NEW PERSPECTIVES ON KNOWLEDGE, ATTITUDES AND PRACTICES IN HEALTH pdf

1: Cass County Today â€“ A Service of KAQC TV

This book focuses on new research in understanding knowledge, attitudes and practices in health around the globe. Advances in medicine as well as computers and electronics have made possible remarkable gains in our understanding of diseases on all levels from the theoretical to the clinical.

Sexual orientation and military service: A social science perspective. American Psychologist, 48 5 , Since , the policy of the U. Department of Defense has been that homosexuality is incompatible with military service. This article reviews the social science literature relevant to such a discussion. Empirical data suggest that lesbians and gay men are not inherently less capable of military service than are heterosexual women and men; that prejudice in the military can be overcome; that heterosexual personnel can adapt to living and working in close quarters with lesbian and gay male personnel; and that public opinion will be influenced by the way this issue is framed. Any change in policy should be accompanied by strong measures to prevent harassment and violence against lesbians and gay men, educate heterosexual personnel, and enforce uniform policies regarding all forms of sexual harassment. Considerations relevant to a new policy that does not discriminate on the basis of sexual orientation are discussed. You can request a reprint via e-mail. Back to bibliography Herek, G. Results from a national survey. The Journal of Sex Research, 30 3 , When asked whether any friends or relatives had "let you know that they were homosexual," approximately one-third of the respondents gave an affirmative answer. Regression analyses indicated that interpersonal contact predicted attitudes toward gay men better than did any other demographic or social psychological variable included in the equation. Interpersonal contact was more likely to be reported by respondents who were highly educated, politically liberal, young, and female. The data indicate that interpersonal contact is strongly associated with positive attitudes toward gay men and that heterosexuals with characteristics commonly associated with positive attitudes are more likely than others to be the recipients of disclosure from gay friends and relatives. Documenting prejudice against lesbians and gay men on campus: The Yale Sexual Orientation Survey. Journal of Homosexuality, 25 4 , College and university communities recently have begun to confront the problems of harassment, discrimination, and violence against lesbians, gay men, and bisexual people on campus. A first step in responding to attacks against gay and bisexual people is to document their frequency and the forms that they take. The present article reports the methodology and results of a survey conducted at Yale University in , which subsequently has been replicated on several other campuses. The Yale survey revealed that lesbians, gay men, and bisexual people on campus lived in a world of secretiveness and fear. Although experiences of physical assault on campus were relatively infrequent, many respondents reported other forms of discrimination and harassment. A majority reported that they feared antigay violence and harassment on campus, and that such fears affected their behavior. Replications on other campuses have yielded similar results. Suggestions are offered for researchers who wish to conduct such a survey on their own campus. A copy of the report on which this paper is based in PDF format can be downloaded from this site. Special attention is paid to the stigma that so closely accompanies HIV disease in the United States. Among the questions considered are whether AIDS attitudes are unidimensional or consist of multiple domains; whether AIDS attitudes in different domains have the same social psychological antecedents; whether these relationships are similar among different demographic groups; what psychological functions are served by AIDS attitudes; and how antigay prejudice combines with other factors to affect public reactions to AIDS. Data are presented from focus groups conducted in different cities and towns in the United States, as well as a national telephone survey. Conspiracies, contagion, and compassion: Trust and public reactions to AIDS. AIDS educational programs can be effective only to the extent that they are perceived as credible by their target audiences. In this study, public trust associated with AIDS was assessed in a national telephone survey. African Americans were more likely than Whites to express distrust of doctors and scientists concerning HIV transmission through casual contact, to believe that AIDS is being used as a form of genocide

against minority groups, and to believe that information about AIDS is being withheld from the public. Individuals high in distrust did not differ from those low in distrust in their exposure to AIDS information. Higher levels of AIDS-related distrust were not related to self-reported personal risk reduction, but were related to inaccurate beliefs about HIV transmission through casual contact and greater willingness to avoid and stigmatize people with AIDS. The importance of overcoming distrust in AIDS education programs is discussed. The Journal of Sex Research, 32 2 , The current article reports findings from a two-wave telephone survey with a national probability sample of Black heterosexual adults. Results indicated that negative attitudes toward homosexuality are widespread, but do not appear to be more prevalent among Blacks than among Whites. The single most important predictor of attitudes was the attribution of choice to sexual orientation: Consistent with previous research in predominantly White samples, respondents were more likely to express favorable attitudes if they were highly educated, unmarried, politically liberal, registered to vote, not religious, and if they included Blacks in their concept of gay men. In addition, respondents reported more favorable attitudes if they had experienced personal contact with gay men or lesbians, but this was not a significant predictor of attitudes when other variables were statistically controlled. A pre-publication version of the paper in PDF format can be downloaded from this site. You can also request a reprint via e-mail. Identity and community among gay and bisexual men in the AIDS era: AIDS, identity, and community: The HIV epidemic and lesbians and gay men pp. This chapter reports data from two studies conducted in with gay and bisexual men from the greater Sacramento CA metropolitan area to identify principal predictors of high-risk sexual behaviors and various aspects of psychological functioning. Among the findings were: Men who were out of the closet, had positive feelings about their sexual orientation, and felt a sense of community with other gay and bisexual men were more likely to have the beliefs and attitudes that foster HIV risk reduction. A pre-publication version of the chapter in PDF format can be downloaded from this site. Some of the scales and measures used in this study are posted to the web site. Personality and Social Psychology Bulletin, 22 4 , At Wave 1, heterosexuals reporting interpersonal contact At Wave 2, these findings were generally replicated for attitudes toward lesbians as well as gay men. Cross-wave analyses suggest a reciprocal relationship between contact and attitudes. Theoretical and policy implications of the results are discussed, with special attention to the role of interpersonal disclosure in reducing stigma based on a concealable status. Effects of direct and vicarious contact. Journal of Applied Social Psychology, 27 1 , Data are presented from a 2-wave national telephone survey with a probability sample of U. Some differences between the general population sample and the Black oversample were observed in the relative impact of direct and vicarious contact. Implications of the findings for reducing AIDS stigma are discussed. Hate crime victimization among lesbian, gay, and bisexual adults: Prevalence, psychological correlates, and methodological issues. Journal of Interpersonal Violence, 12 2 , Although violence based on sexual orientation is now widely recognized as a serious problem in the United States, social science data concerning the prevalence and consequences of such crimes are limited. In the present study, questionnaire data about victimization experiences were collected from lesbians, gay men, and bisexuals 74 females, 73 males in the Sacramento CA area. In addition, 45 of the respondents participated in a follow-up interview. Forty-one percent reported experiencing a bias-related criminal victimization since age 16, with another 9. The distribution of bias-related victimization and harassment experiences in the sample resembled patterns reported in other U. Compared to other respondents, bias-crime survivors manifested higher levels of depression, anxiety, anger, and symptoms of post-traumatic stress. Methodological and substantive issues in empirical research on hate crimes against lesbians and gay men are discussed. Correlates of internalized homophobia in a community sample of lesbians and gay men. Journal of the Gay and Lesbian Medical Association, 2, To systematically assess internalized homophobia and its correlates among gay men and lesbians. A measure of internalized homophobia IHP was administered to a community sample of lesbians and gay men, along with measures of psychological well-being, outness, and perceptions of community. For lesbians and gay men alike, internalized homophobia was associated with less self-disclosure to heterosexual friends and acquaintances and less sense of connection to the gay and

lesbian community. Lesbians and gay men with the highest IHP scores also manifested significantly more depressive symptoms and higher levels of demoralization than others, and high-IHP men manifested lower self-esteem than other men. IHP scores were not associated with disclosure to parents or the recency of developmental milestones for either lesbians or gay men. A conceptual framework and research agenda. Although widely recognized as a problem, AIDS stigma has not been extensively studied by social and behavioral scientists. Empirical research is urgently needed in this area, however. Data are especially needed to inform government leaders, health providers, and the general public as they debate new policies concerning HIV treatment, prevention, and monitoring. The workshop, co-chaired by Gregory Herek and Leonard Mitnick of NIMH, was designed to promote consideration of empirical research and theory-building that would have both basic and applied scientific significance, including implications for policymakers and opinion leaders. The paper provides a conceptual framework for understanding AIDS stigma, and proposes a basic research agenda. A pre-publication version of the report in PDF format can be downloaded from this site. Symbolic prejudice or fear of infection? A functional analysis of AIDS-related stigma among heterosexual adults. Basic and Applied Social Psychology, 20 3 , Using responses to the Attitude Functions Inventory AFI , respondents were categorized according to the dominant psychological function served by their attitudes: Negative affect toward a person who contracted AIDS through homosexual behavior, support for mandatory testing of so-called high-risk groups, and support for other punitive AIDS policies were predicted mainly by attitudes toward gay men for heterosexuals with expressive attitudes but not for those with evaluative attitudes, a pattern labeled functional divergence. Behavioral intentions to avoid persons with AIDS in various hypothetical situations were predicted primarily by beliefs about contagion for heterosexuals with expressive and evaluative attitudes alike, a pattern labeled functional consensus. Implications for AIDS education and for research based on the functional approach to attitudes are discussed. Effects of source, message, receiver, and context. American Journal of Community Psychology, 26,

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2: Perspectives - In Health Information Management

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December 1, Context Jordan has begun to consider a strategy of targeting men for family planning services. Methods A cross-sectional survey was conducted among a convenience sample of men whose wives delivered in three hospitals in Amman in About two-thirds of respondents knew of male contraceptives, but a similar proportion did not know where to get information about them. Attitudes toward birthspacing and contraceptive use were more positive among men with at least a secondary education and among those with a higher income than among their less-educated and less well-off counterparts. Conclusions Culturally sensitive family planning services designed specifically for men in Jordan would increase their involvement in contraceptive use. International Family Planning Perspectives, , 24 4: Most large-scale family planning surveysâ€”the knowledge, attitudes and practice surveys; the World Fertility Surveys; the Contraceptive Prevalence Surveys; and the first round of the Demographic and Health Surveys DHS 1 â€”included only women and focused on determinants of their contraceptive use. The lack of attention to men in surveys probably reflected their limited options for participating in contraceptive use. Moreover, strengthening communication between partners about reproductive health and involving men in health promotion can lead to better health for the entire family. A key recommendation of both the International Conference on Population and Development and the Fourth World Conference on Women was that programs encourage husbands and wives to share in responsibilities pertaining to fertility and reproductive health. In Jordan, where husbands are the main decision-makers in the family, their attitudes and practices regarding contraception have become a major concern of the National Population Committee JNPC , which has begun to consider a strategy of targeting men for family planning services. It covers an area of approximately 90, square kilometers and shares borders with Israel, Syria, Iraq and Saudi Arabia. A predominantly Islamic country, Jordan has been directly affected by most of the political events, as well as economic events, that have reverberated through the region in recent decades. Four in five households are urban; nearly two-thirds are in the region that includes the capital, Amman. More than four-fifths of adults have had at least a primary education, and about one-third have at least completed secondary school. Additionally, as a result of political and economic events of recent decades, a huge number of migrants and refugees from Palestine and the Arabian Gulf have made their way to Jordan. Nevertheless, the average family size, while declining somewhat, has remained high 6. Furthermore, the findings revealed that the majority of husbands in Jordan held negative attitudes toward contraception and had no desire to regulate their fertility. Men aged had higher approval rates than other age-groups. When asked about the degree to which they concurred with seven attitudinal statements about outcomes of family planning use, men who had ever used a method recorded significantly more positive views than never-users. The survey results also indicated that communication between partners is significantly associated with contraceptive use; male current users were twice as likely as never-users to have discussed contraception with their wives. Potential respondents had to have at least one other child; every third eligible man was asked to participate. After giving written or, if they preferred, oral informed consent, participants were interviewed by a specially trained male doctor or male nurse. The questionnaire was designed for the study and was tested on a sample of 20 men who were excluded from the final sample in early February It is important to note that the sample is not representative. Jordan University Hospital is the largest teaching hospital in the country and is a referral center for complicated cases. Al-Basheer is the largest governmental hospital; Royal Medical Services is the second-largest, serving mainly military personnel. Therefore, it is reasonable to assume that these men share many characteristics with the general population of men residing in Amman, particularly those using the same health services. It is evident from these responses that men see a number of drawbacks to having large families

Table 2. Mean scores were calculated for the 15 attitude statements, with higher means indicating higher levels of agreement. These findings are congruent with those from earlier, nationwide surveys. This suggests that policymakers should undertake initiatives to expand male services and encourage greater use of male contraceptives. Subsequently, contraceptive education programs that address youth at the school level should be initiated. While this finding is similar to results of another Jordanian study, 22 it does not necessarily mean that couples reach a decision together, because men in Jordan as in most Arab countries are seen as the main decision-makers in the family. The effect of religion on issues pertaining to family communication should also not be ignored. Men, in particular, are interested in religious programs and are concerned about the acceptability of various contraceptive methods within the religious law. The JNPC has undertaken such a program, but its effectiveness has not yet been evaluated. Future research should examine attitudes about birthspacing and contraceptives in greater detail, including husbands and wives simultaneously. A further limitation is that, as mentioned earlier, the results are not widely generalizable. Yet, the main findings from this survey are consistent with results from the national JNPC survey. Drennan M, Reproductive health: Ringheim K, Factors that determine prevalence of use of contraceptive methods for men, Studies in Family Planning, , 24 2: Drennan M, , op. Jordanian Department of Statistics, Jordanian Department of Statistics, , op. Information, Education and Communication Project, Johns Hopkins Center for Communication Programs, , op. Marshal J, Acceptability of fertility regulating methods: El-Deeb B et al. The Final Report, Amman: Jordanian Population Commission, Jordanian National Population Commission, , op. The research upon which this article is based was funded by the Deanship of Academic Research at the University of Jordan, Amman.

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3: Publications | Measurement and Change (MAC) Lab

A first step toward increasing men's participation in reproductive health is to understand their knowledge, attitudes and practices regarding a range of issues.

Abstract Background For many years, reflection has been considered good practice in medical education. In public health PH , while no formal training or teaching of reflection takes place, it is expected as part of continuous professional development. This paper aims to identify reflective models useful for PH and to review published literature on the role of reflection in PH. The paper also aims to investigate the reported contribution, if any, of reflection by PH workers as part of their professional practice. Methods A review of the literature was carried out in order to identify reflective experience, either directly related to PH or in health education. Free text searches were conducted for English language papers on electronic bibliographic databases in September Thirteen papers met the inclusion criteria and were reviewed. Results There is limited but growing evidence to suggest reflection improves practice in disciplines allied to PH. No specific models are currently recommended or widely used in PH. Conclusions education , employment and skills , models Background The practice of public health PH is a science as well as an art. The Faculty of Public Health provides direction and guidance to enable the development of professionals and establish competencies that specify behaviour, skills and attitudes. The Faculty encourages professionals to reflect as part of essential practice. However, the mere experience of carrying out some developmental activity may not be sufficient to enable future improvements and thus many medical specialities encourage their practitioners to reflect on their experiences. In practice, the cognitive aspects are most easily measured through assessments or performance, while the emotional and social aspects may be less easily captured. Frameworks of reflection could support the development of both these dimensions. The cycle of learning comprises four elementsâ€”a concrete experience, an observation and reflection, formation of abstract concepts and testing in new situations. However, in its simplified form, the learning cycle will begin by carrying out a task, the person would reflect on that experience and apply the learning in a new situation. In order to apply experience to the new situation, the ability to generalize through identifying principles and their connections to actions over a range of circumstances is required. Throughout the process, learners rate themselves which is an important element for adult learners 8 and could be considered relevant for continuous professional development. In his work, Donald Schon 9 concludes that the possible objects for reflection can be as varied as the situations faced and the systems in which they occur. However, as a speciality on the whole, PH has focused heavily on quantitative measures for evaluation. The purpose of this paper is to describe the development of a framework for learning to reflection for individuals as well as for teams and to identify approaches to guide continuous professional development. This paper describes how this could be implemented and used in everyday work to enable professional development. The search terms used were evidence-based practice, research evidence, medical education, qualitative research, reflective practice, reflection and evidence. Other sources included handpicking of books on evidence-based practice, reflection and research. Full texts of potentially relevant articles were obtained. Papers were identified for inclusion in the review by examination of full text articles. Data relating to characteristics of the population, intervention, outcome measures, study design and outcomes were collected. Inclusion criteria Papers written in English only were included. Articles pertaining to reflection in or on practice in PH or related disciplines were included. Documents published between and were included. Peer- and non-peer-reviewed publications were considered. Exclusion criteria Articles that included reflection as by-product rather than the main focus were excluded. Non-English language publications were excluded. Results Electronic searches yielded over citations. Further citations were obtained by hand searching of reference lists. More than 20 full articles were retrieved and assessed against the set inclusion criteria. Of the five papers included in this review, none were from PH, two from nursing and two from other allied health professions or other education literature. One further model was included from non-health background. The

search did not find evidence that particular frameworks were in regular use in current PH practice. The search identified educational concepts from the literature which could be applied to PH. Several approaches to reflection were found. While none of these were linked directly to PH practice, their use in medicine was referenced. The literature discussed here were selected on relevance and focused on the synthesis on framework, service-based learning and mentorship. These are questions which the reflector can answer during the reflective process. Boud describes three main components to considerâ€"experience, reflection and outcome. The experience can be a behaviour, ideas or feelings. The reflection will include returning to the experience, attend to feelings that it brought about and a re-evaluation of the experience. The outcome will look at new perspectives, changes to behaviour and an application of learning into practice. This would be followed by conclusions where other options are considered and reflection upon experience to examine what one would do if the situation arose again. The evaluation component describes what was good and not so good about the experience. The analysis should identify what sense can be made of the situation and the conclusion details of what else could have been done. The process of reflection is ended with an action plan for what could be done if the situation arose again. Atkins and Murphy 5 through their model suggest that for reflection to have a real effect it needs to be followed by an action commitment. The authors describe a cycle of awareness, description, analysis, evaluation and learning. The reflective process begins with the awareness of uncomfortable feelings and thoughts from the action or new experience followed by a description of the situation including thoughts and feelings. This would need to include salient events and key features identified by the reflector. The reflector would need to analyse feelings and knowledge relevant to the situationâ€"identifying knowledge, challenging assumptions, imagining and exploring alternatives. The reflection process would also need to include evaluation and consolidating learning. Evaluate the relevance of knowledge through asking questions includes the following: These steps would be followed by identifying any learning which has occurred. After-action review is a de-brief process in practice originally developed by the US army which aims to identify how to improve, maintain strengths and focus on performance of specific objectives. The de-brief manual provides guidance for individuals and group reviews. What was supposed to happen? Why were they different? What did we I learn? Discussion Main findings There is no published evidence of the use of particular models of reflection in PH practice. The general medical education literature contains various approaches to reflection. There are a variety of theories on reflection in the education literature. The implication this brings to individual PH practitioners is to consider when and how they will reflect as part of their continuous learning cycle. In addition, whether the act of reflection should be done alone or as part of a team or both will need to be established. As a discipline that has focused less on reflection in the past it is possible to draw on theories and models already existent and in use within medicine. There are a range of ways to reflect which include methods like journal writing, discussions and use of technology such as blogs. Ultimately, the aim of reflection would be to improve practice and learn from relevant experiences. It is obvious that this comes from being an analytical reflector and moving beyond pure description. In broader learning terms, it is also useful to consider the relevance of prior experience. Reflection enhances personal development by leading to self-awareness. Often action takes place across multi-sectoral teams and involves multi-phased interventions. Programme delivery is often longer term, should be population focused and policy led. The learner involvement is a key fundamental principle of adult education. PH CPD and the reflection that forms part of it can be viewed in light of adult education as individuals need to take ownership and engage in setting their learning agenda. Reflection can be used as a tool to facilitate professionals to assess beliefs, values and approaches to practice. Adult learners are more likely to believe and instil ideas that they help create. The environment can provide many structured activities that generate the ideas, concepts or techniques if an active decision to do so is taken. The practitioner could then experience surprise, puzzlement or confusion associated with the situation. Reflecting on the phenomena that is being experienced and prior understanding which have implicated, the resulting behaviour will lead the learner to new understanding. These factors, however, could be equally applied to other domains of PH as they will include policy,

professional and societal influences examples of external factors and attitudes, skills, experiences and team dynamics examples of internal factors. A positive impact was noted through reflective journal writing over only scientific report writing for those studying biology. In studies of mathematics students, while reflection was not necessary for high grades of achievements, it supported better conceptualization of meanings of the technical definitions. This is already considered important within health promotion. One can argue that this approach of reflecting on an issue is too straight forward and, in practice, difficult issues may take months to reflect on. Doing so quickly might lead to a paper exercise. Explicit frameworks may not be suitable for some situations. Frameworks vary in their focus of contexts. However, they are aimed to be critical analyses of knowledge and experience to deepen understanding. Time, motivation, initial expertise and lack of peer support are recognized barriers to reflection. To add to this are organizational contexts and team dynamicsâ€”frequent problems faced by PH professionals. What does this report add? There are very few articles relating the use of reflection to current PH practice and furthermore on the strengths and weaknesses of different models that could be applied.

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4: Selected Abstracts

We examined factors associated with health care provider attitudes and practices related to 'Quick Start' provision of combined hormonal contraception (CHC) and depot medroxyprogesterone acetate (DMPA) to adolescents.

National, regional, or other geographical area Ownership of property Socioeconomic status Why is it important to be culturally competent? We are all connected through the increasing globalization of communications, trade, and labor practices. Changes in one part of the world affect people everywhere. Considering our increasing diversity and interconnected problems, working together seems to be the best strategy for accomplishing our goals. Because social and economic change is coming faster and faster, organizations are understanding the need for cultural competence. Studies show that new entrants to the workforce and communities increasingly will be people of color, immigrants, and white women because of differential birth rates and immigration patterns. There are many benefits to diversity, such as the rich resource of alternative ideas for how to do things, the opportunity for contact with people from all cultures and nationalities that are living in your community, the aid in strategizing quick response to environmental change, and a source for hope and success in managing our work and survival. Increases respect and mutual understanding among those involved. Increases creativity in problem-solving through new perspectives, ideas, and strategies. Decreases unwanted surprises that might slow progress. Increases participation and involvement of other cultural groups. Increases trust and cooperation. Helps overcome fear of mistakes, competition, or conflict. For instance, by understanding and accepting many cultures, everyone is more likely to feel more comfortable in general and less likely to feel the urge to look over their shoulders to be sure they are being "appropriate" in majority terms. Promotes inclusion and equality. When does an organization need to become culturally competent? An organization needs to become culturally competent when there is a problem or crisis, a shared vision, and a desired outcome. An organization is ready to become culturally competent when groups and potential leaders that will be collaborating have been identified, the needs of the cultural groups are identified, the organization knows what was done before and how it affected the groups involved, and the organization is open to learning and adapting to better fit current needs. How do you create a culturally competent organization? Indicators of cultural competence: Creating multicultural organizations makes us deal with differences and use them to strengthen our efforts. To reach these goals you need a plan for action. But support from the top should be part of it. Getting everyone to "buy in" can be aided with a committee representing all levels in an organization. Such a committee can establish and facilitate the following action steps. If people at all organizational levels are involved more people are likely to be influenced to become more culturally competent. Identify the cultural groups to be involved who needs to be involved in the planning, implementation, and reinforcement of the change? Identify barriers to working with the organization what is currently not working? What will stop you or slow you down? Assess your current level of cultural competence what knowledge, skills, and resources can you build on? Where are the gaps? Identify the resource needed how much funding is required to bring about the change? Where can you find the resources? Develop goals and implementation steps and deadlines for achieving them who can do what, when, and how? Commit to an ongoing evaluation of progress measuring outcomes and be willing to respond to change what does progress and success look like? What are the signs that will tell you that the organization is on the right track? How to begin building a multicultural organization Form a committee. This Cultural Competence Committee CCC within your organization should have representation from policy making, administration, service delivery, and community levels. The committee can serve as the primary governing body for planning, implementing, and evaluating organizational cultural competence. Write a mission statement. The CCC should be involved in developing this statement. Find out what similar organizations have done and develop partnerships. Other organizations may have already begun the journey toward developing and implementing culturally competent systems. Meet with these organizations, pick their brains, and see if they will continue to

work with you to develop your cultural competence. Then adapt the processes and information that are consistent with your needs to your organization. Aggressively pursue and use information available from federally funded technical assistance centers that catalog information on cultural competence. Do a comprehensive cultural competence assessment of your organization. Determine which instruments best match the needs and interests of your organization. Use the assessment results to develop a long-term plan with measurable goals and objectives to incorporate culturally competent principles, policies, structures, and practices into all aspects of your organization. Among others, this may include changes in your mission statement, policies, procedures, administration, staffing patterns, service delivery practices, outreach, telecommunications and information dissemination systems, and professional development activities. Find out which cultural groups exist in your community and if they access community services. What are the cultural, language, racial, and ethnic groups within the area served by your organization? Then find out if these groups access services and if they are satisfied with what they get. Have a brown bag lunch to get your staff involved in discussion and activities about cultural competence. The object of this get-together is to get your staff members to think about their attitudes, beliefs, and values related to cultural diversity and cultural competence. Invite a guest speaker. Ask your personnel about their staff development needs. Assign part of your budget to staff development programming in cultural competence. Analyze your budget to see where there are opportunities for staff development through participation in conferences, workshops, and seminars on cultural competence. Then commit to provide ongoing staff training and support for developing cultural competence. When you are asking the staff to come together to discuss their attitudes, beliefs, and values related to cultural diversity and competence, consider an outside expert facilitator. Someone might get offended. Include cultural competency requirement in job descriptions. Cultural competency requirements should be apparent from the beginning of the hiring process. Discuss the importance of cultural awareness and competency with potential employees. Be sensitive to the fact that certain seating arrangements or decor might be appropriate or inappropriate depending upon the cultural group. Be aware of communication differences between cultures. For example, in many racial and ethnic groups, elders are highly respected, so it is important to know how to show respect. Collect resource materials on culturally diverse groups for your staff to use. There are many free online resources, as well as printed materials. Visit the library and talk with people at similar organizations to learn about resources. Build a network of natural helpers, community "informants," and other "experts. Effective organizations must do strategic outreach and membership development. Your organization should set ground rules that maintain a safe and nurturing atmosphere. And the structure and operating procedures that you set should reinforce equity. For example, create leadership opportunities for everyone, especially people of color and women. Your organization should engage in activities that are culturally sensitive or that directly fight bias and domination by the majority culture. Is an excellent source of information about working in diverse organizations. Vision and context It can take time and effort for groups with historically negative relationships to trust each other and begin to work together effectively. A common problem is cultural dominance and insensitivity. Frequently, people of color find that when they are in the minority in an organization, they are asked to teach others about their culture, or to explain racism and oppression -- rather than everyone taking an active part in educating themselves. In organizations where white people are the majority, people of color may be expected to conform to white standards and to be bicultural and bilingual. This accommodation takes enormous energy to sustain. Members of a culturally competent organization do not approach fellow members with stereotypical attitudes or generalize about an entire people based on an experience of one person. Involve and include people from all cultures in the process of developing a vision for the organization. It can also minimize real or perceived tokenism, paternalism, and inequality among the people who join later. Recognize that changing the appearance of your membership is only the first step in understanding and respecting all cultures. Develop and use ground rules that establish shared norms, reinforce constructive and respectful conduct, and protect against damaging behavior. Encourage and help people to develop qualities such as patience, empathy, trust, tolerance, and a

nonjudgmental attitude. Diversity training Become aware of the cultural diversity of the organization. Try to understand all its dimensions and seek the commitment of those involved to nurture cultural diversity. Address the myths, stereotypes, and cultural differences that interfere with the full contribution of members. Diversity trainings are typically one-time events. It is important to have other strategies that will reinforce and sustain behavioral and policy changes. Organizational structure and operating procedures Share the work and share the power. Create systems that ensure equity in voice, responsibility, and visibility for all groups. The usual hierarchy with a group or leader in charge may create a power inequity, so create a decision-making structure in which all cultural groups have a voice at all levels. Find ways to involve everyone using different kinds of meetings, such as dialogue by phone, mail, or e-mail. Structure equal time for different groups to speak at meetings.

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5: Survey Seeks Workplace Drug Abuse Knowledge - Inside INdiana Business

Although it is much more difficult to design programs aimed at changing social norms and personal attitudes than ones to increase knowledge, simply knowing which attitudes and norms are associated with risky behavior may help program and policy planners craft sexual and reproductive health messages for young people.

May 8, DOI: METHODS Data related to unintended pregnancy risk were collected from a nationally representative sample of 1, unmarried women and men aged 18â€”29 surveyed by telephone in Among those at risk of unintended pregnancy, multiple logistic regression was used to assess associations between contraceptive knowledge, norms and attitudes and selected risky contraceptive behaviors. RESULTS More than half of young men and a quarter of young women received low scores on contraceptive knowledge, and six in 10 underestimated the effectiveness of oral contraceptives. Given the demonstrated link between method knowledge and contraceptive behaviors, such programs may be useful in addressing risky behavior in this population. American women in their late teens and 20s have higher rates of unintended pregnancy than do women in any other age-group. For example, in , rates of unintended pregnancy varied between 71 and per 1, women aged 19â€”29, but only between 22 and 46 per 1, women aged 15â€”17 or 30â€” The survey was based on a theoretical framework of variables expected to affect pregnancy prevention intentions and behaviors using a model 2 that integrated key components from four major health behavioral theories. BACKGROUND A great deal of research has examined associations between contraceptive behaviors and different combinations of variables; Jaccard has summarized the plethora of studies examining characteristics associated with contraceptive use. Moreover, nationally representative data typically include only measures for background characteristics and a few attitudinal or normative measures. Therefore, most studies looking at contraceptive or reproductive health knowledge have been based on small, localized samples, with the exception of analyses of the National Longitudinal Study of Adolescent Health. In part, this may reflect variation in how knowledge has been measured: Some studies have based it on receipt of sex education, 9â€”11 and some have assessed actual knowledge, typically through a series of true-or-false items. One study found that, compared with teenagers with high perceived knowledge about sex, those with low perceived knowledge were less likely to be sexually experienced, and among teenagers who were sexually experienced, those with low perceived knowledge were more likely to engage in risky contraceptive practices. The survey was designed by the authors and other Guttmacher Institute researchers under contract with the National Campaign to Prevent Teen and Unplanned Pregnancy, and fieldwork was conducted by the Field Research Corporation. Initial survey findings have been reported elsewhere. For the landline sample, two mutually exclusive strata were created: The targeted stratum comprised households with listed telephone numbers and a higher than average probability of having an eligible unmarried 18â€”year-old as determined on the basis of known and inferred demographic data from commercial databases , and a complementary stratum consisted of the remaining households that could be reached via random-digit dialing. The landline sample also included substrata in which black and Hispanic households were oversampled. Because the cell phone sample could not be targeted by age or other social and demographic characteristics, it consisted of a single stratum; this sample was purchased from and designed with the Marketing Systems Group. More than , telephone numbers were sampled and dialed; of these, nearly 50, were found to be nonhousehold numbers. We screened 66, households, identified about 4, with a likely eligible resident and confirmed eligibility for 3, In total, 1, respondents completed interviewsâ€” females and males. At the beginning of each call, respondents were informed that their answers would be confidential, that the survey covered sensitive topics, and that they could skip questions or end the interview at any point. Interviews averaged 29 minutes for females and 23 minutes for males, and were conducted in either English or Spanish; respondents received a small monetary incentive for participating. The questionnaire and survey protocols were approved by the institutional review board of the Guttmacher Institute. The level of response or cooperation obtained from respondents of a telephone

survey can be expressed in different ways. Cooperation rates can be calculated at the household or the respondent level, and include only households or respondents who are contacted and fully screened. The difference between these rates arises because many households reported that someone eligible resided there, but interviewers could not contact these individuals to confirm eligibility and request participation. We validated the representativeness of the data by comparing key characteristics with similar measures for a comparable subpopulation of respondents to the National Survey of Family Growth. Additional detail about the survey methodology has been published previously. In a model that assessed contraceptive nonuse, the sample was further restricted to respondents who were in a sexual relationship females and males. A final model looking at inconsistent contraceptive use included female respondents who reported current use of a method. Four dichotomous dependent variables were included. One assessed whether respondents reported that it was likely either very or somewhat that they would have unprotected sex in the next three months. Another measured whether respondents reported that they or their partner were currently using a hormonal or long-acting reversible contraceptive method the pill, injectable, patch, vaginal ring, IUD or implant. The third variable measured whether respondents in a relationship reported that they were not using any medical method to prevent pregnancy either using no method at all or depending only on withdrawal or natural family planning. The last variable measured whether female contraceptive users reported inconsistent use in the past three months; inconsistent use included missing any pills, not using a condom each time, getting an injection late, and relying on withdrawal or natural family planning. We excluded men from this measure because they were asked only about consistency of condom use. The social and demographic variables used were age 18â€”19, 20â€”24 or 25â€”29 ; race, ethnicity and nativity white, black, U. In the bivariate analysis, summary scores were coded into grades: For the bivariate analysis, we summed the responses and created a four-category scale: For the regression analyses, the full scale 0â€”8 was used. Fear or dislike of side effects, whether due to actual experience or to subjective expectations, is often reported as a reason for discontinuing or avoiding use of certain methods. After asking respondents about six possible side effects e. In the multivariate analyses, this was treated as a continuous variable 0â€”2; the small number of respondents who indicated more than two were combined with the highest group. Analysis We examined frequencies and correlations, and conducted factor analysis, to understand bivariate relationships between measures, and to assess whether and how to construct scales or composite measures and which independent variables to use in multivariate analyses. We tested bivariate associations between all independent and dependent variables using correlation and chi-square tests. All independent variables included in the multivariate models exhibited significant bivariate associations with at least one of the dependent variables. Each dependent variable was coded dichotomously; we therefore used multiple logistic regression to test each model. Models were constructed by entering the domains according to their placement in the overarching theoretical model: In several cases, we examined interaction terms for measures that were strongly correlated with each other and might theoretically vary in a systematic way. However, none of the interactions tested was significant, so they were excluded from our final multivariate models. We also calculated the pseudo-R2 Nagelkerke for each domain, in two ways: When men and women were combined in an overall model, gender was highly significant, and some other variables lost significance because of differing, and even opposite, associations with the dependent variable according to gender. Therefore, models are presented for women and men separately. Results are presented according to domain, to highlight the significant findings across the dependent variables. The analysis was conducted using SPSS, version Sample weights and an adjustment for the complex survey design were used so that significance tests correctly accounted for the design, as well as for differential non-response and coverage. Six in 10 respondents were white, and one-third were black or Hispanic. About two-thirds were employed, and one in four were students only; more than half of respondents had received at least some college education or vocational training. Four in 10 women had received Medicaid or welfare in the past year, as had one in six men. Many young adultsâ€”men, in particularâ€”displayed serious gaps in objective knowledge about the major contraceptive methods. Half of young women and one in

five young men received an A or B knowledge grade; a quarter of women and six in 10 men received a grade of D or F. Six in 10 of both young men and women underestimated the effectiveness of oral contraceptives. Subjective knowledge about condoms, the pill, the injectable and the IUD also was low. More than half of young men and one in four young women reported that they knew only a little or nothing about the four methods. High proportions of young adults agreed with social norms that both contribute to and protect against unintended pregnancy. Young adults expressed conflicting attitudes regarding pregnancy and contraceptive use. Two in five young men and one in five young women were ambivalent. Six in 10 young adults reported some mistrust of the government as regards birth control safety or inappropriate promotion of contraception among minority populations. Eight percent of young women who were using a contraceptive said they were not completely satisfied with their current method. Among respondents in relationships, one in four of each gender were not using any medical contraceptive method. Bivariate and Multivariate Objective knowledge. In five of the seven multivariate models, at least one of the two variables measuring objective knowledge was significant Table 2. Compared with young women who correctly estimated the effectiveness of the pill, those who underestimated it were more likely to expect to have unprotected sex in the next three months odds ratio, 2. For men in a relationship, the higher the perceived rating of how much they knew, the lower their odds of being nonusers odds ratio, 0. For women, perceived knowledge was marginally associated with the odds of using a hormonal or long-acting method 1. Evaluation of side effects. At the bivariate level, young men and women who expected that none of the cited side effects was extremely likely to occur were significantly more likely than those who expected side effects to use a hormonal or long-acting method Figure 3. In the multivariate model Table 2 , with each additional side effect that women thought was extremely likely, they had reduced odds of using a hormonal or long-acting method odds ratio, 0. Among the social norms included in the models, what friends think about birth control use had the strongest associations with behavior. The more strongly that both men and women agreed with the statement that most of their friends think using birth control is important, the higher their odds of relying on hormonal or long-acting methods odds ratios, 1. The more strongly that women agreed with this statement, the lower their odds of being nonusers 0. Agreement with this statement was also positively associated with inconsistent method use among women 1. Agreement with a fatalistic attitude about pregnancy was significant in only one multivariate model: The more fatalistic men in relationships were, the greater their odds of being nonusers 1. The composite measure of pregnancy ambivalence showed mixed results. In most cases, ambivalent women and men were no different in their behavior from respondents who were committed to avoiding pregnancy. However, ambivalent men in relationships had elevated odds of being nonusers odds ratio, 2. Furthermore, respondents who reported low commitment to avoiding pregnancy were more likely than those who were highly committed to engage in risky behavior: Such men in relationships had higher odds of being nonusers 6. Women in relationships had elevated odds of being nonusers if they expressed mistrust in the government with regards to birth control odds ratio, 2. And women who reported greater dissatisfaction with their current contraceptive method had increased odds of using their method inconsistently 1. Amount of Variance Explained Combined, the background variables contributed about half of the total variance explained in each model Table 3. The specific background variables that were significant also varied from model to model not shown ; race, ethnicity and nativity and relationship status were significant in several models e. Consistent with the literature, 1,10,17 these results generally indicate that young adults who are disadvantaged have elevated odds of engaging in risky contraceptive behaviors, as do those who are not currently in stable ongoing relationships. However, in the related multivariate models, the contribution of this domain was greatly diminished. Substantial proportions of young women and men who are sexually active and not trying to get or get their partner pregnant expect to have unprotected sex in the near future.

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