AIDS To Cultural Competence: Addressing Health Care Challenges for **Women of Color** *Living with HIV/AIDS*

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Disclosures

- Judith Mairs-Levy & Louis A. Marino

- Has no financial interest or relationships to disclose.

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- Grants/research support: Roche, Amgen
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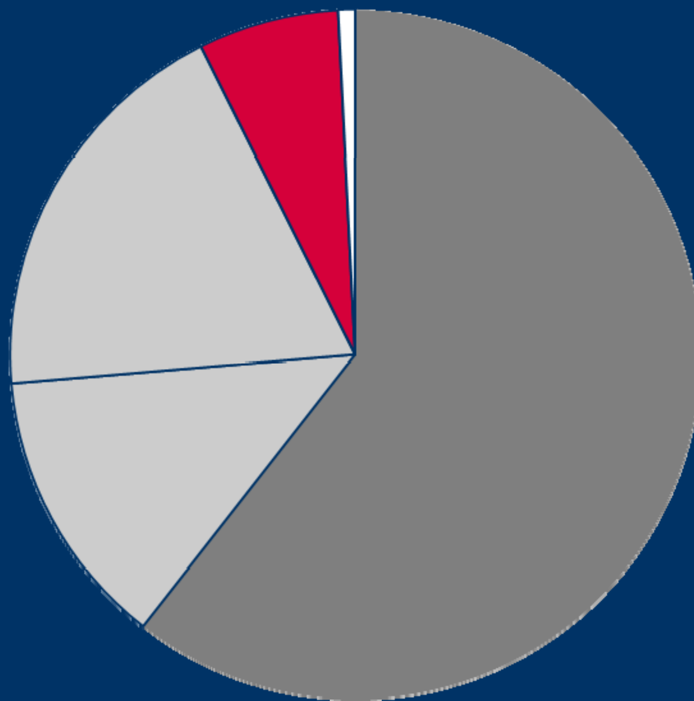
Learning Objectives

- ***Recognize*** the value of implementing culturally appropriate health care and providing an ***Ideal First Visit*** for women of color living with HIV/AIDS(WOCLWHA)

- ***Identify*** at least 3 HIV/AIDS related issues affected by culture that often challenge the provider-patient relationship in communities of color

- ***Integrate*** at least 3 strategies to overcome specific multicultural health care challenges that are present in health care settings and daily practice

Racial and Ethnic Distribution of the Population of the US: Projected 2030



- White, Non-Hisp. 60.5%
- African American 13.1%
- Hispanic 18.9%
- Asian/ Pacific Is. 6.6%
- American In./Alaska Nat. 0.8%

U.S Bureau of the Census, Statistical Abstract of the U.S. 1999

HIV/AIDS Among Women
VIH/SIDA Entre Las Mujeres

Women (in thousands)

	Black (81,349)	White (24,298)	Hispanic (19,211)	Asian/Pacific Islander (652)	American Indian/Alaska Native (558)
Other	2%	2%	2%	4%	2%
Injection drug use	24%	33%	29%	16%	29%
High-risk heterosexual contact	74%	65%	69%	80%	68%

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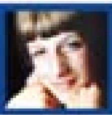

Key Disparities in HIV/AIDS Treatment in Women of Color

Blacks/African Americans are twice as likely as Whites to NOT receive triple drug antiviral therapies; and 1.5 times as likely to not get prophylaxis for PCP.

Latinos are 1.5 times as likely as Whites to NOT get triple drug antiviral therapies.

(Kaiser Family Foundation www.kff.org)

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Good Reasons For Incorporating Cultural Competence In Health Care Delivery

- Changing Demographics
- Racial and Ethnic ***HEALTH DISPARITIES*** and ill-effects on health outcomes.
- Lack of cultural competence=patient dissatisfaction

Implications For Women of Color: Delays in linkage into care and poor retention rates = increased complications= death.

….Connecting…..The Dots….Disparities &….
…..Cultural…..Competence…..

- **Access to** health care differs by race and ethnicity-Racial and Ethnic Minorities are:
- Racial and Ethnic Minorities **are Less Satisfied** with the Health Care They Receive and **less Likely** to have a Regular Care Provider and Health Insurance
- **Implementing Cultural Competence** in health care delivery can help to eliminate disparities thereby **increases the quality of care** and individual **outcomes** in WOCLWHA.

Being Culturally Competent Means Being Able to:

- Understand the importance and interaction of socio-cultural influences on patients' health beliefs and behaviors

- Assure and devise quality health care delivery to diverse patient populations

(Betancourt et al., 2005).

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Cultural Competence Is a Process..

- A number of interrelated factors must synchronize in order to establish and maintain an *ongoing* standard of cultural competence.

- Cultural competence workshop training sessions can improve clinical practices.

- Skill however can only be acquired through ongoing multicultural education & training (i.e options for learning Basic Medical Spanish).

It is a dynamic developmental, on-going process….

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Communication="The Essence of Clinician-Patient Encounter"

- **Role of Trust, Care and Communication is Critical:**
  - Patient satisfaction increases when clinician uses psychosocially-oriented interview…..but is least used by providers.
  - Patients' initial statement of concerns was completed in only 28% of interviews.
  - In 24.6% of visits-provider did not ask the Patient about his/her concerns
  - Average visit length was 15 minutes-and 32 seconds for patient concerns

Marvel, MK, Epstein, RM, Flowers, K & Beckman, HB (1999) Soliciting the patient's agenda: have we improved? JAMA, 281(3):283-287

Pasick, RJ.,Stewart, SL, Bird, JA & D'Onofrio, CN (2001) Quality of Data in Multiethnic Health Surveys, Public Health Reports, Supplement 1, Vol. 116:223-243

Setting the Stage for Cultural Competency

Provider-Patient ‘Back Translation’

- Use simple language, and where possible, easy to communicate basic concepts.
- All literature ***must be*** “back translated”.
- Translate English> to target language>target dialect.
- Translator who speaks target language and target dialect> translates document back to English.
- Independent translator> re-translates document.

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WATCH YOUR LANGUAGE!

1. Paying attention to the "language" we use is a **first step** to bridging gaps in communication barriers.

2. Learn how to say a typical greeting: shows interest in improving communication and learning about your patients.

3. Even if phrased incorrectly, patients appreciate the effort, and interest in their culture.

4. Learning other phrases such as, "I don't understand" or "speak slower please" can be very useful.

Do You Even Speak My Language?

- Many languages **do not** contain the same terms as Western Medical Terminology
- *Examples:*

- ***"O-N-C-E" -means E-L-E-V-E-N in Spanish***
- *"Are you bleeding? -"No I did not cut myself"*
- *" Take with food"- Take every time you eat!*
- *"Has sugar" = Diabetes*
- *"High blood pressure" = Hypertension*

- ***Believe it or not:***
- *When interviewed in English, patients sometimes responded positively to questions even when they were confused by the terminology used.*
- *When interviewed in their language of origin=better understanding*

“Culture-Bound” Beliefs

- Many racial and ethnic patients still question if a provider is ***experimenting on them***
- More difficult for patients who are being treated for diseases with no apparent symptoms to comply with treatment regimens
- Many ethnic groups believe that medications used to treat whites are ***“too strong for their system”***

Discussing Perceptions of Time

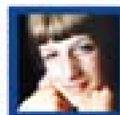
Through What Cultural Lens?

- Patients who are not regularly employed outside the home are usually less “clock-bound” in their perceptions of and organization of time. In many communities time is organized in a more fluid manner …
- ***”Go With The Flow”***

- Some patients organize time by tasks, rather than by clock time.

- **So…**Instead of “clocking’ it may be necessary to relate dosing to an activity or event:

- e.g. “Take the medication about the time your children usually get home from school.”



“You Are Invading My Personal Space”

Examples of Gender Taboos for Touch and Space:

Anglo American patients may ***desire a wider circle*** of personal space, and touch.

A ***Japanese*** woman may reach out to a female provider, but shy away from her male colleague.

In contrast, for many ***Blacks- touch is an essential part of health care***, and personal space is minimal by comparison.

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Prescribing Treatment In A Culturally Sensitive Manner.

- ***Determine The Patient's View Of the Medication Regimen By Asking Patient:***
- *Do you think you will have any problems with the medication?*
- *Have you taken a medication similar to this in the past?*
- ***Provide Information & Strategies***

Cohn, E. R. (2000) Communication to Promote Therapeutic Adherence. (www.pitt.edu)

Framework Of A Culturally Responsive Health System That Displays Quality Care for WOC

- Culturally Sensitive Staff, that ensures patient's dignity, privacy & confidentiality .
- Allows Equal Provider-Patient Input in the decision-making process & offers sufficient & correct information
- Makes recommendations and lends socio-cultural support, and address barriers to linkage and retention

Follows up----ALWAYS!

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Campinha-Bacote's 'Be Safe" Model

- ***NOT AIDS SPECIFIC*: Used** by the National Minority AIDS Education & Training Center (NMAETC), a HRSA-funded training and technical resource based at Howard University in Washington, D.C., to develop series of cultural competency(CC) models for health care providers, and launching point for new HIV/AIDS projects.
- **Designed:** To help clinicians understand and address the cultural needs of HIV/AIDS patients from specific racial and ethnic minority populations.
- ***BE SAFE:*** Series currently includes CC models for African Americans, Latinos, American Indians, Alaska Natives, Native Hawaiians, Asian Americans, and Pacific Islanders-can be downloaded from www.nmaetc.org free of charge.

THE BE SAFE MNEMONIC

- **Barriers to Care—**in WOC LWHA(mistrust, lack of access to care, stigmas, bias in medical decision-making).
- **Ethics--**Morality, belief systems and “right” vs. “wrong” behavior.
- **Sensitivity of the Provider--**Cultural awareness , examination of biases and prejudices & own cultural background.
- **Assessment—**Collect patient health history data in the context of the patient’s culture (outcomes, adherence and follow-up).
- **Facts--**understanding of physiology, behavior, health disparities, cultural beliefs and values, perceptions of their illness, biological variations in HIV/AIDS.
- **Encounters--**communicating effectively with minority patients and WOCLWHA awareness of cultural norms related to communication.

- Source: Campinha-Bacote, J. (1998, 2002 rev.). The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care. Cincinnati: Transcultural C.A.R.E. Associates.

Andersen's Behavioral Model:

Utilization of Health Care Services

- People's use of health services is a function of their predisposition to use services, factors which enable or impede use, and their need for care."(p.7).

Ronald Andersen,(1995, March). "Revising the Behavioral Model and Access to Medical Care: Does it Matter?" *Journal of Health and Social Behavior*.36: 1-10.

- CHS's Adapted Andersen's Model as Its Framework for working with and caring for Women Of Color Living With HIV/AIDS (WOCLWHA).

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LIFT: Latinas Involved in Full Treatment

Culture Specific Level Barriers Encountered:

- ***Multiple risk factors:*** substance abuse and mental health problems

- In many ***Latino marriages*** and sexual relationships, the expectations and rights of a partner are determined by traditional gender roles.

- In the ***farmworker community,*** these gender roles are often dictated by *the twin doctrines* of: ***'Machismo'*** and ***'Marianismo'***

LIFT: Latinas Involved in Full Treatment in

Targets Latinas and Migrant Women Living with HIV in:

Cumberland County, NJ

- *Client-Level Barriers Eencountered:*
- ***Lack of access to quality medical services***
  - Apprehension of medical services
  - Stigma of being HIV-positive
  - *Provider-Level Barriers Encountered:*
- ***Language and communication:***
- The lack of culturally competent and bilingual health care providers creates significant barriers to getting treatment for Latinas with Limited English Proficiency (LEP).

KEY COMPONENTS TO CHS's "LIFT" SUCCESS
Enhances Access to Quality Care for WOC By providing:

(1)**A Woman-Responsive** and **Bilingual** care environment.

(2) **Flexibility:** Meeting the women's goals regardless of her stage of engagement in care.

(3)**Wrap-Around" & Bio-PsychoSocial-Cultural Needs:** Through peer system navigation & coordinated care.

(4)**Efficient Care Team: Aggressive work of** CM's, Outreach workers, peer navigators(follow-ups, appointment alerts)

(5) Positive-2-way- Provider / Patient Relationships

We Do not pretend to care—WE Just DO

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AN INNOVATIVE MODEL OF CARE THAT WORKS?

"Patient Navigator" *system whereby peers assist each other in finding and engaging in HIV/AIDS treatment-Considers…Multi-disciplined way of thinking: that is:* **Bio*-Medical-Psycho-Socio-Cultural.***

The Model: "Bridges The Gap" *between patient and provider and assists with cross cultural communication, which is often a particular challenge for women of color living with HIV.*

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Ways To Reduce HIV-Related Health Disparities In High-Risk Communities

1. ***Adopt*** community-level approaches to reduce HIV.

2. ***Reduce*** stigma and discrimination against WOCLWHA (***Starts with the first visit***).

3. ***Develop*** improved mechanisms to monitor, evaluate, and report on progress toward achieving provider and national goals.

"TAKE ME HOME WITH YOU"

- Cultural competence=***not an isolated*** aspect of medical care
- It is an ***important*** component of ***overall excellence*** in health care delivery.
- Issues of health care ***quality and satisfaction*** are of particular concern to WOCLWHA.
- Becoming proficient in another's culture is a ***deliberate, conscious*** act… It is ***learned***…and does ***not*** happen overnight.

Competence in practice means learning new patterns of behaviors and effectively applying them in appropriate settings.

- Involve the extended family in the intervention process
- Address elderly persons more formally (by their last name and title) than younger clients
- Acknowledge and work with traditional and/or faith healers
- Be cautious about touching
- Small talk at the beginning of a session will be considered good manners and keeps from appearing too rushed
- Conduct the session in the preferred language of the client or arrange for a professional interpreter
- Add culturally related questions during the evaluation process

(Shirley A. Wells, MPH, OTR, FAOTA, Chairperson, SEC (2001-2004)

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SUMMARY (1)

- ***Any degree*** of a lack of cultural diversity and competence challenges the health care system and compromise the care for WOCLWHA.
- Placing & Retaining WOC in quality HIV/AIDS Care =More-Focused, Individualized and Comprehensive Culturally Competent System of Care.

SUMMARY (2)

- Move away from thinking that any ***ONE*** approach to HIV prevention will work(education, condom, Treatment).

- Work together to develop, evaluate, implement effective prevention strategies and combinations of approaches that are ***Culturally Competent.***

Let's Make A "Positive" link with Women of Color Living With HIV/AIDS

FIRST IMPRESSIONS ARE LASTING…..

Make That First Visit Special and Help Create a Safe Place For Women of Color Living with HIV/AIDS

"Let Us Care Like We Mean It"

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Your Resource Connections To Culturally Competence: Guides

The End: Questions?

Thanks-Merci-Gracias!

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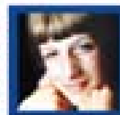

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