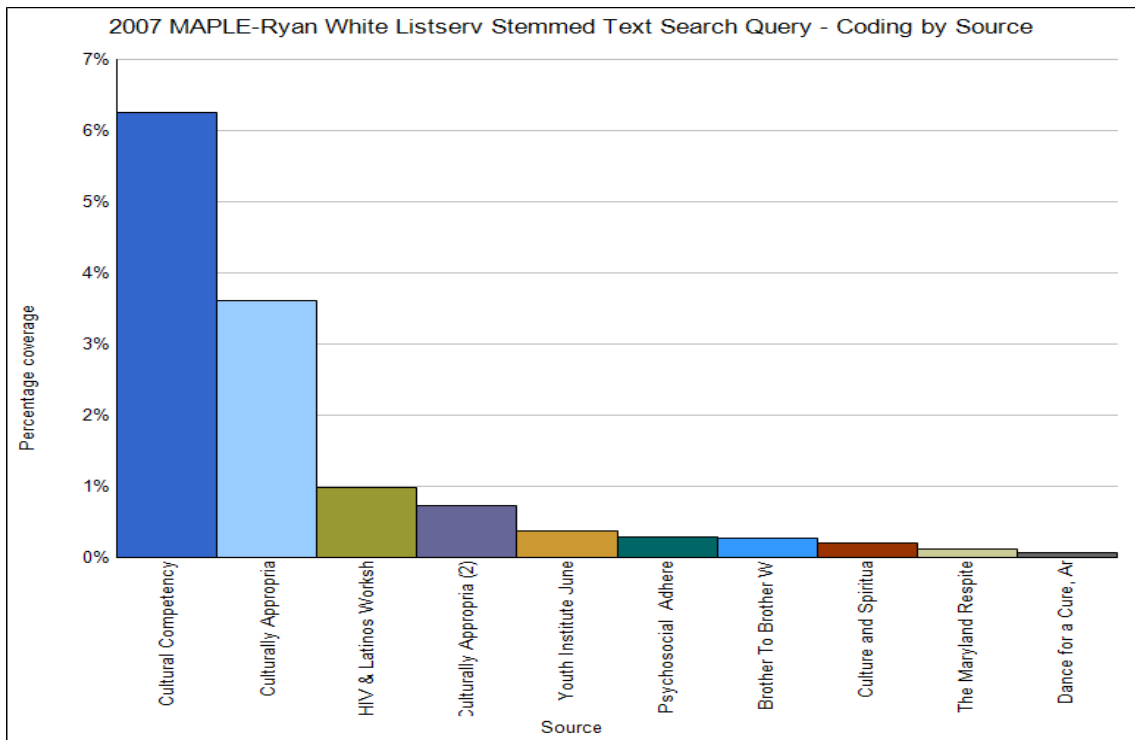
Figure 7.2: 2007 MAPLE/Ryan White Listserv Stemmed Text Search Query Results
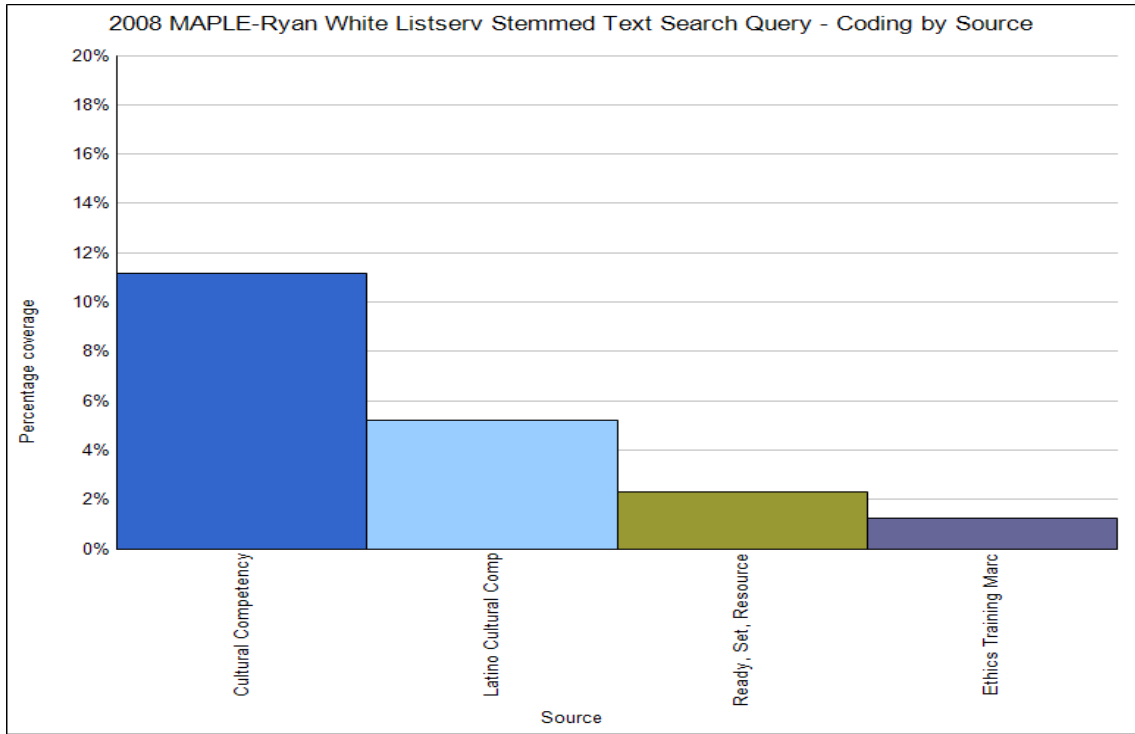
Figure 7.3: 2008 MAPLE/Ryan White Listserv Stemmed Text Search Query Results
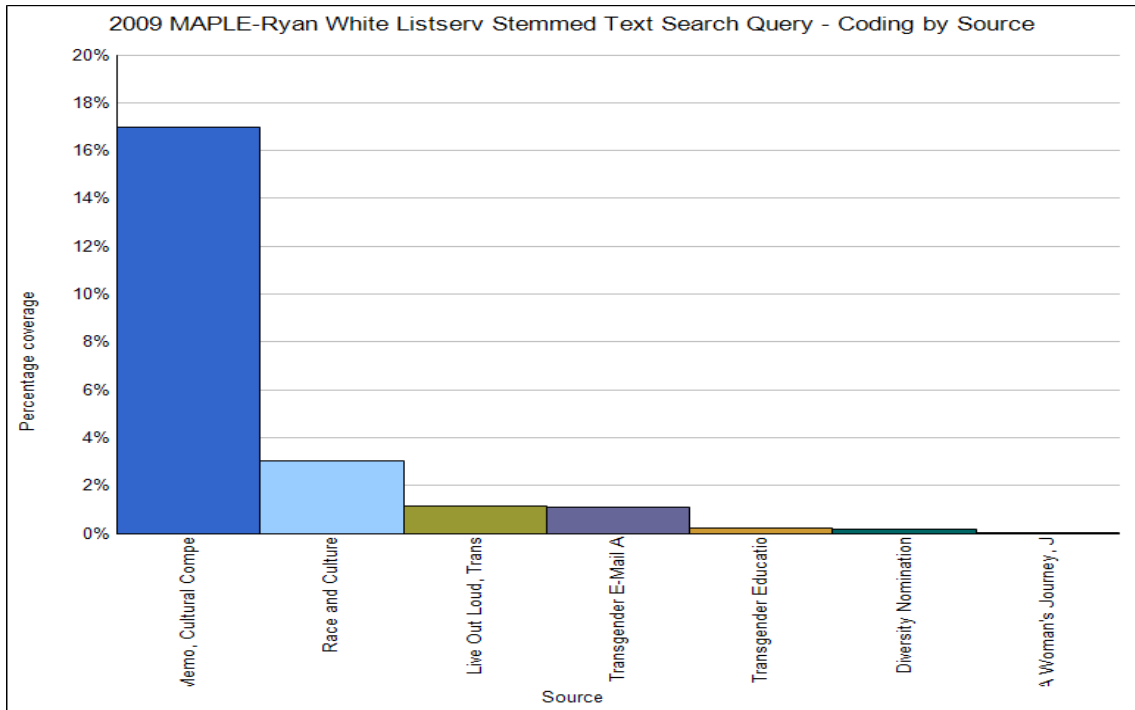
Figure 7.4: 2009 MAPLE/Ryan White Listserv Stemmed Text Search Query Results

Limitations: Coding Queries

One limitation in analyzing the coded data is that most narrative data did not exactly correspond to the CLAS. Because of this, and in anticipation of dispute, the researcher *leniently coded* to the CLAS variables as if there were direct correlations. For example, any mention of education was coded to staff education, even though the concept may have pertained to education and/or training for persons other than staff. In spite of this lenient approach, results were sparse.

Another limitation of the method rests in the presumption that significant interventions are documented within the archival documents. There could be instances where culturally competent interventions are being provided, but not indicated within said documents, which should extensively capture provision of any lucrative prevention and health services.

For instance, the Maryland DHMH Office of Faith-Based and Community Partnerships routinely hosts activities that are not mentioned in the source documents, yet may exemplify culturally appropriate interventions.

This realization created the need to seek documented evidence via alternate sources and inspired the researcher

to search the State-operated, electronic mailing lists for additional evidence.

Summary of Findings

Collectively, the Maryland archival documents contained a number of references to politically correct yet uneventful prospects. However, such *lip services* need *teeth* to demonstrate that the State is actually advancing in the right direction according to national recommendations to meet the needs of the Black Community.

Shortcomings of the documents include a lack of detail describing culturally appropriate interventions to address obstacles to customer engagement (*reach*), access and retention in health care, particularly HIV health services.

The only intervention promoted in the *2006-2008 Ryan White HIV Health Services Plan* that could be considered culturally competent was portrayed by the Administration as a project targeting African American MSM (AAMSM). The project intervention included a convenience sample of "more than 20" participants.

Such a total number in sampling is not considered to be statistically significant or able to be generalized to the diverse community of Black *androphilic* men in Baltimore City. Moreover, further inquiry revealed that the project

was a result of a *sole source*, uncompetitive selection process, which created even more speculation on the validity and reliability of results, particularly since the State allegedly maintains a rigid and competitive procurement process.

Moreover, the listserv documents revealed multiple flyers and training events. However, overall, such events, other than two annual trainings on cultural competency, did not significantly highlight culturally and linguistically appropriate services or the CLAS. (The researcher attended three different trainings on cultural competency between 2006 and 2007 and found them to be elementary in scope and in need of technical assistance in many of the areas already identified in this work).

For these very reasons, the researcher in collaboration with members of the BAAM!!!!!!! created the aforementioned visual diagrams as reminders of the obstacles and barriers to be overcome. Such factors need to be considered in tandem with statewide and local issues in order to achieve practitioner, organizational and systems accountability in providing culturally proficient services, and thereby, establish effectual HIV prevention and customer service, access and retention in HIV care and treatment.

Limitations: Listserv File Conversion

For multiple years, one source document, a flyer for cultural competency training, contained the repeated term cultural competency and several other references, as many as 12 on one flyer. However, it had not been displayed as a text search reference in the query results node. The researcher had saved the file as a text file and the system saved it as a *Notepad* file that was not displayed in NVivo8.

To address this problem, the researcher reviewed all MAPLE/Ryan White Listserv source documents that had been saved as text files to ensure appropriate conversion into NVivo8 and noticed that, ironically, this flyer (the one with the most references) was the only source document that had not been successfully imported into the NVivo 8 software from Microsoft Outlook.

After several unsuccessful import/save attempts, the researcher typed the text of the flyer as a memo and linked it to the source document, the actual flyer. When running the 2009 MAPLE/Ryan White Listserv Stemmed TS query, the researcher selected the respective *Memos* folder to be searched.

Limitations of the Listserv Query Method

Limitations of the listserv query method include not initially accommodating for duplication of data due to saving multiple entries of the same source document. For example, some entries were sent multiple times via both the MAPLE and Ryan White listservs.

In order to minimize rater recall bias (not remembering what had, or had not, been saved, all e-mail attachments and text therein were initially copied and saved as they appeared in the original text, when possible. However, some e-mail attachments had been saved and e-mailed under a different name or under a different e-mail *cover*.

On occasion, this caused duplication of some source documents, even though in most instances, the save feature would alert and prompt *override* options.

Nevertheless, because of the possibility of this re-occurrence, the researcher later re-read and compared all source documents and de-duplicated re-occurring source document texts.

As a result, the initial over-rated percentage coverage was normalized due to the de-duplication, or *cleaning*, of source document data.

In addition, some community-based organizations hold activities that may be considered culturally competent, yet

the information is not sent via the State-operated MAPLE or Ryan White listserv. Information is shared via electronic networking venues or communicated via *word-of-mouth*. (In most instances, said activities were "not funded" by the State).

Lastly, there is always the possibility that there could have been activities that were either not documented in primary source documents or communicated via electronic mailing lists.

As stated in the aforementioned premises, it would behoove stewardship agencies and sub-grantees to make public any information that would demonstrate effort. States would be remiss for not informing sub-grantees of HIV prevention and health services and the community-at-large of culturally appropriate education and training opportunities and other activities that would move them "toward improving the lives of the communities their organizations serve" (Reynolds 2004, 246).

DISCUSSION

This section highlights issues relating to significant findings of Phase II as well as several re-occurring

issues, themes and areas of interest that emerged during either or both phases of the project.

Recommendations were made by the researcher and the BAAM for deeply-contemplated issues while other problems require continued discussion, deliberation, support, and community mobilization.

Lastly, the researcher lists several prospective post-doctoral activities to advance cultural competence and proficiency in Public Administration.

Contradictory Claims and Disclaimers

The *Maryland 2004-2008 HIV Prevention Plan* contained several issues warranting further inquiry and explanation.

Firstly, the plan states, "Compared to national AIDS cases, a higher percentage of Maryland cases are African-American (Maryland 81% versus national 48%)" (MD DHMH, AIDS Administration 2007, 7). The plan also acknowledges that, "There continues to be a consistent and disproportionate impact on people of color, especially African Americans" (MD DHMH, AIDS Administration 2007, 12).

Yet when explaining the method used to target prevention interventions, the plan, under the section entitled *Targeting Considerations*, states that "Behavior, not membership in racial groups, puts people at risk for HIV

infection. In addition, CDC requires that prevention programs be targeted, organized, and evaluated by risk factors" (MD DHMH, AIDS Administration 2007, 26).

This disclaimer repudiates the epidemiological correlations of race on the disproportionate impact of HIV/AIDS among Blacks.

To discount the demographic data by magnifying the HIV risk-based data disfavors addressing the problem for those most impacted today, particularly since the HIV/AIDS methodology and hierarchical surveillance system used to access "risk factors" was developed during the primitive years of the epidemic (more than 20 years ago) when, purportedly, very little was known about how the virus replicated or spread, and the virus was only common among White, gay males.

Overhaul of HIV/AIDS Surveillance and Assessment of Risk Language

This underscores the need to revise the CDC hierarchical surveillance risk category system, in consideration of recent epidemiological trend data. Accordingly, the CDC is making progress.

The *2005 HIV/AIDS Surveillance Report* included the following categories to survey adolescents and adults:

injection drug users (IDU); "male-to-male sexual contact,"
"high-risk heterosexual contact," and "other" in commentary
narratives, HIV/AIDS case tables and technical notes (CDC
2007, 5-9, 10-46, 47-52).

However, the term men who have sex with men (MSM) was
still used in narratives (CDC 2007, 6-8), as an umbrella
term to refer to males who have same sex contact (gay men,
bisexual men, non-gay identifying men, and transgender
persons).

The *2008 HIV Surveillance Report* similarly uses the term
male-to-male sexual contact in data tables and the term MSM
in narratives and pie charts and histograms (CDC 2010, 6-
16, 17-116).

Use of behavioral-based terms to more accurately
describe modes of transmission, facilitates objective and
consistent grouping and avoids debatable and personalized
labels, which could invoke deception in customer disclosure
and reporting.

For instance, some men have not accurately reported
engaging in sex with members of the same sex to avoid
labeling and others have falsely reported their risk as IDU
to avoid negative implications of stigmatized sexual
identities, particularly within the Black and
Hispanic/Latino communities.

Consequently, in consideration of new surveillance language and epidemiological trend data that reveal an increase in heterosexual transmission, practitioners must also use culturally and linguistically appropriate language when providing health education and discussing risk reduction with their customers, especially when assessing sexual orientation and behaviors, since: 1) topics related to HIV-acquisition are sensitive in nature 2) the precursors to becoming HIV-positive are, blamelessly, to be human and to have come into contact with the virus (through bodily fluids) 3) unprotected sexual activity is a potential risk regardless of sexual orientation and conjugal status and 4) most humans have the anatomical capacities to engage in the same, or inventively similar, exposure behaviors that are considered to be "risky."

Simply speaking, the condition necessary to contract the HIV is to, be exposed to HIV-infected bodily fluids, and such exposure usually occurs without complete knowledge and within a specific set of socioeconomic variables and circumstances.

For example, risk exposure categories are still defined based upon male sexual orientation (i.e. MSM, heterosexual and "partner of bisexual," used to explain transmission among women) instead of associated behaviors, when, in

203

fact, both men and women alike have the capability to
similarly engage in unprotected oral and anal sex.

Despite this insight, and with evidence of
disproportionate epidemiological increases in HIV/AIDS
among Black women, youth and MSM (Kaiser 2008, 2010), the
HIV surveillance system does not adequately reflect the
diversity of risk behaviors relating to sexual behaviors
regardless of gender and relies upon 1) practitioner
reporting of the perceived sexual identity of customers, 2)
self-reports provided by customers who may deceive those
they do not identify or *connect* with and 3) chart
abstractions that may be unreliable, based upon subjective
interpretations and judgmental errors of field reviewers;
with inter-rater reliability seldom or never measured.

Stalling to Shroud the True Epidemic

Secondly, the HIV Prevention Plan claims that "Maryland
AIDS cases differ from the national cases in terms of
gender, race/ethnicity and mode of exposure. HIV
comparisons are not investigated because national HIV
surveillance information is incomplete at this time" (MD
DHMH, AIDS Administration 2007, 7).

Logically speaking, comparisons could have been made
with the available data compiled from the 42 jurisdictions

that complied with the CDC recommendation to transition to

HIV name-based reporting.

According to the CDC, diagnosis and characteristics data

were available between 2005-2008 from "37 states and five

U.S. dependent areas with confidential name-based HIV

infection reporting" (CDC 2010b, 1).

Additionally, the *Maryland Status Report on the*

Transition to Name-Based HIV Reporting claimed that:

> Although Maryland's coded unique identifier system
> was not required to change, the CDC did not accept
> the State's HIV surveillance information. However,
> since not all states performed HIV surveillance and
> some states, such as Maryland, were using code-based
> reporting, both the CDC and the Health Resources and
> Services Administration (HRSA) utilized AIDS case
> counts submitted by states to the CDC through the
> established AIDS surveillance system in funding
> formulas and subsequent allocations of federal
> funding for HIV prevention and HIV treatment services
> to states and eligible metropolitan areas (EMAs).
> Under this funding methodology, states, including
> Maryland, and eligible metropolitan areas, including
> the Baltimore and Washington metropolitan areas,
> received their proportional share of available funds
> based on estimated living AIDS cases. (MD DHMH, AIDS
> Administration 2009b, 2)

Although confidently stated in the document, this was

not the national plan.

Moreover, since federal funding was commensurate with

the number of AIDS cases and as the epidemic spread among

African Americans (particularly IDU, correctional

recidivists, young persons, those with little or low

income, and others with low political valence), it served as no incentive of the Maryland Ryan White Program to decrease the progression of HIV disease, particularly since health care costs associated with AIDS cases are absorbed through other non-Ryan White funding mechanisms such as Medicaid and Medicare.

Obvious Conundrum for Epidemiological Intervention

Transmission of HIV disease has always been *driven* by men, but has not consistently been framed in terms of male gender role identity, sexuality, socialization, and intra-cultures. Neither have significant discussions been held in ways to solicit continuous input from non-gay identified men.

As early as 1993, Jerome Wright, called for "more research on African American male sexual behavior and the risk for HIV infection" (Whitehead 1997, 411).

Cool Pose in Black male cultures (Majors and Billson 1993, 1-9) contains elements of normalized hyper-masculinity, homophobia, and even cognitive-affective compartmentalization of dissonant beliefs and attitudes in sexual practice and male gender role identity.

Similarly, similar practices and homophobia are evident and normalized among other cultural groups.

Within the Hispanic/Latino community, masculinity or *Machismo* is valued and normal, whereas femininity in men and masculine traits and feminism in women are disparaged.

According to Guillermo Chacon, President of the Latino Commission on AIDS, "The number [one] problem is the stigma associated with HIV and AIDS…. This stigma, which is fueled in part by a rigid Catholic belief system and the machismo ideal of the masculine, domineering head of the household discourages Latinos from getting tested and into care" (Ryan 2010, 36).

In addition, Asian Pacific Islander Americans or (APIA), "discouraged" the "uninhibited expression of sexuality, including homosexuality, bisexuality, and transgenderism" due to the cultural value of procreation or "perpetuating the family line" (Chng and Collins 2000, 26).

In short, this commentary only skims the surface of the impact of male sexuality on the transmission of the HIV, a male-driven and *injective* disease.

Nevertheless, it is a critical piece that has always been under-rated, if not ignored, in the development and sustainment of public health programs to target Black males, in general, and Black men, in particular.

Even though labeled as disproportionate catalysts of HIV disease, only marginal efforts are made to enroll, retain

and re-engage them into health care systems primarily
operated by non-Black males despite critical
epidemiological relevance and attributed stigma.

And, to continue to impose a White, gay sociopolitical
construct to respond to the spread of HIV disease in the
Black Community constitutes a disservice and culturally
destructive practice that has been perpetuated in the State
of Maryland for more than 20 years.

As a result of such continuous sociopolitical approaches
in the State, which do not address the impact of Black male
culture and sexuality on the transmission of HIV disease
and which do not consider the input and representative
norms of groups being impacted, the HIV has become
prevalent among Black women, and soon to be Hispanic/Latino
women, including those of diverse sexual orientation.

But, since viruses mutate as they do, who's to say that
strains that are less concentrated in particular bodily
fluids (i.e. saliva), could, one day, become reportedly
virulent in them and spread among other populations? That's
what viruses do; thrive and mutate under less ideal and
even adverse circumstances.

Be that as it may come to pass, it has not yet been
evidenced that HIV disease is impacting the diverse groups
of *gynephilic* women. Such groups, generally thought to be

far distanced from the sexual practices of males, have not been truly captured in HIV/AIDS surveillance data groups; that is, not yet.

Rachel Rabkin Pechman's interview with Amber Hollibaugh of the Howard Brown Health Center in Chicago revealed that "women who have sex with women" may have "increased risk" for acquiring the HIV due to sharing needles and/or having "sex with men in exchange for housing and food, to care for their children or to satisfy a drug addiction" (Pechman 2009, 26-27).

According to Hollibaugh, "Women who have sex with women fall into a multitude of categories where there is increased risk." She continues, "The reality of the epidemic is that people have complicated crossover degrees of risk" (Pechman 2009, 27).

Desperate Need for Culturally Proficient Approaches

Considering an individual's desire to evade or deny stigmatizing yet reportable risk behaviors of HIV transmission, traditional "monocultural" or "Euro American" approaches to the delivery of health care or models may not be "as appropriate for different cultures" (Reynolds 2004, 239).

Nonetheless, the traditional White gay-centered approach continues to be promulgated by Maryland State stewards, with a sociopolitical approach that promotes, and even influences, Black Americans, including Black youth, to accept, adopt, label themselves, and be "proud" to identify as *gay* or a multiplicity of other identities (e.g. *LGBT*, *LGBTQ*, *questioning*, *transgender*, *queer*, etc.).

Black Americans have reported that adoption of such identities have led, or may lead, to increased ostracism by family and heightened potential for further social and institutional stigmatization.

This may also lead to added disrespect, conflict, and "interpersonal violence and aggression" according to the "code of the streets" (Guy 1994, 81).

In addition, strategies that have been successful for Whites are not proven effective for Black Americans in Maryland.

In-your-face political strategies include: imposition, subtly coerced assimilation, acquiescence bias in research, frequent saturation of promotional campaigns, and diversion away from critical racial-ethnic issues in order to advance gay-centered sociopolitical platforms and agendas.

Such are particularly inappropriate for cultures that elude the publicizing of sexual behaviors, or other

personal or *private* issues, which may lead to further unwarranted slander and defamation, isolation, family and community divisiveness, partner retaliation, and even violence, particularly when controversies are not candidly discussed, disclosed or even considered.

After all, many believe that too much "familiarity breeds contempt" (Aesop 2004, 1).

Not to say that such political strategies are inappropriate for all intra-cultural groups within the Black Community; simply put, they are not appropriate and accepted by most, and therefore, should not take precedence over, or overshadow, the need for more effective and culturally proficient approaches for historically unnoticed and neglected groups of the diverse Black Community; especially during a time of disproportionate, epidemiological impact among heterosexuals and increased incidence among Black women.

Even more alarming, no culturally proficient outreach efforts have been made to reach Black, non-gay androphilic men or bisexual men, "men who identify themselves as homosexuals, as well as those who do not identify as such, but periodically have sex with other men" (Whitehead 1997, 413); those with the propensity to spread the HIV to women.

Thomas and Quinn state, "In addition, [B]lack men who may participate in sex with other men during periods of incarceration or extended military duty return to female sex partners once they go back to their community" (Dula and Goering 1994, 80).

Ironically, the State promotes a curriculum, entitled *Pharaoh*, for Black inmates. The intervention was perceived by some Black intra-cultures as placating, imposing and disaffirming of the cultural norms and values of the target population. Yes, inmates do have values of their own.

Moreover, simply applying *Kente cloth* patterns to, and including *Nguzo Saba* principles on, written educational materials, and then, imposing such values on incarcerated Black populations do not cultural proficiency make. To some, it may even constitute ethical offense.

When testifying in support of *Maryland House Bill 980: HIV Testing, Education, and Treatment for Inmates*, sponsored by Delegates Nathan-Pulliam, Benson, Kullen, Mizeur, and Tarrant, the BAAM ombudsman reiterated:

> Public health messages must be promoted in culturally appropriate ways with language that is affirming of people in the Black Community, including those who are incarcerated, their partners and their families, and surveillance lingo must not be literally included in the delivery of health education. HIV health education must be delivered in an affirming and culturally proficient manner that does not insult, blame or victimize. (BAAM 2007, 1)

To compound matters more, Black American men are not represented in State leadership and decision-making. Notwithstanding, apathetic responses by leadership of local and state HIV/AIDS programs on these issues have been clouded by: 1) articulated disrespect with little to no affinity or concern for Black men; 2) extreme promotion of White feminism with devaluating attitudes toward Black men and their sexual or needle sharing counterparts, namely Black women; and 3) demonstrated continuance to do *business as usual*.

Health Care Access

Based upon the collective experience of the researcher and collaborative community partners of the BAAM, the following issues were identified as barriers or obstacles to health service access in Maryland.

Some of the obstacles and barriers to health care access for newly-diagnosed PLWH/A included customer requirements to: 1) provide initial documentation to determine eligibility; 2) provide repeated proof of eligibility to remain in care 3) complete multiple and intrusive assessments and complicated applications; 4) transition from *discretionary*, Ryan White programs, which are designated as *payor of last resort*, to *non-emergency* health

entitlement programs such as Medicaid, Medicare, Medicare savings programs (QMB and SLMB), and supplemental pharmacy assistance programs; 5) respond to repeated *coordination of benefits (COB)* inquiries; and 6) navigate throughout a system of fragmented, federal and state health and social programs.

These issues have caused many challenges for PLWH/A customers, especially those who are disabled and lack the physical stamina to endure the distress and red tape.

Other complexities include customer housing instability, substance abuse, unresolved mental health issues in addition to the lack of provider competence to serve diverse cultures and competing stakeholder values in prioritizing customer service needs. These also compound the frustration of practitioners, who are obligated to assist their ailing customers to overcome such hurdles.

In addition, stigma continues to be a major problem because many PLWH/A do not access health care, leave care, or do not return to care because of the perceived insult, insensitivity and lack of empathy and compassion.

For these reasons, it becomes critical to measure, monitor and optimize cultural competence to ensure the delivery of culturally proficient care and treatment,

delivered by qualified practitioners in order to minimize customer *fall out*.

PLWH/A customers also expressed institutionalized stigma and patient blaming as a deterrent to health care. Some do not access Ryan White health and support services due to continued stigmatization of HIV disease by health care providers and the community-at-large. Some reported that others have viewed PLWH/A as being "irresponsible" and lacking "respect" for themselves for having been exposed to the HIV through behaviors that conceivably "could have been prevented." Some customers have even stated that clinicians have spoken to them as if they were "deserving" of being infected.

Moreover, many PLWH/A reported a lack of information and publicity on the availability of Ryan White and other health services and a lack of continual, persistent and sustained outreach while providers reported inflated promotional costs of advertising and funding restrictions.

Nevertheless, the BAAM made a recommendation to require promotional activities to be budgeted as a routine business activity in order to target and reach disproportionately HIV-impacted populations; similar to financial planning, resource allocation and marketing costing to achieve health care deliverables for the general population of customers.

215

According to Derald Wing Sue (1991), "Counselors should get out of the office to meet clients in their own home environment (outreach) and to learn that many problems encountered by the culturally different individual reside in institutions. Thus, counselors must learn to intervene in the system (institutions) and act as change agents" (Sue 1991, 99).

In response to the aforementioned issues, the BAAM also recommended promotion of immediate health care access for newly diagnosed and disconnected customers by routinely publicizing availability of services through multiple and strategically placed points of entry into the Ryan White continuum of care as well as other *coordinated* systems of health care.

Misrepresentation in the Media Revisited

Despite Maryland's epidemiological evidence of the rise in HIV disease among African Americans, there have been limited Maryland public service campaigns to inform Blacks on the availability of HIV/AIDS antiretroviral drugs. Those that mentioned or referred to such services lacked cultural appropriateness.

Additionally, nationally promoted campaign messages, such as *"Respect Yourself"* and *"Evolve. Don't Be a Pig,"*

which suggest or prescribe from a negative point of view, may be perceived by PLWH/A to be demeaning, and thus, serve to further alienate prospective customers from health care.

The implications of such messages insinuate that PLWH/A don't respect themselves and that those exposed through unprotected sex or faulty/failed condom use are less than human.

These are just two examples of the many marketing strategies that do more disservice than good.

Other examples of such perpetuated stigma and cultural insensitivity are demonstrated by the stereotypical *Red Ribbon Media Campaign* advertisements, promoted by the State of Maryland (MD DHMH, AIDS Administration, 2002, 1).

Although members of the Black Community reiterated that the ads depicted contradictory and insulting HIV prevention messages and are "offensive," they remain available in the public domain.

To remedy the effects of such stereotypical images, public administrators must promote blameless HIV prevention and treatment messages without negative association and labeling of "risk," according to *risk exposure categories* defined by the CDC-defined, which were developed for surveillance purposes.

11 years with HIV and he can still dunk in your face. Live long. Live strong. Get tested. Call now for free, confidential help.

Figure 8.1: Red Ribbon Campaign Advertisement

What kind of mother could give her baby HIV? An untested one. HIV is one thing you don't have to pass along to your child. Because now there are treatments to avoid it. But you must get tested early. Live long. Live strong. Get tested. Call now for free, confidential help.

Figure 8.2: Red Ribbon Campaign Advertisement

Yet another example of stigma in the media is promotion of the *Down Low* descriptor to refer to Black men.

The term was first popularized in the heterosexual, or *straight*, community by recording artists such as the *girl group*, TLC (1994), and R. Kelly, featuring Ronald Isley (1995), to refer to discreet, or secretive, sexual activity.

The term was quickly adopted as *argot* among Black men *seeking* other men for sex via personal ads in newspapers and the Internet.

The concept has now become semantically sensationalized in the media to solely refer to the sexual identities and behaviors (e.g. infidelity) of Black men, who do not publically profess a *gay* identity yet engage in sex with both men and women. Today, such marginalization is also perpetuated by non-Blacks, who engage in the same behaviors and who may also be ostracized within their respective racial/ethnic groups. However, the term is usually applied when referring to Black men.

This has raised suspicion, distrust and other negative emotions of intimacy among Black women, resulting in further disenfranchisement of Black men from Black women, based upon over-generalized situations.

The term is now customarily used by non-Blacks and Blacks alike to promote a subtle yet generalized misandry, and more particularly, to *demonize* Black men; consequently, victimizing and/or enraging Black women.

Such misrepresentation has been negatively framed in the media and used to induce fear, which causes "splitting" between Black men and women through unwarranted suspicious allegations of distrust and infidelity.

On the other hand, such sensationalized yet isolated cases, impressionistic as they may be, draw attention to the epidemic, such as the case involving a man residing in Florida, who willfully engaged in sex with several women, even though he had been diagnosed with HIV disease.

Consequently, many states have since enacted *willful exposure* laws to guide civil and criminal litigation.

Although such behavior could be perceived as criminal, amoral or immoral, and while on the one hand, some allegations may be merited, on the other hand, it must not become a self-righteous mantra to be projected upon the vast majority of Black male PLWH/A.

However, such racially-targeted dramatization has been over-rated and far too frequently targeted against Blacks, without consideration of: 1) errors in the reporting of heterosexual transmission during the earlier years of

HIV/AIDS; 2) emerging data on heterosexual transmission between Black men and women; 3) the ubiquitous potential of males to infect multiple female (and/or or male) partners; and lastly, 4) irreverent misogamy and acceptance of *de facto polygamy* among intra-cultures of the Black Community.

Disclosure and Breach of Confidentiality

Promotion of customer disclosure of HIV status, medically protected information, has been subtly marketed under the pretense that encouraging PLWH/A to disclose their HIV sero-status to others will help to gain support and decrease the spread of HIV/AIDS.

More specifically, there seems to be an irrational belief among health care professionals that disclosure of patients' HIV statuses benefits public health and will help to slow the spread of HIV disease and garner support. This notion has not been proven.

Even more disconcerting is that practitioners have reported deliberate client exposure to the HIV in exchange for love, affection, sex, money, drugs, to get pregnant, to receive health care, simply "to get off the streets for a night," and/or because HIV antiviral drugs are so readily available that living with HIV/AIDS is no longer perceived as a "death sentence."

221

Consequently, some public health administrators and practitioners have promoted customer disclosure and/or sharing of sero-status and other medical information without a rightful *need-to-know*.

In more extreme instances, practitioners, administrators and members of the community-at-large themselves have reported the willful breach of confidentiality by other administrators and practitioners, some through *hearsay*, and in one reported case, through actual copying, delivery and distribution of medical records throughout a funding agency; a malicious act, committed out of hyper-retaliation against a colleague.

Additionally, offhand violations, even those claimed to be unintentional, are just as liable and demonstrative of practitioner/professional, organizational and systemic incompetence and carelessness.

Consequently, appropriate civil and criminal lawsuits may be filed to vindicate such matters. Whereas most practitioners are familiar and comply with statutes and requirements of the Health Insurance Portability and Accountability Act (HIPAA), which protects patient health information, malfeasance and malpractice are matters most befitting to be resolved in the judicial system, especially in extreme cases.

Additionally, litigation and professional licensure and accreditation authorities have enacted penalties for willful breach of customer information and privacy, leading to exclusion from practice and disbarment; and rightfully so.

Whereas it is, ultimately, at the discretion of the customer to pursue legal vindication or social justice, over the past seven years, the researcher, serving as Volunteer Ombudsman for the BAAM, has maintained a journal of such occurrences (as reported by customers and practitioners) of HIV health services in Maryland for the purpose of providing aggregate-level information on such unethical practices to be rectified.

Other Ethical Issues

Another complaint of the Black Community has been State promotion of token programs to camouflage unresponsiveness to issues proclaimed by the Black Community.

Despite protests from members of the BAAM and the extended Black Community, the Administration continued to *sole source* funds for research projects, under the disguise of obtaining evidence to further HIV prevention and care.

Such egregious procurement activities have been perpetuated by bureaucrats who have historically served as

adversaries to culturally proficient interventions in the Black Community; cronyism and cultural destructiveness at its best.

Because of perceived unfairness in State funding allocation processes, such sole sourced research projects continue to elicit community distrust and are considered a waste of public funds since such funds were not equitably or competitively availed to communities with vested interest.

Rightfully doing so could have ensured for culturally proficient and vigorous research methods, robust data, and generalizability of results to intra-cultural groups within the Black Community.

Moreover, such unfair and fraudulent procurement magnifies the prejudices of the organizational culture in selecting sub-grantees as well as the unwillingness to truly partner and collaborate with culturally proficient organizations that are most qualified, credentialed and experienced in implementing collaborative approaches within the Black Community to target Black populations.

In essence, a few *bad pennies* have oppositionally represented the State through stonewalling funding practices as well as illegitimate and marginal distribution of federal funds to serve the Black Community.

Moreover, it is not sufficient to over-generalize about groups, provide prescriptive instruction on working with cultural groups, and promulgate *best practices* for groups based upon social research that is flawed in design and methodology and without significant statistical application and findings.

Such studies, conducted in impoverished, urban neighborhoods, may also provide repeated monetary inducements. Yet results may never be explained in terms of convenience sampling, inducements or limitations in generalizing outcomes.

From an ethical point of view, such conveniently located research laboratories and methods may be considered questionable, if not unconscionable. Yet, findings are published and disseminated as fact.

Despite such claims, analyses of HIV/AIDS surveillance data continue to reveal that Blacks are currently, disproportionately, more likely to become infected, even though behaviors are similar, if not the same, as non-Blacks.

Conclusion

For all the aforementioned reasons, it is crucial that practitioners recognize the mutually destructive impact of

devaluing cultural beliefs at the expense of advancing sociopolitical agendas to gain or retain resources.

Imposing ethnocentric values under the pretense of caring, or even more cunningly, under the guise of human rights advocacy on behalf of those who have that much more to lose, has become commonplace even though unjustifiably deceitful.

Cultural beliefs and norms and rules are intrinsic to cultures and should be seriously considered and respected when discussing socioeconomic and political issues as well as dynamics of equality pertaining to race, ethnicity, gender, and sexual freedom and diversity. Campaigns designed or imposed from a xenophobic and/or ethnocentric point of view (and their implications) must be considered in terms of the specific challenges, cultural tenets and respective applicability to the diverse, communities for which they are to be provided.

Pretentiously developing interventions that do not actually benefit the populations and communities being served should be discarded.

Future Activities to Advance the Field of Public Health Administration

Richard J. Stillman III (1999) also states that "public administration theory will undoubtedly remain confused,

complex, and unresolved for some time to come until such big questions are resolved." In confronting emerging challenges, practitioners can "advance the art and science of public administration" by creating new, innovative and comprehensive approaches by pulling from various theories and approaches (Stillman 1999, 238).

For all the identified issues and the aforementioned reasons, this body of work, a work in action, continues to serve as a catalyst to incite community activism and scholarly response as well as future research prospects.

Future data collection and analysis may include additional anecdotal and narrative source data obtained from informal focus groups and unstructured interviews, especially since advocacy, activism and whistleblowing, oftentimes, involve employment discomfort, uncertainty and fear of retaliation. These anonymous research venues have already provided a safe environment for disclosure and high threshold for authenticity.

But more importantly, the development and utilization of *The Capacity Building Model* shall lead to several output and outcome-related activities/studies including, but not limited to, the following recommendations.

Immediate Advancement of the Field of Public Administration in Health Care

- Magnification of the ambiguity of the term cultural competence, particularly in HIV prevention and health services.
- Expansion of the definition of the term cultural proficiency.
- Introduction of a tabular lexicon for culturally proficiency and clarification of language used in the discussion of cultural proficiency (i.e. intra-cultural substituted for sub-cultural, customer usurpation or *usury*).
- Clarification of misperceptions regarding what cultural proficiency *is* and what it *is not*.
- Advocacy for the shift toward a cultural proficiency paradigm shift.
- Increased discussion on cultural proficiency as an ideal goal of cultural competency in Public Administration, including:
  - Opportunities to actively participate in public administration braintrust and roundtable discussions.
  - Opportunities to actively participate in multidisciplinary, task forces on cultural proficiency, with a focus on increasing organizational and systems capacity in public administration to improve the delivery of culturally appropriate services.

Theory into Practice: Inciting Much Needed Change through Community Mobilization

- Refinement of the *Community Mobilization Logic Model for Organizational and Systems Accountability*.
- Development of additional case study scenarios to encourage ethical contemplation and decision-making in Public Administration.
- Development of a toolkit with visual schematics, including a fundamental means-objectives hierarchy, means-objectives network and influence diagram, to structure "logical frameworks" and "the various decision elements—decisions and alternatives, uncertain events and outcomes, and consequences," to be actually used in Public Administration decision-making processes (Clemen and Reilly, 2001, 43-52).

- Development of a toolkit with schemas, fundamental means-objectives hierarchy, means-objectives network and influence diagram for advocates, activists, elected officials, and community members to use to heighten awareness, encourage change in attitudes and mobilize the community to address unresolved issues (i.e. advocacy and action to facilitate change in the exacerbating spread of HIV/AIDS in the State of Maryland).
- Further revision of *The Capacity Building Model* to assist Public Administration and other professional practitioners to translate theory into practice (i.e. program implementation).

Future Advancement in the Field of Public Administration

- Development of a comparable monograph to guide a paradigm shift toward culturally proficient public administration and oversight of programs.
- Development of operational definitions of *cultural proficiency* with measurable goals, objectives, performance indicators, and proxy measures. These are to be developed based upon issues facing Black Americans in consideration of regionalism and local culture.
- Development of *The Cultural Proficiency Code of Ethics for Public Administration Practitioners*.
- Search for funding for additional inquiry, study and research to corroborate and/or challenge assumptions made in this paper.
- Additional research and studies to include the following:
  - Quantitative research to compare service utilization outcomes of providers of HIV care and treatment that promote cultural proficiency within organizations for staff and programs with those providers that do not promote cultural proficiency.
  - Quantitative research to compare service utilization outcomes of providers of HIV care and treatment that promote cultural competence within organizations for staff and programs with those providers that promote cultural proficiency.
  - Qualitative research to compare client satisfaction of providers of HIV treatment that promote *cultural proficiency* within organizations for staff and programs with those providers that do not promote cultural proficiency.

- Qualitative research to compare client satisfaction of providers of HIV treatment that promote *cultural competence* within organizations for staff and programs with those providers that promote cultural proficiency.
- Qualitative research to determine the change in attitudes of Public Administration practitioners who utilize *The Capacity Building Model*.

Further development of the model may include traditional, qualitative social research since qualitative research "confronts a changing historical world, new intellectual positions, and its own institutional and academic conditions" (Denzin and Lincoln 2000, 8).

According to Erik Blas and Anand Sivasankara Kurup, editors of Equity, *Social Determinants and Public Health Programmes* and authors of Chapter 14 entitled, *Synergy for Equity*, "The competence base of programmes in relation to social determinants needs to be strengthened. In the short term this can be done through changing the incentive structure of programmes, including with regard to how results are measured and valued" (Blas and Kurup 2010, 279).

This work in action is full of values since it has involved, and will continue to involve, a participatory advocacy approach, laden with values of humanistic and civil accountability for parity, integrity and decency. The project has inspired the researcher to collaborate with

leaders of the Black Community, and through community

mobilization, hold stewards of public funding accountable

in the delivery of HIV prevention and treatment programs,

while collectively demanding effectiveness and

responsiveness.

During this process, the researcher utilized knowledge

acquired during matriculation at the University of

Baltimore to conceptualize elements of cultural proficiency

and develop visual tools to inspire public administrators

and practitioners, elected officials, community

stakeholders, and consumers of HIV health services to: take

action, facilitate change, raise the bar of cultural

competence, and advocate for a paradigm shift toward

cultural proficiency.

The researcher summarizes cultural proficiency as

imperative to public administrator conduct when serving the

community, especially when officiating programs on behalf

of unfamiliar cultures. Because of this, the researcher

also recommends the development of a *Cultural Proficiency*

Code of Ethics in Public Administration.

In the words of the Spokesperson of the BAAM!!!!!!!,

Robin Hamlett,

> HIV risk behaviors and risk categories (target
> populations) are defined by the CDC for surveillance
> purposes. However, HIV disease is a public health

issue that must be viewed and treated as a medical condition without overemphasizing and sensationalizing risk behaviors and targeted populations because correlating HIV risk behaviors with designated groups and presenting HIV disease as strictly a behaviorally-acquired illness allows people to compare themselves out of risk categorization when, in fact, the only precursor to HIV infection is to be human. (BAAM 2007, 1)

More current advances in HIV prevention and education shall include underscoring basic understanding of epidemiology, human behavior and culture; and not negatively framing and sensationalizing moralistic concepts of infidelity and risk-taking.

In addition, the *call* in public administration is to stop the promotional and systemic, health care prophecy that Blacks are predestined to be unhealthy and prone to acquiring any and all diseases and move toward a health care system of accountability, designed to "encourage the growth of a community of medical ethicists whose analyses embody an ethic of caring and respect for all groups, a responsibility to condemn unjust medical practices, and a humility and an empathy regarding human suffering, which in the end transcends all cultural and racial prejudices and differences" (Dula & Goering 1994, 8).

REFERENCES

Alba, Richard. 2009. *Blurring the color line: The new chance for a more integrated America*. Cambridge: Harvard University Press.

American Psychiatric Association. 2000. *Diagnostic and statistical manual of mental disorders, text revision (DSM-IV-TR)*. Arlington, VA: American Psychiatric Publishing, Inc.

Anderson, Elijah. 1994. The code of the streets. *The Atlantic Monthly*: May, 81-94.

Arendt, Hannah. 2006. *Eichmann in Jerusalem: A report on the banality of evil*. New York: NY. Penguin Group (USA) Inc.

Arthur, Thomas E., Iris Reeves, Oscar Morgan, Naomi C. Booker, Llewellyn J. Cornelius, Janice Brathwaite, Teresa Tufano, Kim Allen, and Irma Donato. 2005. Developing a cultural competence assessment tool for people in recovery from racial, ethnic and cultural backgrounds: The journey, challenges and lessons learned. *Psychiatric Rehabilitation Journal* 28(3):243-50.

Back, Les and John Solomos, eds. 2009. *Theories of race and Racism: A reader*. New York, NY: Routledge.

Baltimore City Commission on HIV/AIDS. 2006. *Interim Report 2005, HIV/AIDS in Baltimore: An Ongoing emergency*. Baltimore: Baltimore City Council.

Barrera Isaura and Robert M. Corso. 2003. Cultural competency as skilled dialogue. *Topics in Early Childhood Special Education* 22(2):103-13.

Bazeley, Pat. 2007. *Qualitative data analysis with NVivo*. Los Angeles: Sage Publications.

Bazeley, Pat and Lyn Richards. 2000. *The NVivo qualitative project book*. London: Sage Publications.

Betancourt, Joseph R., Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park. 2005. Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs* 24(2):499-505.

Black AIDS Action Movement!!!!!!! 2007. Testimony in support of house bill 980: HIV Testing, education, and treatment for inmates. Testimony presented during the Maryland General Assembly, Annapolis, MD.

Blas, Erik, and Sivasankara Kurup, eds. (2010). *Equity, social determinants and public health programmes*. Switzerland: World Health Organization.

Box, Richard C. 2005. *Critical social theory in public administration*. Armonk, New York: M.E. Sharp, Inc.

Calhoun, Craig. 1995. *Critical social theory: Culture, history, and the challenge of difference*. Cambridge, MA. Blackwell Publishers.

Carter, Robert T. 2003. Becoming racially and culturally competent: The racial-cultural counseling laboratory. *Journal of Multicultural Counseling and Development* 31 (January): 20-30.

Chen, Moon S. 2000. Informal care and the empowerment of minority communities: Comparisons between the USA and the UK. *Ethnicity & Health* 4(3):139-51.

Chng, Chwee L. 2000. Providing culturally competent HIV prevention programs. *American Journal of Health Studies* 16(1):24-33.

Clemen, Robert T., and Terence Reilly. 2001. *Making hard Decisions: With DecisionTools*. Pacific Grove, CA: Brooks/Cole.

Cohen, Elena P. 2003. Framework for culturally competent decisionmaking in child welfare. *Child Welfare League of America* 82(2):143-55.

Conley, Dalton, ed. 2003. *Wealth and poverty in America: A reader*. Malden, MA: Blackwell Publishing.

Cox, Taylor, Jr. 2001. *Creating the multicultural organization: A strategy for capturing the power of diversity*. San Francisco: Jossey-Bass.

Creswell, John W. 2003. Research design: *Qualitative, quantitative, and mixed methods approaches*. Thousands Oaks, CA: Sage Publications, Inc.

Cross, Terry L., Barbara J. Bazron, Karl W. Dennis, and Mareasa R. Isaacs, (with the assistance of the Portland Research and Training Center for Improved Services to Severely Emotionally Handicapped Children and Their Families. 1989. *Towards a culturally competent system of care (Volume 1): A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: National Technical Assistance Center for Children's Mental Health Georgetown University Child Development Center.

De Maio, Fernando. 2010. *Health and social theory*. New York, NY: Palgrave MacMillan (St. Martin's Press, LLC).

Delgado, Richard, and Jean Stefancic. 2001. *Critical race theory: An introduction*. New York: New York University Press.

Denzin, Norman K., and Yvonna Lincoln, S., eds. 2000. *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications, Inc.

Denzin, Norman K., Yvonna Lincoln, S., and Linda Tuhiwai Smith, eds. 2008. *Handbook of critical and indigenous methodologies*. Thousand Oaks, CA: Sage Publications, Inc.

Dévieux, Jessy G. 2004. Cultural competent care: A strategic imperative. *The ABNF Journal* (November/December): 107-8.

Dula, Annette, and Goering, Sara, eds. 1994. *"It just ain't fair": The ethics of health care for African Americans*. Westport, CT: Praeger.

Falk, Gerhard. 2001. *Stigma: How we treat outsiders*. Amherst, NY: Prometheus Books.

Farmer, Paul. (2005). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley and Los Angeles, CA: University of California Press.

Farmer, Paul (1992). *AIDS & accusation: Haiti and the geography of blame*. Berkeley and Los Angeles, CA: University of California Press.

Flick, Uwe. 1998. *An introduction to qualitative research: Theory, method and applications*. London: Sage Publications, Inc. Quoted in Denzin and Lincoln 2000, 7.

Fowler, Kellie. 2004. PTs confront minority health and health disparities. *Physical Therapy Magazine*, no. 5:42-7.

Frow, John and Meaghan Morris, eds. 1993. *Australian cultural studies: A reader*. Urbana and Chicago: University of Illinois Press.

Gerald, Gil, and Kai Wright. 2007. *We're the ones we've been waiting for: The state of AIDS in Black America… and what we're doing about it*. Los Angeles: Black AIDS Institute.

Gibran, Kahlil. 1989. *The prophet*. New York, NY: Alfred A. Knopf, Inc.

Grossberg, Lawrence, Cary Nelson, and Paula A. Treichler, eds. 1992. Cultural studies. New York: Routledge.

Hassett, Patricia. 2005. Taking on racial and ethnic disparities in health care: The experience at Aetna. *Health Affairs* 24(2):417-420.

Heydt, Margo J., and Nancy E. Sherman. 2005. Conscious use of self: Turning the instrument of social work practice with cultural competence. *The Journal of Baccalaureate Social Work Program Directors* 10(2)25-40.

Johannes, Christopher K., and Philip G. Erwin. 2004. Developing multicultural competence: Perspectives on theory and practice. *Counseling Psychology Quarterly* 17(3)329-38.

Koestler, Arthur. 1967. The ghost in the machine. New York, NY: The Macmillan Company.

Lemert, Charles, ed. 2010. *Social theory: The multicultural and classic readings*. Boulder, CO: Westview Press.

Majors, Richard and Janet Mancini Billson. 1993. *Cool pose: The dilemmas of Black manhood in America*. New York, NY: Touchstone.

Martorell, Paco and Isaac McFarlin, Jr. Forthcoming. Help or hindrance: The effects of college remediation on academic and labor market outcomes. *The Review of Economics and Statistics*.

Matus, Justin C. 2004. Strategic implications of culturally competent care. *The Health care Manager* 23(3):257-61.

Nelson, Cary, Paula A. Treichler, and Lawrence Grossberg. 1992. *Cultural Studies: An Introduction*. New York: Routledge. Quoted in Denzin and Lincoln 2000, 7.

Norton, Watt S. 2004. Culture, ethnicity, race: What's the difference? *Paediatric Nursing* 16(8):37-42.

Pechman, Rachel Rabkin. 2009. Lesbians with HIV. *POZ: Living,* June, 26-7.

Powers, Charles H. 2010. *Making sense of social theory: A practical introduction*. Lanham. MD: Rowman & Littlefield Publishers, Inc.

Qualitative Solutions for Researchers (QSR) International. 2008a. *Starting to work with your material*. Doncaster, Melbourne, Victoria, Australia: QSR International Pty Ltd.

---. 2008b. *Moving on in NVivo 8: Exploring, visualizing and sharing your material*. Doncaster, Melbourne, Victoria, Australia: QSR International Pty Ltd.

Razack, Sherene. 1998. *Looking white people in the eye: Gender, race, and culture in courtrooms and classrooms*. Toronto: University of Toronto Press.

Reynolds, Duane. 2004. Improving care and interactions with racially and ethnically diverse populations in healthcare organizations. *Journal of Healthcare Management* 49(4):237-49.

Rice, Mitchell F. 2006. Cultural competency: A missing framework for contemporary public administration and public service delivery. Paper prepared for presentation and distribution at the Fifth Annual Social Equity Leadership Conference, hosted by The College of Public Affairs and Community Service, The University of Nebraska-Omaha.

---. 2009. Changing demographics, diversity, cultural competency, and public administration in the United States. Lecture prepared for presentation at the School of International Relations and Public Affairs, Fudan University, Shanghai, China.

Richards, Lyn. 2005. *Handling qualitative data: A practical guide*. Los Angeles: SAGE.

Rogers-Adkinson, Diana L., Theresa A. Ochoa, and Bernadette Delgado. 2003. Developing cross-cultural competence: Serving families of children with significant Developmental needs. *Focus on Autism and Other Developmental Disabilities* 18(1):4-8.

Ryan, Benjamin. 2010. La vida Latina: Stigma, belief systems, and other cultural differences can combine to create formidable obstacles—but barriers can be torn down. *HIV Plus*, September/October, 33-9.

Ryan, Gery W., and H. Russell Bernard. 1999. *Data Management and Analysis Methods*. Quoted in Denzin and Lincoln 2000, 772.

Sabatier, Paul A., ed. 1999. *Theories of the policy process: Theoretical lenses on public policy*. Boulder, CA: Westview Press, a Member of the Perseus Books Group.

Saldaña, Johnny. 2009. *The coding manual for qualitative researchers*. Los Angeles: SAGE.

Seidman, Steven. 2008. *Contested knowledge: Social theory today*. Malden, MA: Blackwell Publishing.

Shelby, Tommie. 2005. *We who are dark: The philosophical foundations of black solidarity*. Cambridge: The Belknap Press of Harvard University Press.

Sidelinger, Dean E., Dodi Meyer, Gregory S. Blaschke, Patricia Hametz, Milagros Batista, Rachel Salguero, and Vivian Reznik. 2005. Communities as teachers: Learning to deliver culturally effective care in pediatrics. *Pediatrics* 115 (4), (April):1160-4).

Smedley, Audrey. 2007. *Race in North America: Origin and evolution of a worldview*. Boulder: Westview Press.

Smiley, Tavis. 2006. *The covenant with Black America*. Chicago: Third World Press.

Smith, Philip and Alexander Riley. 2009. *Cultural theory: An introduction*. Malden, MA: Blackwell Publishing.

Stevenson, Howard, Jr. 1994. The psychology of sexual racism and AIDS: An ongoing saga of distrust and the "sexual other." *Journal of Black Studies* 25(1):62-80. Sage Publications, Inc.

Stillman, Richard J., III. 1999. *Preface to public administration: A search for themes and directions*. Burke, VA: Chatelaine Press.

Straube, Trenton. 2010. Homophobia, the church and AIDS. *POZ: Health, Life and HIV,* September, 35-9.

Straw, Barry M. and Robert I. Sutton. 2001. *Research in organizational behavior: an annual series of analytical essays and critical reviews. Volume 23.* Kidlington, Oxford OX5 1GB, UK: Elsevier Science Ltd.

Sue, Derald Wing. 1991. A model for cultural diversity training. *Journal of Counseling & Development* 70(September/October): 99-105.

Tehranian, John. 2000. Performing Whiteness: naturalization litigation and the construction of racial identity in America. *The Yale Law Journal* 109 (4):817-31.

Thomas, Gail E., ed. 1995. *Race and ethnicity in America: Meeting the challenge in the 21st Century*. Washington, DC: Taylor & Francis.

University of Chicago. 2003. *The Chicago manual of style: The essential guide for writers, editors, and publishers*. 15th ed. Chicago: University of Chicago Press.

Vinh-Thomas, Patricia, Megan M. Brunch, and Josefina J. Card. 2003. A research-based tool for identifying and strengthening culturally competent and evaluation-ready HIV/AIDS prevention programs. *AIDS Education and Prevention* 15(6):481-98.

Whitehead, Tony. 1997. Urban low-income African American men, HIV/AIDS, and gender identity. *Medical Anthropology Quarterly* 11(4):411-47. American Anthropological Association.

Whyte, William Foote, ed. 1991. *Participatory action research*. Newbury Park, CA: Sage Publications, Inc.

Williams, Raymond. 1959. *Culture & society: 1780-1950*. London: Chatto & Windus Ltd.

Wilson, Deborah W. 2004. Cultural diversity: What do we fear? *Diversity in Health and Social Care*, no. 1:145-50.

Wilson, Phill, Kai Wright, and Michael T. Isbell. 2008. *Left behind: Black America: A neglected priority in the global AIDS epidemic*. Los Angeles: Black AIDS Institute.

Electronic Resources

Aesop. 2004. Page By Page Books: Read Books Online for Free.
   The fox and the lion. Page By Page Books.
   http://www.pagebypagebooks.com/Aesop/Aesops_Fables/The_Fox_an
   d_the_Lion_p1.html
   (accessed September 28, 2010).

Andrulis, Dennis, Thomas Delbanco, Laura Avakian, and Yoku
   Shaw-Taylor. n.d. Conducting a cultural competence self-
   assessment. http://erc.msh.org/provider/andrulis.pdf
   (accessed May 26, 2008).

American Medical Student Association (AMSA). 2005. Cultural
   competency in medicine.
   http://www.amsa.org/programs/gpit/cultural.cfm
   (accessed November 2, 2005).

---. 2008. Cultural competency in medicine.
   http://www.amsa.org/programs/gpit/cultural.cfm
   (accessed May 26, 2008).

Associated Press. 2007. Race and Ethnicity on MSNBC.Com.
   Maryland issues apology for its role in slavery: Lawmakers
   make state the second to express 'profound regret' for
   practice.
   http://www.msnbc.msn.com/id/17813609/
   (accessed September 26, 2010).

Baum, Fran, Colin MacDougall, and Danielle Smith. 2006.
   Participatory action research. *Journal of Epidemiology
   and Community Health* 60:854-857.
   http://jech.bmj.com/cgi/reprint/60/10/854.pdf
   (accessed May 25, 2008).

Betancourt, Joseph R., Alexander R. Green, and J. Emilio
   Carrillo. 2002. Field report. Cultural competence in health
   care: Emerging frameworks and practical approaches. The
   Commonwealth Fund.
   http://www.commonwealthfund.org/usr_doc/betancourt_culturalco
   mpetence_576.pdf
   (accessed October 5, 2010).

Centers for Disease Control and Prevention. National Center for
    HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2007.
    HIV/AIDS surveillance report: Cases of HIV infection and AIDS
    in the United States and dependent areas, 2005. (Revised
    2007). 17:1-54. U.S. Department of Health and Human Services.
    http://www.cdc.gov/hiv/topics/surveillance/resources/reports/
    2005report/pdf/2005SurveillanceReport.pdf
    (accessed May 18, 2008).

---. 2008. Maryland-2007 profile. U.S. Department of Health and
    Human Services.
    http://www.cdc.gov/nchhstp/stateprofiles/Maryland/Maryland Pr
    ofile.htm
    (accessed May 18, 2008).

---. 2010a. HIV/AIDS surveillance report: Diagnoses of HIV
    infection and AIDS in the United States and dependent areas,
    2008. 20:1-143. U.S. Department of Health and Human Services.
    http://www.cdc.gov/hiv/surveillance/resources/reports/2008rep
    ort/index.htm
    (accessed June 28, 2010).

---. 2010b. HIV/AIDS surveillance report: Tables 1a-1b.
    Diagnoses of HIV infection, by year of diagnosis and
    selected characteristics, 2005–2008—37 states and 5 U.S.
    dependent areas with confidential name-based HIV infection
    reporting, 2008. 20:1-2. U.S. Department of Health and
    Human Services.
    http://www.cdc.gov/hiv/surveillance/resources/reports/2008rep
    ort/table1a.htm
    (accessed August 21, 2010).

---. 2010c. Summary of changes to the national HIV surveillance
    Report. July 2010. U.S. Department of Health and Human
    Services.
    http://www.cdc.gov/hiv/topics/surveillance/resources/qa/pdf/s
    ummary changes.pdf
    (accessed September 19, 2010).

Centers for Medicare & Medicaid Services. 2006. Emergency
    Medical Treatment & Labor Act (EMTALA). U.S. Department
    of Health and Human Services.
    http://www.cms.hhs.gov/EMTALA/
    (accessed October 1, 2008).

Chang, Alicia. 2010. Yahoo News. NASA Deep Impact spacecraft
    flies by small comet. 2010. Associated Press.
    http://news.yahoo.com/s/ap/20101105/ap on sc/us sci comet enc
    ounter/print
    (accessed November 5, 2010).

Continental Congress. 1776. The unanimous declaration of
    the thirteen United States of America. The Library of
    Congress: American Memory.
    http://memory.loc.gov/cgi-
    bin/query/r?ammem/bdsdcc:@field(DOCID+@lit(bdsdcc02101))
    (accessed March 22, 2008).

Exum, Nathaniel, Britt, Gwendolyn, Conway, Joan Carter, Frosh,
    Brian E.,   Gladden, Lisa A., Jones, Verna L., Madaleno,
    Richard S., Jr., McFadden, Nathaniel J., Muse, C. Anthony,
    Pugh, Catherine E. 2007. Senate joint resolution 6.
    http://mlis.state.md.us/2007RS/bills/sj/sj0006e.pdf
    (accessed September 26, 2010).

Fullilove, Robert E. 2006. African Americans, health
    disparities and HIV/AIDS: Recommendations for
    confronting the epidemic in Black America. National
    Minority AIDS Council.
    http://www.sfaf.org/files/site1/asset/fullilove-nmac-
    report.pdf
    (accessed May 26, 2008).

Health Services Resources Administration. 2007. Cultural
    competence resources for health care providers. U.S.
    Department of Health and Human Services.
    http://www.hrsa.gov/culturalcompetence/curriculumguide/chapte
    r3.htm.
    (accessed February 5, 2007)

Health Services Resources Administration. HIV/AIDS Bureau.
    2002. Providing HIV/AIDS care in a changing environment.
    HRSA Care ACTION (August):1-8.
    http://hab.hrsa.gov/publications/august2002.htm
    (accessed May 28, 2008)

Health Resources and Services Administration. Bureau of
    Health Professionals. 2008a. Programs>Diversity>Other
    definitions of cultural competency. U.S. Department of
    Health and Human Services.
    http://bhpr.hrsa.gov/diversity/cultcomp.htm
    (accessed March 18, 2008).

---. 2008b. Programs>Diversity>Other definitions of
    cultural competency. Health careers opportunity program
    definitions. U.S. Department of Health and Human
    Services.
    http://bhpr.hrsa.gov/diversity/definitions.htm#Cultural%20Com
    petence
    (accessed March 18, 2008).

The Henry J. Kaiser Family Foundation. May 2008. HIV/AIDS
    policy fact sheet: Black Americans and HIV/AIDS.
    http://www.kff.org/hivaids/upload/6089 05.pdf
    (accessed May 18, 2008).

---. September 2009. HIV/AIDS policy fact sheet: Black
    Americans and HIV/AIDS.
    http://www.kff.org/hivaids/upload/6089-07.pdf
    (accessed September 18, 2010).

---. 2010a. Statehealthfacts.org: Your source for state health
    Data. Estimated rates (per 100,000 population) of AIDS
    diagnoses, adults and adolescents, by race/ethnicity, 2008.
    http://www.statehealthfacts.org/comparetable.jsp?ind=847&cat=
    11&sub=120&yr=63&typ=3&rgnhl=22
    (accessed September 18, 2010).

---. 2010b. Estimated numbers of AIDS diagnoses, all ages, by
    race/ethnicity, cumulative through 2008
    http://www.statehealthfacts.org/comparetable.jsp?ind=844&cat=
    11
    (accessed September 18, 2010).

---. 2010c. Maryland: Estimated number of persons living with an
    AIDS diagnosis, all ages by race/ethnicity, 2007.
    http://www.statehealthfacts.org/profileind.jsp?ind=848&cat=11
    &rgn=22
    (accessed September 18, 2010).

---. 2010d. Maryland: Estimated numbers of AIDS diagnoses, all
    ages by race/ethnicity, 2008.
    http://www.statehealthfacts.org/profileind.jsp?ind=846&cat=11
    &rgn=22
    (accessed September 18, 2010).

---. 2010e. Maryland: Estimated number of persons living with an
    AIDS diagnosis, all ages by race/ethnicity, 2008.
    http://www.statehealthfacts.org/profileind.jsp?ind=844&cat=11
    &rgn=22
    (accessed September 18, 2010).

---. 2010f. Maryland: Estimated rates (per 100,000 population)
    of AIDS diagnoses, adults and adolescents, by race/ethnicity,
    2008.
    http://www.statehealthfacts.org/profileind.jsp?ind=847&cat=11
    &rgn=22
    (accessed September 18, 2010).

---. 2010g. Maryland: Population.
    http://statehealthfactsonline.org/profileind.jsp?cat=1&sub=1&
    rgn=22
    (accessed October 1, 2010).

---. 2010h. Total HIV/AIDS federal funding, FY2008.
    http://www.statehealthfacts.org/comparetable.jsp?ind=528&cat=
    11
    (accessed September 18, 2010).

The Lewin Group, Inc. (Prepared for the Health Resources
    and Services Administration. 2001a. Health Resources and
    Services Administration study on measuring cultural
    competency in health care delivery settings. Section I:
    Introduction. U.S. Department of Health and Human
    Services.
    http://www.hrsa.gov/culturalcompetence/measures/default.htm
    (accessed March 21, 2008).

---. 2001b. Health Resources and Services Administration
    study on measuring cultural competency in health care
    delivery settings. Section II: Conceptualizing cultural
    competence and identifying critical domains. U.S.
    Department of Health and Human Services.
    http://www.hrsa.gov/culturalcompetence/measures/sectionii.htm
    (accessed March 21, 2008).

---. 2001c. Health Resources and Services Administration study on measuring cultural competency in health care delivery settings. Section III: Overview of the Measurement Framework and Identification of Specific Measures for Cultural Competence. U.S. Department of Health and Human Services. http://www.hrsa.gov/culturalcompetence/measures/sectioniv.htm (accessed March 21, 2008).

---. 2001d. Health Resources and Services Administration study on measuring cultural competency in health care delivery settings. Section IV: Conclusion. U.S. Department of Health and Human Services. http://www.hrsa.gov/culturalcompetence/measures/sectioniv.htm (accessed March 21, 2008).

Maryland Department of Health and Mental Hygiene (MD DHMH), AIDS Administration. 2002. Decline in New HIV Cases in Northwest Baltimore. Baltimore, MD: DHMH. http://www.dhmh.maryland.gov/AIDS/Data&Statistics/reportProjects.htm (accessed September 18, 2010).

---. 2005. Ryan White Title II 2006-2008 comprehensive HIV services plan. Baltimore, MD: DHMH. http://www.dhmh.state.md.us/AIDS/Data&Statistics/2006-2008%20MD%20Comprehensive%20Plan%20for%20HIV%20Services.pdf (accessed July 31, 2010).

---. 2007. Maryland's comprehensive HIV prevention plan, 2004-2008. Baltimore, MD: DHMH. http://www.dhmh.state.md.us/AIDS/reports/StatewidePriorities.pdf (accessed July 31, 2010).

---. 2008. Maryland HIV/AIDS epidemiological profile, fourth quarter 2007-data reported through December 31, 2007. Baltimore, MD: DHMH. http://www.dhmh.maryland.gov/AIDS/Data&Statistics/NewMDQtrEpi.pdf (accessed September 19, 2010).

---. 2009a. Ryan White Part B statewide coordinated
    statement of need (SCSN). Baltimore, MD: DHMH.
    http://www.dhmh.state.md.us/AIDS/ProviderResources/Treat&Care
    /Maryland200SCSN1509.pdf
    (accessed July 31, 2010).

---. 2009b. Status report on the transition to name-based
    HIV reporting. Baltimore, MD: DHMH.
    http://dhmh.md.gov/AIDS/Data&Statistics/108 AIDS Name-
    based%20Reporting Signed%2001-16-09 OGA 797.pdf
    (accessed July 31, 2010).

Maryland Department of Health and Mental Hygiene (MD DHMH).
    Infectious Disease and Environmental Health Administration
    (IDEHA). 2009. IDEHA memo to community partners regarding
    departmental reorganization. Received via the Maryland AIDS
    Prevention Listserv by E-Mail (MAPLE). Baltimore, MD: DHMH.

Maryland Department of Health and Mental Hygiene (MD DHMH).
    Infectious Disease and Environmental Health Administration
    (IDEHA). Center for HIV Surveillance and Epidemiology. 2010.
    Maryland HIV/AIDS epidemiological profile, fourth quarter
    2009-data reported through December 31, 2009. Baltimore, MD:
    DHMH.
    http://www.dhmh.state.md.us/AIDS/Data&Statistics/MarylandHIVE
    piProfile122008.pdf
    (accessed September 19, 2010).

Maryland Department of Health and Mental Hygiene (MD DHMH).
    Office of Minority Health. (2006). Maryland plan
    to eliminate health disparities: A healthier future for
    all Marylanders 2006-2010. Baltimore, MD: DHMH.
    http://www.dhmh.state.md.us/hd/pdf/MDPlantoEliminateHealthDis
    paritiesPreliminary2006.pdf
    (accessed July 31, 2010).

McTaggart, Robin. 1989. 16 tenets of participatory action
    research. The Caledonia Centre for Social Development.
    http://www.caledonia.org.uk/par.htm
    (accessed March 27, 2011).

Microsoft Corporation. 2006. Microsoft Professional Office 2007
    Upgrade Software (Word 2007, Excel 2007, Outlook 2007).
    Part No. X12-49229-01. Redmond, WA: Microsoft Corporation.
    http://www.mircosoft.com/office/
    (accessed November 15, 2007).

National Association of School Psychologists. 2003.
    Defining cultural competence.
    http://www.nasponline.org/resources/culturalcompetence/02 DEF
    INING CULTURAL 52F.doc
    (accessed February 7, 2007)

National Association of Social Workers. 2007. Indicators
    for the achievement of the NASW standards for cultural
    competence in social work practice.
    http://www.naswdc.org/practice/standards/NASWCulturalStandard
    sIndicators2006.pdf
    (accessed March 16, 2008).

National Center for Cultural Competence. 2002. A guide to …
    planning and implementing cultural competence,
    organizational self-assessment (Winter):1-6. Georgetown
    University.
    http://www11.georgetown.edu/research/gucchd/nccc/documents/nc
    ccorgselfassess.pdf
    (accessed February 4, 2007).

National Center for Cultural Competence. 2007. Foundations
    of cultural & linguistic competence. Georgetown
    University.
    http://www11.georgetown.edu/research/gucchd/nccc/foundations/
    assessment.html
    (accessed May 26, 2008).

Obama, Barack. "A More Perfect Union." Keynote address,
    Constitution Center, Philadelphia, PA, March 18, 2008.
    http://my.barackobama.com/page/content/hisownwords
    (accessed May 26, 2008).

O'Brien, R. 2001. Um exame da abordagem metodológica da pesquisa ação [An overview of the methodological approach of action research]. In Roberto Richardson (ed.), *Teoria e Prática da Pesquisa Ação* [*Theory and Practice of Action Research*]. João Pessoa, Brazil: Universidade Federal da Paraíba. (English version) Available: http://www.web.net/~robrien/papers/arfinal.html (accessed March 26, 2011).

Office of the High Commissioner for Human Rights (OHCHR). 1996-2005. Universal declaration of human rights. http://www.unhchr.ch/udhr/lang/eng.htm (accessed March 22, 2008).

Office of the President of the United States. 2010. National HIV/AIDS Strategy for the United States. Office of National AIDS Policy. http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf (accessed September 5, 2010).

Qualitative Solutions for Researchers (QSR) International. 2010. NVivo 8 Software. Doncaster, Melbourne, Victoria, Australia: QSR International Pty Ltd. http://download.qsrinternational.com/Software/NVivo8/NVivo8.exe (accessed March 30, 2010).

Quinn, Thomas C. 2001. The global HIV pandemic: Lessons from the past and glimpses into the future. The Hopkins HIV Report. http://www.aegis.com/pubs/jhopkins/2001/JH20010104.html (accessed April 2, 2011)

Social Security Administration. 2008. Compilation of the Social Security laws: Including the Social Security Act, as amended, and related enactments through January 1, 2007. http://www.ssa.gov/OP_Home/ssact/title18/1867.htm (accessed October 1, 2008).

Srinivas, Hari. 2010. Participatory action research: A menu of methods. The Global Development Research Center (GDRC). (accessed March 27, 2011).

The Sullivan Commission. September 2004. Missing persons: Minorities in the health professions. A report of the Sullivan Commission on diversity in the healthcare workforce. http://www.aacn.nche.edu/Media/pdf/SullivanReport.pdf (accessed October 1, 2010).

United States Census Bureau. 2010a. American FactFinder. Geographic Comparison Table. Maryland—County. GCT-P6. Race and Hispanic or Latino 2000. Data Set 2000 Summary File 1 (SF1). 100-PercentData. http://factfinder.census.gov/servlet/GCTTable? bm=y&-geo id=04000US24&-ds name=DEC 2000 SF1 U&- lang=en&-redoLog=false&-format=ST-2&-mt name=DEC 2000 SF1 U GCTP6 ST2&-CONTEXT=gct (accessed September 19, 2010).

---. 2010b. State & County QuickFacts. Baltimore (city), Maryland. http://quickfacts.census.gov/qfd/states/24/2404000.html (accessed September 19, 2010).

---. 2010c. State & County QuickFacts. Maryland. http://quickfacts.census.gov/qfd/states/24000.html (accessed September 19, 2010).

University at Albany. 2011. Public Administration & Policy Master of Public Administration Program. Admissions. State University of New York. http://www.albany.edu/graduatebulletin/public admin policy mp a degree.htm (accessed March 30, 2011).

Wright, Kai. ed. 2006. AIDS in Blackface: 25 years of an epidemic. Black AIDS Institute. http://www.blackaids.org/docs/6 06 25 years.pdf (accessed April 2, 2011)

Sound Recordings

Kelly, Robert S. "Down Low," 1995. *R. Kelly*, Jive. Audio Cassette, ASIN, B00000053D.

TLC ("T-Boz" Watkins, Lisa "Left-Eye" Lopes, Rozonda "Chilli" Thomas). "Creep," 1994. *CrazySexyCool*, LaFace Records. Audio Cassette, ASIN: B001TFNUIE.