



Oregon

John A. Kitzhaber, M.D., Governor

Department of Human Resources

Health Division

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June 23, 1998

Alisa Adamo, Project Officer
HCFA
7500 Security Blvd.
Baltimore, MD 21244



Dear Alisa:

The following faxes (two) include information from a variety of resources as it pertains to cultural competency. Please call me so I can walk you through the material. I hope this is **helpful**,

I'll **talk** to you soon.

Thanks!

Sincerely,

Julie
Julie L. Andersen Abrams
(503) 731-4235

Fax #1

*Assisting People to Become Independent, Healthy and Safe
An Equal Opportunity Employer*

TEXT FROM THE PROPOSAL

13

Provider Network

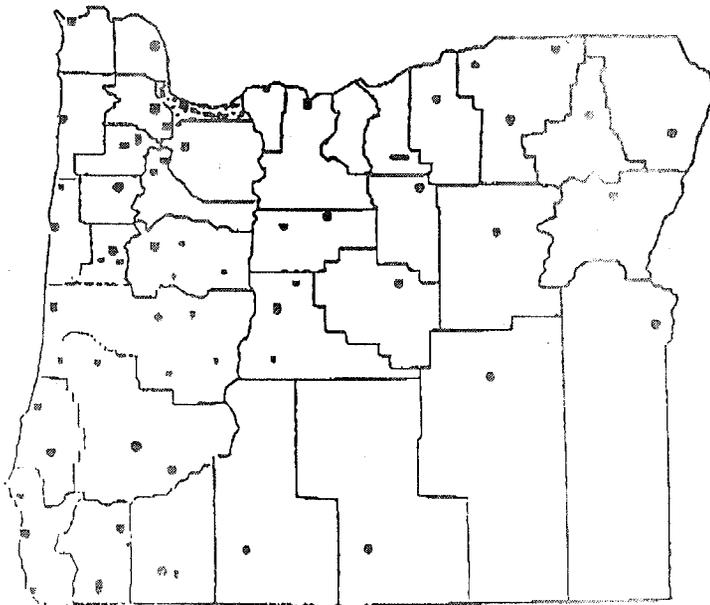
The provider network for the Family Planning Expansion Project is envisioned as a network of clinics which are easily identified by the eligible population as sources of free, user-friendly, confidential family planning services.

Public (Title X) Clinic System

The provider network for the Family Planning Expansion Project will be based on Oregon's existing public family planning clinic system, i.e., those agencies which currently receive federal Title X and state funds *specifically* for providing family planning services. This approach was chosen for several reasons:

Expertise: Title X agencies specialize in family planning services for low income, high risk Oregonians and for sexually active teens. They serve hard-to-reach populations, including those not likely to seek and sustain services (e.g., homeless, non-English speaking, and people with risk taking behaviors such as using drugs). They also have expertise in addressing the special needs of teens and persons with disabilities. In addition to providing clinical services, Title X agencies provide extensive patient education and counseling, referrals and linkages to other health services and community resources, and community education and outreach. Most Title X agencies have been providing public family planning services for more than 25 years. They have dedicated, experienced staff with extensive training in family planning service delivery.

Accessibility: As shown on the map below, Oregon's 36 public family planning agencies have more than 90 clinic sites serving all of Oregon's 36 counties. Eighty one percent of the people in Oregon's population centers (i.e., towns with a high school) have a clinic located in their town. Several clinics are based in high schools. Refer to Exhibit F for a directory of Title X clinic sites by county.



Please note that the large counties with few sites shown are arid, sparsely populated areas.

migrant and community health centers, rural health clinics, women's health clinics, and other providers serving special populations. These agencies could become direct Expansion Project providers or elect to subcontract with the local Title X agency. Oregon has a culture of local control and community collaboration which will help assure the best system for each community.

As Title X providers have already, non-Title X Family Planning Expansion Project providers will need to meet specific requirements, criteria, and conditions. Major requirements will include meeting Title X standards, using the Ahlers data system, and demonstrating ability to meet an unmet community need such as improving geographic access or providing services to a special population group.

All federally recognized Indian tribes in Oregon have been invited to participate in the project. All Indian Health Service and tribal clinics which are interested in providing Expansion Project services will become part of the provider network.

Eligible Population

The eligible population for the Family Planning Expansion Project includes:

- ▶ Women and men with a family income between 100 and 185 percent of the federal poverty level and
- ▶ Teens based on their own income up to 185 percent of the federal poverty level.

Client Projections/Demographics

The Family Planning Expansion Project will serve approximately 66,500 clients annually at capacity, essentially filling the "unmet need" for financial access to family planning services for Oregonians under 185% of poverty level. It is anticipated that this level will be reached by the end of year two of the project. The following table shows the projected age, gender, and racial ethnic breakdown of the projected clients.

Demographics

Age			Gender			Racial / Ethnic Group		
Adults	41,900	63%	Women	65,900	99%	White	59,500	89%
Teens	24,600	37%	Men	600	1%	Hispanic	2,700	4%
						African American	1,700	3%
						Asian/Pac. Isl.	1,500	2%
						Native American	700	1%
						Other	400	1%
Total	66,500	100%	Total	66,500	100%	Total	66,500	100%

BENEFIT PACKAGE

Oregon Family Planning Expansion Project

- HCT/HGB
- Wet mount
- Finger stick glucose

Other lab tests, when indicated

- Pregnancy test
- Chermpanel
- Endometrial biopsy
- FSH
- Gonorrhea culture
- Gram stain
- Herpes culture
- HIV test
- Prolactin
- TSH
- RPR/VDRL

EDUCATION AND COUNSELING

Education and counseling appropriate to client's needs, age, language, cultural background, **risk behaviors**, sexual orientation, **psychosocial** history and designed *to strengthen decision-making skills*, promote healthy behaviors and help clients make informed choices about their pregnancy.

- Basic female/male reproductive anatomy and physiology
- Partner's role in contraception/family planning
- Procedures conducted in clinic
- Clinic **scheduling and** emergency services
- Preconception
- Safer sex
- Breast self exam
- Risk behavior reduction (i.e., smoking, **nutrition** and exercise)
- Results of physical exam **and** lab tests
- Other health/social problems
- All contraceptive methods/procedures including:
 - Abstinence
 - Natural family planning
 - Withdrawal
 - IUD
 - Cervical cap
 - Diaphragms
 - Contraceptive **supplies**: foam, condoms (male and female), cream, jelly, spermicide, **vaginal** contraceptive film (VCF)
 - Oral contraceptives
 - Subdermal hormone implants
 - Contraceptive injections
 - Emergency contraception
 - Sterilization procedures (i.e. vasectomy, tubal ligation)
 - Other

Ore Family I I E on Project

REFERRAL SERVICES

Referral services to assure that health or social problems identified during the client's visit are referred elsewhere for medical, social and behavioral services not offered at the clinic.

FOLLOW-UP SERVICES

Systematic follow-up mechanisms to monitor the patient and the continuity of her care.

CLIENT CONFIDENTIALITY ASSURANCE

Assurance of client confidentiality and sensitivity to the client's concerns regarding privacy and confidentiality.

OTHER ANCILLARY SERVICES

Other ancillary services include those activities that assure services are accessible and available to all clients. Accessibility encompasses geographic access, assistance with application for Medicaid coverage, convenient hours of service, community awareness, cultural relevance and sensitivity to- sexual orientation, age and gender. Accessibility also involves attention to the special needs of adolescents and persons with disabilities; and effective outreach and education to communities and target populations.

CONTRACEPTIVE DISPENSING SERVICES

These are services related the administration, storage, handling, packaging and dispensing of contraceptive supplies,

Pregnancy Test Visit

FPS14

Not payable in addition to another family planning visit code. No limit per year.

Payable in addition to all other maternity services.

ELIGIBILITY DETERMINATION

- Citizenship
- Financial
- Data collection
- Enrollment
- Medical record

BRIEF CONTRACEPTIVE/MENSTRUAL HISTORY

PREGNANCY TEST

- One step or slide

PELVIC EXAMINATION, AS INDICATED

OTHER LABORATORY SERVICES, AS INDICATED

(See list of acceptable lab tests under FPS13)

RISK SCREENING, AS INDICATED

EDUCATION AND COUNSELING

Education appropriate to client's needs, age, language, cultural background, risk behaviors, sexual orientation and psychosocial history. Counseling appropriate to client's needs, age, language, cultural

PROVIDER ANNUAL PLAN

FAMILY PLANNING PROGRAM PLAN, FY 99

Agency: _____

Completed by: _____

PROBLEM STATEMENT

General Statement. Fill in the blanks in the following narrative, using the highlighted data on the Data Sheet provided on the next page.

In 1996 there were _____ females aged 10-54 in our county. Based on national estimates by the Alan Guttmacher Institute for 1995, 50% of these were at risk of unintended pregnancy, and 49% of the pregnancies that did occur were unintended.

In 1996 there were _____ female teens 15-17 in our county. Based on statewide estimates, 36.5% of these girls are sexually active (defined as "ever had intercourse"). In our county, we are serving an estimated _____% of these sexually active teens, compared to the state's 38.5%.

In our county there were _____ pregnancies to teens 10-17, for a rate of _____ compared to the state rate of 18.8 and the year 2000 benchmark goal of 15.0 per 1,000 population. In our clinic(s) in FY 96/97 we served _____ teen clients 10-17, which represent _____% of our total clients, compared to the state's 20.4% of total clients.

Our county's female population 10-54 includes _____% people of color, compared to the state's 11.6%. The largest non-white population group in our county is _____ at _____% of our population. Our clients are _____% people of color, compared to the state's 25.9%. The largest non-white client group served in our county is _____ at _____% of our clients.

The percent of the population in our county that is below 100% of poverty is _____%, compared to the state's 12.7%. Of our clients who are below 100% of poverty, _____% are on Medicaid, compared to the state's 27.3%.

We can measure the impact of family planning services by an estimate of the number of unintended pregnancies averted. Statewide in FY 96/97, it is estimated that 15,275 unintended pregnancies were averted, which is 29.7% of the total clients. The comparable numbers for our clinic(s) are _____ unintended pregnancies averted, and _____% of our total clients.

Other Problems or Issues. You may want to describe additional data from the Data Sheet or other issues unrelated to the Data Sheet (for example: additional information about the problem of teen pregnancy; funding; staffing levels; political issues; or the impact of Oregon Health Plan on your service delivery system). You may also use this area to describe specific issues or concerns which the Family Planning Program Staff at the Oregon Health Division could help address.

(2)

Clinical Services (continued)	Report July 1997-June 1998		Plan July 1998 - June 1999	
	Yes/No	Comments	Yes/No	Comments
Name of Pap smear lab and cost per lab?				
What is your current Pap smear turn-around time?				
What is the brand of pregnancy test that you use most often and what is the cost per test?				
What is your current average waiting time between call for initial exam appointment and appointment?				
List any special clinic sites (e.g., homeless shelter) which do not have an Ahlers number.				
Teen-Friendly Clinic Services				
Are teens able to call M-F 9-5 (including lunch) for appointments?				
Are appointments for teens available after school on weekdays?				
Are appointments for teens available on weekends?				
Are teens able to be seen within 1 week of calling?				
Are teen appointments available within 24 hours on an emergency basis?				
Do teens receive first choice of all methods (including Depo) regardless of cost?				
Are free condoms readily available to teens without requiring them to interact with staff?				
Is there anything else you'd like to tell us about your Teen Services? (Continue on back of page as needed.)				

Describe if any change from current:

3

Community Collaboration	Report July 1997 - June 1998		Plan July 1998 - June 1999	
	Yes/No	Comments	Yes/No	Comments
Are you involved in RAPP or a similar collaborative community effort to reduce teen pregnancies?				
Community Education/Outreach	Report July 1998 - June 1999		Plan July 1998 - June 1999	
	Yes/No	Comments	Yes/No	Comments
Do you provide community education aimed at reducing unintended pregnancies including teen pregnancies?				
Do you have working relationships with potential referring organizations (e.g., school-based health centers, schools, youth groups, domestic violence shelters, substance abuse treatment programs)?				
Do you provide special outreach activities to help assure that teens and underserved populations (e.g., homeless, disabled, substance abusers, people of color, non-English speaking) access your services?				
Do you have a community outreach program with services provided by nurses, social workers, or health educators?				
Do you have a community outreach program using teens to reach teens?				
Do you have a community outreach worker or lay health promoter program using members of the target community (ies)?				

(7)

General Family Planning Services	Report July 1997 - June 1998		Plan July 1998 - June 1999	
	Yes/No	Comments	Yes/No	Comments
Are you systematically monitoring for the cultural appropriateness of your services?				
Do you use any formal methods to evaluate family planning services including your teen services?				
Use this space to describe any other current activities or plans for major changes which have not been covered (e.g., changes in clinic hours, staffing patterns, clinic sites, services offered). Continue on back of page as needed. Jackson, Josephine, Lane, Marion, Mult. and Washington counties please use this space to describe your plan to share resources with other FP providers in your county.				

PROGRAM ASSURANCES

FAMILY PLANNING

ASSURANCES	CITATION
<p>Grantee agrees to comply with all Title X program requirements as detailed in legislation, regulations, program guidelines, & Region X DHHS program instructions.</p>	<p>Public Law 91-572, Section 1001 of the Public Health Service Act (42 U.S.C. 300) 42 CFR Part 59, Grants for Family Planning Services (Federal Register, June 3, 1980) Program Guidelines for Project Grant for Family Planning Services (All documents are included in the Family Planning Program Manual, Volume 1.)</p>
<p>Grantee assures that it will:</p>	
<p>1. Provide a broad range of acceptable and effective medically approved family planning methods and services (including infertility services and services for adolescents). Planning services.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>
<p>2. Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular method of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other service, assistance from or participation in any other program of the applicant.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>
<p>3. Provide services in a manner which protects the dignity of the individual.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>
<p>4. Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>
<p>5. Not provide abortions as a method of family planning.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>
<p>6. Provide that priority in the provision of services will be given to persons from low-income families.</p>	<p>Grant Assurance for OHD's Title X grant from DHHS/42 CFR 59.5</p>



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Dear Alisa:

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I'll talk to you soon

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Sincerely,

Julie L. Andersen Abrams
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Fax #2

*Assisting People to Become Independent, Healthy and Safe
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FAMILY PLANNING PROGRAM MANUAL

CULTURAL DIVERSITY**Section H.4**

This Section includes:

MINORITY HEALTH CONFERENCE VIDEOS. List of videotapes from the OHD Minority Health Conferences. Tapes can be checked out through Office of Multicultural Health. Call Ruth Ascher at 731-4019 for a complete listing of videos and for checkout.

SPANISH-LANGUAGE FAMILY PLANNING MATERIALS
Description and where to obtain.

STRATEGIES FOR WORKING WITH CULTURALLY DIVERSE COMMUNITIES AND CLIENTS.

Cover and table of contents. Available from:

MCH Clearinghouse
38th and R Streets N.W.
Washington D.C. 20057

OFFICE OF MINORITY HEALTH RESOURCE CENTER, DHHS
Flyer describing resources and copy of mailing list form.

ADDITIONAL ARTICLES / RESOURCES:

What is Cultural Competence?
Characteristics of a Culturally Skilled Provider
Cultural Competence Criteria for Service Providers
Lesbian Health Care

What Is Cultural Competence?

Cultural Competence is being able to function effectively in the context of cultural differences.

To be a culturally competent provider one needs to:

- Be aware of and accept cultural differences.
- Be aware of one's own cultural values
- Understand that people of different cultures learn different ways of communicating, behaving, and problem solving.
- Have basic knowledge about a client's culture
- Be willing to adapt or adjust the way one works with people to take into consideration cultural differences.

Adapted from Focal Point
Fall 1988, The Bulletin of
the Research and Training
Center, Portland State Uni-
versity.

CULTURAL COMPETENCE

is a set of congruent

Practice Skills

Attitudes

Policies

and

Structures

**which come together in a system, agency, or among
professionals and enable that system, agency, or
those professionals to work effectively in
cross-cultural situations.**

Why Cultural Competence?

- ▶ Demo's
- ▶ Belief Systems
- ▶ History of health provision
 - Native Americans
 - African Americans
 - Hispanic or Latino-Americans
 - Asian Americans and Pacific Islanders
 - Refugee and Immigrant Populations
 - Non-ethnic Populations
- ▶ Lack of Early Intervention Costly
- ▶ Methods of Help-Seeking
- ▶ Education Lead to Biases
 - Social Learning
 - Formal Education and Training
 - Contemporary influences
- ▶ Historic and Contemporary Racism
 - Individual
 - Institutional
 - Cultural and Symbolic
- ▶ Research Base Incomplete re: Racial and Ethnic Cultural Groups
 - Unrepresentative Samples
 - Historic Myths re: Race and Gender
- ▶ Political Correctness
 - Trivialization of Differences
 - Biases Go Underground
 - Real Issues Go Unchallenged and Uncontested

Why Cultural Competence?

- ▶ Terminology Non-Standardized
 - Minority
 - Needs to Consider Power and Influence*
 - Cultural Groups of Color
 - African Americans*
 - Asian Americans and Pacific Islanders*
 - Hispanic or Latino-Americans*
 - Native Americans*
 - Non-Ethnic Cultural Groups
 - Women*
 - People with Disabilities*
 - Religious Minorities*
 - Class Minorities*
 - Gays and Lesbians*
 - Senior Citizens*
 - Refugees and Immigrants

- ▶ Labels Lack Specificity
 - Ignores Within Group Diversity
 - Invokes New Stereotypes
 - Promotes *Cultural Blindness*
 - Obscures Bi- and Multi-Racial Heritages

- ▶ Results of Ineffective Service Provision
 - Overrepresentation on In-Patient Services
 - Cost of Interventions
 - Further Lack of Credibility in Tx's and Staff

Typical Cultural Issues of Significance

- ▶ **Definitions of Illness and Health**
 - Western Beliefs and Practices
 - Research Based
 - Non-Spiritual Therapies
 - Focus on the Individual
 - Non-Western Beliefs and Practices
 - Spiritual Basis for Cause and Cure
 - Emphasis on Quality of Life
 - Non-surgical Techniques
- ▶ **Perceptions of Relevant Services & Service Delivery Models**
 - Culturally Competent Characteristics
 - Connections with Informal Support Networks
 - Consumer and Community Advocacy
 - Community Based and Accessible Entry Points
- ▶ **Definitions of Credible Providers**
 - Culturally-Informed
 - Personal Involvement
 - Connections with Key Informants
 - Linkages to Natural Leaders
 - Comprehensive Systems of Care
- ▶ **Help-Seeking Behaviors**
 - Natural Networks of Support
 - Natural Leaders and Community Elders
 - Ethnic Media and Personalities

INTRODUCTION TO CULTURAL COMPETENCE (SUGGESTED READINGS)

GENERAL

Comas-Diaz, L. & Griffith, E. (eds.). Clinical Guidelines in Cross-Cultural Mental Health. John Wiley & Sons, NY 1988.

Green, J. & Leigh, J. (eds.). Cultural Awareness in the Human Services. Prentice Hall, New Jersey 1982.

Letley, H. & Pedersen, P. Cross-Cultural Training for Mental Health Professionals. Charles C. Thomas, Pubs., Ill 1986.

McGoldrick, M., Pearce, J. Giordano, J. (eds.). Ethnicity and Family Therapy. The Guilford Press, NY 1983.

Pinderhughes, E. Understanding Race, Ethnicity and Power. The Free Press, NY 1989

Powell, G., Morales, A., Romero, A., and Yamamoto, J. (eds.). The Psychosocial Development of Minority Children. Brunner/Mazel Pubs., NY 1983.

AFRICAN AMERICAN

Bass, B., Wyatt, G., Powell, G. (eds.). The Afro-American Family: Assessment, Treatment, and Research Issues. Grune and Stratton, NY 1982

Coner-Edwards, A. & Spurlock, J. Black Families in Crisis: The Middle Class. Brunner/Mazel Pubs., NY 1988.

^ [
Jones, R. (Ed.). Black Adult Development and Aging. Cobb and Henry Pubs., Berkeley 1989.

ASIAN AMERICAN

Ho, D., Spinks, J., & Siu-Hing, Yeung, C. (eds.). Chinese Patterns of Behavior: A Sourcebook of Psychological and Psychiatric Studies. Praeger Pubs., NY 1989.

Kitano, H. & Daniels, R. Asian Americans: Emerging Minorities. Prentice Hall, New Jersey 1988.

Morishima, J.K., Sue, S., Teng, L.N., Zane, N.W.S., & Cram, J.R. Handbook of Asian American/Pacific Islander Mental Health. National Institute of Mental Health, Rockville, MD. 1979.

HISPANIC AMERICAN

Becera, M., Escobar, K., & Escobar, J. (eds.). Mental Health and Hispanic Americans: Clinical Perspectives. Grune & Stratton Pubs., NY 1982.

Rogler, L., Malgady, R., Constantino, G., & Blumenthal, R. "What Do Culturally Sensitive Mental Health Services Mean? The Case for Hispanics." American Psychologist, (1987), 42 (6) 565-570.

Abad, V., Ramos, J., & Boyce, E. "A Model for Delivery of Mental Health Services to Spanish Speaking Minorities." American Journal of Orthopsychiatry, (1974) 44 (4), 584-595.

NATIVE AMERICAN

Blanchard, E., & Unger, S. "Destruction of American-Indian Families," Social Casework (1977) 58 (5), 312-314.

Red Horse, J., Shattuck, A., & Hoffman, F. (eds). The American Indian Family: Strengths and Stresses. Iaieta, N.M., American Indian Social Research and Development Associates 1981.

Trimble, J.E., Manson, S., Dinges, N., & Medicine, B. "American Indian Concepts of Mental Health, Mental Health Services: The Cross Cultural Context, Pedersen, P., Sartorius, N., & Marsella, A. (eds.). Sage Pubs., Beverly Hills 1984, pp 199-220.

INTRODUCTORY READINGS

- Atkinson, D.R. & Hackett, G. (eds.) (1988). *Counseling Non-Ethnic American Minorities*. Illinois: Thomas Publishers.
- Bell, D. (1992). *Faces at the Bottom of the Well: The Permanence of Racism*. New York: Basic Books.
- Bleier, R. (1984). *Science and Gender: A Critique of Biology and Its Theories on Women*. New York: Pergamon.
- Davis, A. (1981). *Women, Race, and Class*. New York: Random House.
- Dovidio, J.F. & Gaertner, S.L. (1986). *Prejudice, Discrimination, and Racism*. Florida: Academic Press, Inc.
- Eichler, M. (1988). *Non-Sexist Research Methods: A Practical Guide*. Boston: Allen & Unwin.
- Fernandez, J.P. (1991). *Managing a Diverse Work Force: Regaining the Competitive Edge*. Massachusetts: Lexington Books.
- Gochros, H., Gochros, J., & Fischer, J. (eds.) (1986). *Helping the Sexually Oppressed*. New Jersey: Prentice-Hall.
- Hacker, A. (1992). *Two Nations: Black and White, Separate, Hostile, and Unequal*. New York: Chas. Scribner's and Sons.
- Harrison, D., Wodarski, J., and Thyer, B. (eds.) (1992). *Cultural Diversity and Social Work Practice*. Illinois: Thomas Publishers.
- Kelly, G. (1990). *Sexuality Today: The Human Perspective*. Connecticut: Duskin.
- Parker, W. (1988). *Consciousness-Raising: A Primer for Multicultural Counseling*. Illinois: Thomas Publishers.
- Randall-David, E. *Strategies for Working With Culturally Diverse Communities and Clients*. Washington, DC: Association for the Care of Children's Health/Bureau of Child and Maternal Health.
- Thomas, G. (1990). *U.S. Race Relations in the 1980's and 1990's: Challenges and Alternatives*. New York: Hemisphere Publishing Corp.
- van Dijk, T.A. (1987). *Communicating Racism: Ethnic Prejudice in Thought and Talk*. California: Sage Publications.

THE EASTERN VS THE WESTERN MIND

Written by Reverend Tran Binh Trong
 Revised and Edited by
 Chareundi Van-Si, Cross-Cultural Consultant

The Easterners live in time
 The Westerners live in space
 The Easterners are always at rest
 The Westerners are always on the move
 The Easterners are passive
 The Westerners are aggressive
 The Easterners like to contemplate
 The Westerners like to act
 The Easterners accept the world as it is
 The Westerners try to change it accordingly to a blue print
 The Easterners see a part connecting to a whole
 The Westerners view the whole in many parts
 The Easterners live in peace with nature
 The Westerners try to impose their will on her
 The Easterners revere interdependence
 The Westerners value independence
 The Easterners believe in freedom of silence
 The Westerners believe in freedom of speech
 The Easterners lapse in meditation
 The Westerners strive to articulate
 The Easterners glorify austerity
 The Westerners emphasize living and enjoyment
 Self-abnegation is the secret of survival
 Self-assertiveness is the key to the Westerners' success.
 Poverty is to the Easterners a badge of elevation
 It is to the Westerners a sign of degradation
 In the sunset years of life the Easterners renounce the World and
 prepare for the hereafter
 The Westerners retire to enjoy the fruits of their labor.

HELP-SEEKING RESOURCES

Extended Family

Community Elders

Folk Healers

Community Ceremonies

Business Community

Self-Help Organizations

Neighborhood Clinics and Medical Staff

Community Leaders and Natural Helpers

CHARACTERISTICS OF THE CULTURALLY SKILLED PROVIDER

Becoming culturally skilled

- is an *active process*;
- is *ongoing*;
- is a process that *never reaches an end point*.

1. The provider is aware of own assumptions, values, and biases and:

- Has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage and to valuing and respecting differences;
- Is aware of how they may affect patients from diverse culturally backgrounds;
- Is comfortable with differences that exist between themselves and their clients in terms of race and beliefs;
- Is sensitive to circumstances that may dictate referral of patients to a member of his/her own race/culture or to another health care provider;
- Acknowledges his/her own racist attitudes, beliefs, and feelings.

2. The provider understands the world view of patients from different cultures and:

- possesses specific knowledge and information about the particular group he/she is working with;
- has a good understanding of the sociopolitical system's operation in the United States with respect to its treatment of individuals from culturally diverse backgrounds;
- has a clear and explicit knowledge and understanding of how the "medical culture" fits within the frame of reference of the patient's "culture";

- is aware of institutional and socio-economic barriers that prevent people from culturally diverse groups from accessing and using health care services.

3. The provider understands the need to acquire and develop appropriate strategies and skills and:

- recognizes the need to develop and adapt a new set of approaches in order to be able to provide appropriate care for patients from diverse cultural backgrounds;
- is able to generate a wide variety of verbal and nonverbal responses;
- is able to send and receive both verbal and non verbal messages accurately and "appropriately";
- is able to exercise institutional intervention skills on behalf of his/her client when appropriate;
- is aware of his/her helping style, recognizes the limitations he/she possesses, and can anticipate the impact on patients from different cultural backgrounds.

Adapted by the Institute for Family-Centered Care from: Sue, Donald Wing & Sue, David. (1990). *Counseling the Culturally Different: Theory & Practice*. Second Edition. The culturally skilled counselor. (pp 159 -172). John Wiley & Sons.

Cultural Competence Criteria for Service Providers

Knowledge

Understanding of provider's own cultural values and norms.

Understanding of the important role of culture, race, class, age, gender, and sexual orientation in interpersonal and professional encounters.

Understanding of the historical factors which impact the health and mental health of minority populations, such as racism and immigration patterns.

Understanding of the particular psychosocial stressors relevant to minority clients. These include war trauma, migration acculturation stress, and socioeconomic status.

Understanding of cultural strengths of diverse populations.

Understanding of the minority client within a family life cycle and inter-generational conceptual framework in addition to a personal developmental network.

Understanding of the differences between "culturally acceptable" and "culturally unacceptable" behavior of different minority groups.

Understanding of the natural support networks and indigenous healing practices in minority communities.

Understanding of the clients' need to receive services in their own native language.

Understanding of the cultural beliefs and help-seeking patterns of minority clients.

Understanding of community resources and availability for minority clients.

Understanding of the public policy in developing, implementing, and evaluating programs for minority populations.

By: Evelyn Lee

Cultural Competence Criteria for Service Providers
Continued

Skills

Ability to interview and assess minority clients and families based on a psychological/social/biological/cultural/political/spiritual model.

Ability to communication cross-cultural situations. Ability to work effectively with interpreters.

Ability to diagnose minority clients with an understanding of cultural differences in psychopathology. Ability to avoid under-diagnosis or over-diagnosis.

Ability to form professional relationships across cultures.

Ability to recognize clinical issues of transferences and countertransference in working with clients and families.

Ability to formulate culturally sensitive treatment plans.

Ability to utilize community resources.

Ability to know his or her own limitation and ask for consultation when appropriate.

Ability to advocate effectively on behalf of minority clients.

Ability to effect organizational change from within the system as well as outside.

Cultural Competence Criteria for Service Providers
Continued

Attitudes

Respect the "Survival Merits" of immigrants and refugees.

Respect the importance of cultural forces.

Respect the holistic view of health and illness.

Respect the importance of spiritual beliefs respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.

Shows respect for the family as the primary system of support and preferred point of therapeutic intervention.

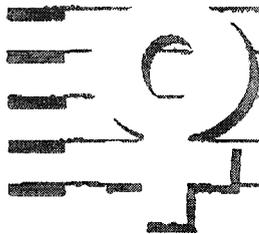
Flexibility and patience.

Be humble and responsible for own personal and professional growth.

Competencies in Program Design

- Staffing pattern reflects the makeup of the client population
- Availability of culturally sensitive programs and services
- Language accessibility at all points of contact
- Community-based and easy accessibility
- Flexibility in service sites and hours
- Comprehensive service to address complexity of service needs
- Maintains clients in least restrictive settings
- Client-driven approach
- Family focus
- Strong prevention orientation
- Strong educational, vocational and rehabilitative components
- Coordination and collaboration across systems.
Partnerships with outside agencies
- Close working relationship with community helping networks and healers
- Consumer involvement in need assessment, planning and evaluation
- Affordable cost

By: Evelyn Lee



**FEMINIST
WOMEN'S
HEALTH
CENTER**

Lesbian Health Care

in a feminist setting, lesbians can find sensitive, quality health care

If you've gone to regular doctor's offices or medical clinics for an annual exam, or for gynecological health problems, you may have experienced what many lesbians do: inappropriate questions about your supposed sexual relations with men, an assumption that you should be using birth control, and other judgmental, invalidating attitudes about your sexuality. You might be very uncomfortable with having a male doctor or nurse examine your vagina or breasts, yet not feel like you have a choice in the matter because you need to be seen for a health problem. Or maybe a health care provider has made insensitive comments about your size, shape or body hair. If you've experienced an uncomfortable exam in the past, you may be reluctant to go back to the doctor for follow-up care, or for a different health problem. Particularly if your health problems are related to your sex life, to reproductive health care, or involve your lesbian family, you may find it difficult to trust health care providers.

Many lesbians don't even think we need gynecological care. A lot of us put off getting annual ex-

ams, or don't get them at all, because we figure we're not at risk for STD's, and don't need birth control, abortions or prenatal care. WRONG! There are a lot of myths at work here. Lesbians do pass STD's, including gardnerella, yeast, herpes, and HIV. Lesbians do seek birth control, the morning after pill, and abortions, because we occasionally have male lovers, have had them in the past, or have been sexually assaulted. Lesbians do seek prenatal care, as many of us choose to have children. And being a lesbian doesn't make us

immune to the universal health problems of women: fibroid cysts, genital warts, painful menstruation, urinary tract infections, endometriosis, or breast and cervical cancer. Lesbians do need gynecological care.

So, what if you need health care? You still face a medical system which has been oppressive to women in general, and particularly hostile to lesbians. You don't want to subject yourself to heterosexist and male-dominated health care. What can you do?

At the Feminist Women's Health Center, we

"In healthcare, as in every aspect of society, lesbians are invisible."

Lesbians have been ignored in medical research, overlooked in most women's clinical programs and unreached by instruction on preventive health care. The failure of the medical industry to recognize (let alone address) lesbian health needs means that we are at higher risk for breast cancer, pelvic inflammatory disease and other common serious illnesses. In addition, lesbians who come out to their doctors report being treated with fear, hostility and violence." Lesbian Health Program, Community Health Project, New York, 1994

provide lesbians with a different health care experience. We see our clients as our equals, and provide health care the way we like to receive it.

- ♦ Are you seeking an annual well-woman exam, just to make sure everything's OK? The health workers and naturopaths at the FWHC will listen to your concerns and insights, answer all your questions, and will address your needs as an individual woman and a lesbian. Your exam will be gentle, sensitive, and woman-centered.
- ♦ Do you have recurring vaginal problems such as gardnerella or yeast? At the FWHC we know that these infections are easily passed back and forth between women; we'll guide you in treating and preventing vaginal infections.
- ♦ Are you thinking about becoming a parent? Our donor insemination program welcomes lesbians, and no judgment will be made about who you've chosen to be part of your family, whether it's just you, or you and your lesbian partner, or your unique network of support.

Feminist health care fits in neatly with the independence many lesbians try to maintain in our lives. The philosophy in our woman-controlled clinic is to keep you in charge of your own health care, and informed about what's going on with

your body. That's part and parcel of what we do, and it's particularly helpful to lesbians. In a world where lesbians are told we should feel shame about who we are, it's empowering to learn about our bodies and how to take care of ourselves.

At the FWHC, you can learn about self help (vaginal self exam using a plastic speculum), which is the foundation of woman-controlled health care. Through self help, we monitor our vaginal health and treat most common problems ourselves, using home remedies. Self help is great for any woman who wants to know what's going on "down there" — we learn an incredible amount about both our health and our attitudes towards our bodies through self exam. We've also found self help to be empowering in exploring our feelings about being women, and combatting the homophobia we experience as dykes.

Lesbians in Oregon have a wonderful resource in the Feminist Women's Health Center. If you want to keep your money in the community, you'll be glad to know that we're Oregon's only woman-controlled, non-profit women's clinic.

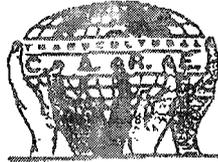
If you have health care questions you'd like to discuss, or to make an appointment, call our phone counselors at 342-5940 (toll-free outside Eugene: 800/995-2286).

***“Lesbians are more likely to skip critical health care evaluations and screening tests than our straight sisters.*”**

This is especially true of tests such as mammograms and pap smears. There are several reasons why. Often gay women simply lack the resources to obtain health care. Sometimes, fear stops us; frequently, lesbians encounter outright hostility in health care settings. Most health care for women is targeted to women who have sex with men, and is organized around events related to hetero-sex and hetero-reproduction — prenatal care, STD clinics, family planning programs, etc. But lesbians require the same health care services that straight women receive....” from “I’m Gay, So Why Do I Need a Pap Smear,” LAP Notes, Issue #2, Spring 1994. LAP (Lesbian AIDS Project) is part of Gay Men’s Health Crisis, New York.

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