



Working Together to Increase Immigrant Women's Access to Reproductive Health Care

**A Report of the Center for Women in Government
& Civil Society and Family Planning Advocates of
New York State**

**Proceedings of the
Downstate Regional Workshop
October 23, 2003**

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Health.**

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Project Directors: Karen Anderson , Maud Easter, Dina Refki

Report written by: Dina Refki

**Edited by: Karen Anderson, Maud Easter, Alison Guernsey ,
Sang Hee Won**

**Center for Women in Government &
Civil Society
Rockefeller College of Public
Affairs & Policy
University at Albany
135 Western Ave.
Albany, NY 12222
(P) 518-442-3887
(F) 518-442-3877
www.cwig.albany.edu
Maud Easter- Easter@albany.edu
Dina Refki- Drefki@albany.edu**

**Family Planning Advocates of New
York State, Inc.
17 Elk Street
Albany, NY 12207
(P) 518-436-8408
(F) 518-436-0004
www.fpaofnys.org
Karen Anderson-
Karen@fpaofnys.org**



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Executive Summary

This report documents the proceedings of the Downstate Regional Workshop on Immigrant Women's Access to Reproductive Health Care held on October 23, 2003 in New York City. The Workshop brought together 30 immigrant serving programs and 24 family planning providers for two purposes: to deepen their shared knowledge of the barriers separating immigrant women from needed reproductive health care; and to explore how downstate programs can develop and strengthen partnerships to increase immigrant women's access to care.

The Keynote Panel examined cultural influences on reproductive health for immigrant women. Maria Uribebarrea of MIC-Women's Health Services, Zeinab Eyega of RAINBO, the African Immigrant Program, and Rashida Abdul-Khabeer of the Circle of Care discussed the impact of cultural constructs in the Latina, South Asian, African and Muslim immigrant communities on accessing reproductive health care. Moderator Marianne Yoshioka of Columbia University urged participants to consider the complex interrelationship of gender, race, class and immigration status in the lives of immigrant women and to avoid the trap of simplistic stereotypes.

A second panel shared promising models for reaching and serving immigrant women. Three programs which have utilized innovative, cutting edge program strategies were showcased. Mazza Seyoum of the African Services Committee, Dinah Surh of the Lutheran Family Health Centers, and Zerena Khan of Sakhi for South Asian Women discussed how their organizations were able to transcend barriers of culture, language and immigration status to provide a welcoming safe haven to immigrant women in their communities. Lessons gleaned from these models all pointed to the necessity of thinking outside the box, in non-traditional ways, in order to reach and serve immigrant women effectively.

Afternoon sessions addressed the need for culturally competent program materials, adequate language services, and the removal of legal and funding barriers to care for undocumented women. Claudia Ayash of the New York University Cancer Institute described the development of a video targeted to Latinas. Adam Gurvitch of the New York Immigration Coalition stressed the importance of addressing patients' risks, and fears of risk, related to immigration status. Mara Youdelman of the National Health Law Program (NHeLP) presented strategies for overcoming language barriers, model programs nationwide and language services funding, including state plans which utilize federal Medicaid and SCHIP resources.

Attorney Hillary Seo of the Center for Battered Women's Legal Services described the complicated intersection between public benefits and immigration status. Alice Berger of Planned Parenthood of New York City provided valuable information on navigating the labyrinth of public health programs to find care for undocumented women. Participants ended the workshop renewing their commitments to work together to increase immigrant women's access to reproductive care.

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The Center for Women in Government & Civil Society and Family Planning Advocates of New York State extend their sincere thanks to the New York State Department of Health, Bureau of Women's Health for its generous support of this project. Special thanks go to Barbara Brustman and Ellen Anderson for their wise vision and commitment to immigrant women's health. We also wish to thank Tammy Nazarko, Coordinator of Women's Health at the Department of Health, for her participation and valuable contributions at the event.

Our deepest gratitude goes to the speakers: Maria Uribelerrea of MIC Women's Health Services; Zeinab Eyega of RAINBO, the African Immigrant Program; Rashida Abdul Khabir of the Circle of Care; Dinah Surh of Lutheran Family Health Center; Maaza Seyoum of the African Service Committee; Zerena Khan of Sakhi for South Asian Women; Claudia Ayash of the Cancer Institute, New York University; Adam Gurvitch of the New York Immigration Coalition; Mara Youdelman of the National Health Law Center; Hilary Seo of Sanctuary for Families; and Alice Berger of Planned Parenthood of New York City. Their valuable expertise and unique insights made this event an extremely rich and productive exchange. We also wish to express our appreciation to the moderators for their contributions to the success of this event: Marianne Yoshioka of Columbia University; Silvia Henriquez of the National Latina Institute for Reproductive Health; Linda Gonzalez of Planned Parenthood Federation of America; and Mala Desai of Northern Queens Health Coalition.

A thanks also goes to the participants. We appreciate all the work they do for, and with, immigrant women and recognize them for taking valuable time out of their schedules to deepen their knowledge about the needs and challenges immigrant women face each day.

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1. Background

Since 2002, the NYS Department of Health, through the Bureau of Women's Health and the Office of Minority Health, has made possible an initiative to strengthen reproductive health services for the state's two million immigrant women. The Center for Women in Government & Civil Society (the Center) and Family Planning Advocates of New York State (FPA) are leading this long-term effort to strengthen reproductive health care for foreign-born women, by developing effective partnerships between immigrant women's organizations and family planning providers statewide.

The Planning Phase

In June 2002, a Planning Committee of immigrant-serving programs and family planning providers met to advise each other on program development. Participants discussed priority issues to address in a Statewide Roundtable and at follow-up Regional Workshops. A Needs Assessment was conducted in mid-2002 to identify more fully the barriers to services as perceived by both immigrant women and family planning providers.

The Statewide Roundtable

In December 2002, a Statewide Roundtable brought together twenty-eight representatives of immigrant-serving programs and eighteen family planning providers from across New

York State to examine barriers and share solutions.

Immigrant-serving programs identified the following barriers:

- Lack of community education about available services;
- Lack of linguistically competent reproductive health services;
- Use of male relatives as interpreters;
- Male domination and lack of personal decision-making power;
- Intersection of domestic violence, gender power and reproductive health;
- Fear of deportation and detention;
- Lack of health insurance;
- Inflexible health clinic hours;
- Lack of culturally-sensitive services, including insensitivity of front-line health workers.

Family planning providers cited the following barriers:

- Lack of health care worker training for provision of culturally-competent services;
- Difficulty hiring and retaining staff members who reflect the continuously changing demographic/ethnic diversity of immigrant communities;
- Ineffective outreach to immigrant women;
- Insufficient funding to reimburse provider costs for delivering culturally and linguistically appropriate services;

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- Language barriers; and
- Under-representation of immigrants at decision-making tables.
- Using mobile outreach units that take clinical services to immigrant communities;
- Transcending language barriers through remote simultaneous interpretation; and
- Utilizing immigrant-serving organizations as bridge builders, linking and educating both immigrant communities and providers.

Together family planning and immigrant-serving participants identified the following promising strategies to help transcend barriers:

- Embracing diversity at an organizational level;
- Hiring staff members who reflect ethnic/demographic makeup of the community;
- Training staff;
- Providing linguistically competent services;
- Engaging men in immigrant women's lives;
- Making information about services more readily available;
- Streamlining the service delivery process;
- Strengthening partnerships between providers and immigrant serving programs;
- Targeting outreach to immigrant women in non-traditional settings; and
- Advocating for enhanced reproductive health service delivery at the state policy level.

Several promising models for service improvement were identified including:

“It is a great challenge indeed to reach and serve effectively women from 150 different cultures, speaking as many different languages.”

Maud Easter

The Regional Workshops

Three Regional Workshops were held across the state during 2003. They were designed to introduce a large number of immigrant-serving and family planning programs to each other, and to increase understanding of cultural, language, and immigration law barriers. Regional Forums were held in Albany in April, Rochester in May and New York City in October. A report on the Albany and Rochester workshops is available at www.cwig.albany.edu and www.fpaofnys.org.

2. Introduction

At the Downstate Regional Workshop on October 23, 2003, 30 representatives of immigrant-serving programs and 24 family planning providers joined to deepen their knowledge of the needs and barriers facing immigrant women. Together they explored how programs in this region can further develop and strengthen their partnerships to increase immigrant women's access to reproductive care.

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A keynote panel, with knowledge of Hispanic, African, Muslim, and South Asian communities, offered unique perspectives on the influence of culture on access to reproductive health care. With insights into the immigrant women's complex cultural formations, they discussed the intersection of gender with race, ethnicity, and immigration status, and how these issues influence access to, and use of, reproductive health services by immigrant women.

"The very interrelated barriers of gender, culture, immigration status and lack of health insurance are going to require complex and innovative responses."
Maud Easter

The second panel shared promising models for reaching and serving immigrant women. Participants discussed how their organizations were able to transcend the barriers of culture, language, and immigration status to provide a welcoming safe haven to immigrant women in their communities.

"Showcasing promising innovative models that have proven successful on the ground provides an opportunity for learning and exchange of information, so that these programs and models can hopefully be replicated and adapted elsewhere."
Karen Anderson

Afternoon sessions addressed the need for culturally competent program materials, adequate language services and the removal of legal and funding barriers to care for undocumented women.

"Strengthening partnerships between immigrant-serving programs and family planning providers is a key element in increasing access to service and care."
Karen Anderson

3. Cultural Influences of Different Immigrant Communities on Reproductive Health

3.1. Cultural Influences on Latinas and South Asian Women

Maria Uribelarrea of MIC-Women's Health Services discussed the findings of a focus group study her organization conducted in 2002. Seventy-eight women within the reproductive age range, from Mexican, Ecuadorian, Pakistani, and Bangladeshi backgrounds, participated in eight focus groups. While this study produced

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important findings, Uribe Larrea warned of inherent limitations because the study focused on women who were already seeking reproductive care at clinics. In addition, she pointed out, these findings are based on a relatively small group of women and cannot be considered representative of a larger group. Findings of the study:

- Immigrant women are highly motivated to control their reproductive choices. The high cost of raising children in the US is a factor in those decisions.
- According to Pakistani and Bangladeshi women, husbands play a strong role in their reproductive choices.
- Participants reported real apprehension about misinformation concerning methods of birth control.
- Religion did not play a large role in making reproductive health decisions, contrary to expectations.

Implications of the study for health care providers:

- Reallocate resources from motivating women to consider birth control to providing clear information about reproductive health options.
- Involve immigrant women's partners in the decision-making

process.

- Provide a safe space for a woman to reveal if she is experiencing violence.
- Shed the assumption that you know best what immigrant women need and learn which contraceptive methods different immigrant women prefer.
- Avoid bringing one's own culture into the encounter and strive to be as sensitive as possible to the needs of the women.

Uribe Larrea urged that the study of cultural influences on reproductive health choices be expanded to different cultural groups and women who are not already accessing reproductive health care.

"It is pivotal to understand an immigrant woman's cultural self, her beliefs, values and priorities, then place this self within the context she inhabits-- which is shaped by the systems of gender, race, class and ethnicity. It is then critical to consider the intersections of immigration, racism, sexism, classism and xenophobia."

Marianne Yoshioka

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3.2. Cultural Influences of African Immigrant Women

Zeinab Eyega of RAINBO pointed out that African women come from a very culturally and linguistically diverse continent where societies are not standardized nor women's roles homogenous, but where different historical and geographic forces affect women.

The population of African immigrant women in New York State is on the rise.

Currently women make up 55% of African immigrants in this country, yet hard data regarding the family planning and health needs of these women is scarce.

What providers should know about African women:

- African women do not tend to access preventive care. The providers' promotion of preventive care, including an annual gynecological exam, is important.
- African cultures place tremendous value on having children. The idea of not being able to bear children is frightening. To prove the ability to procreate is critical, and marriages often break-up over issues of fertility.
- Many African women desire spacing methods rather than preventing the birth of children.
- Many ethnic groups define status by the number of male children a woman has. If a woman does not have a male child, this means she will keep making attempts to have that child.
- Involving partners is critical, and if a partner is excluded from decisions, this creates a source of conflict in the family. The partner's omission is interpreted as disrespectful. Often, involving the partner facilitates access to services. Excluding men may inadvertently exclude women from services.
- Involving men, however, should not mean giving their needs equal footing with women's needs or giving them free reign. Male involvement means acknowledging that having peace in the family is important to women.
- If the provider suspects the presence of violence, then having a private visit with the woman is warranted. This should not be difficult and such visits provide opportunities for a provider to conduct private talks with the woman.
- It is culturally acceptable for a man to have multiple partners, but not for a woman. Women may not request the use of condoms for fear of conveying the impression of infidelity.

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- Religion has a degree of influence on African women; religious leaders often serve as counselors to couples.
- It is very rare to encounter African women who do not use some kind of contraceptive device. A variety of birth control methods are used and women often remind one another to take birth control pills at night by citing the phrase, "Let's drink our secrets."

"Providers have an obligation to educate themselves about the experiences of immigrant women."
Marianne Yoshioka

- Traditional methods of birth control include: bead necklaces, herbs, amulets, chains, and love potions. Providers ought to ask women if they are taking any medicines/herbs in addition to those prescribed by the clinic. Providers should identify and integrate cultural practices that are not harmful to women's health.
- Secondary influences on election of birth control methods include: socio-economic status, education, length of stay in this country, marital status,

language, and rural/urban upbringing.

- Rural women prefer IUDs as they do not require reminders.

"There are often negative consequences to acculturation. Studies have shown that women who have been in the US for more than ten years are less likely to bring their babies for routine physical examination. Eating disorders and substance abuse, for example, are not typically an immigrant woman's problem."

Maria Uribebarrea

3.3. Cultural Influences on Muslim Immigrant Women

Rashida Abdul-Khaberr pointed out that Islam is a way of life for more than two billion people worldwide. It does not

recognize a secular life separate from a religious life. Muslims are found on every continent of the world, and there are an estimated five million Muslims in North America where Islam is the fastest growing faith.

In Islam, men and women are spiritually equal. The roles of males and females are different yet complimentary and work together to balance the social order. Each person is accountable for his/her own actions.

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“It is important that each woman is treated as an individual, that stereotypes are avoided and that being informed about common patterns of thinking and behaving should never give way to patronizing.”

Marianne Yoshioka

Providers should know the following about Muslim women:

- Women are expected to stay virgins until marriage.
- Sexual relationships outside of marriage are prohibited.
- Certain hygienic practices are mandated during reproductive cycles.
- Emphasis on modesty of dress requires limiting exposure during physical examination. Exposure of the woman’s body during a physical exam should take place in a gradual fashion to achieve the minimum amount of exposure at any one time.
- There is emphasis on being “fruitful” and “multiplying,” but the use of contraceptives is not prohibited. Their use, however, is

influenced by the specific culture of the client.

- Cultural codes emphasize physical distancing between women and men who are not husbands or blood relatives. This may make women more responsive to female providers.
- A female friend accompanying the patient may provide assurance to the woman that she will be cared for in a modest and proper way.

“An individual’s ethnic background has great influence on her cultural practices. These practices are often subsumed under religious beliefs, but because of their cultural nature, they are limited to the cultural group.”

Rashida Abdul-Khabir

- Abortion is permitted. Life is believed to start in the second trimester.

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“Understanding the cultural influences of Muslim women would facilitate provision of culturally and religiously-competent services, which would in turn increase the comfort level of these women and would increase their participation in reproductive health care.”

Rashida Abdul-Khabir

Barriers to care include:

- Fear of anti-immigrant sentiment caused and promoted by misrepresentation in the media.
- Conservative viewpoints on sex and sexuality.
- Impact of immigration law on the accessibility to medical benefits.
- Lack of private services for Muslim women.
- Language and family constraints.
- The negative stigma attached to “disbelievers.” Due to different religious views, a Muslim may see a non-Muslim provider in a light of distrust or prejudice.

Strategies for building cultural competence include:

- Avoid scheduling short, abbreviated appointments.
- Recognize that some clients are illiterate in their native language and may never have had access to traditional medical care before.
- Exercise caution in discussing matters of violence against women as such discussions may generate withdrawal or fear.
- Avoid overgeneralizations and identify cultural norms practiced by each woman.
- Use interpreters. Have bilingual staff on site whenever possible, and offer multi-lingual clients appropriate educational materials.
- Share cultural information and provide training to staff to promote their understanding of reproductive health in other cultures.
- Learn about local cultural healers, as many clients who access traditional health care use them.
- Strive to integrate alternative medical practices used by immigrant women in order to provide a holistic approach to care.
- Connect with local mosques and Islamic organizations and resource centers.

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4. Promising Models in Reaching & Serving Immigrant Women

4.1. Institutionalization of Cultural Competency within the Organization: The Lutheran Health Centers Model

In response to a mandate to become a managed care operation, Dinah Surh explained that Lutheran Family Health Centers underwent a dramatic organizational transformation. To be more responsive to the populations it serves, the health center employed multiple systemic changes to respond to the cultural needs of their clients, including the following actions:

- Undertaking a “vision quest” to cultivate a mission that embeds cultural competency in all policies and procedures of the organization’s operations.
- Forming a Cultural Access Task Force of multi-disciplinary staff. The group developed recommendations for cultural initiatives and follow up procedures.
- Conducting a feedback survey asking staff at all levels of the organization whether they thought the organization was “doing the right thing.”
- Ensuring “buy-in” from the top levels of the organization.
- Designing an inviting and welcoming physical environment. Displaying pictures, posters, artwork, and other décor that reflected the cultures and ethnic backgrounds of its patients. Developing multilingual signage and ambiance. Establishing an Islamic prayer room and initiating holiday celebrations in the hospital lobby and additional sites. At the reception area, making available magazines and brochures that reflect the interests of the different cultures and families served.
- Hiring multilingual and multi-cultural staff. Reaching out to community-based organizations, such as churches and associations for help in recruiting staff.
- Developing community partners to “do it right.”
- Changing staff job descriptions, performance appraisals, interpreter policies, and interpreter availability to more efficiently respond to cross-cultural needs.
- Acquiring competent medical translators and interpreters. Instituting a language bank.
- Training staff on cultural diversity, customer service, and

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stress management. Conducting team building activities.

- Incorporating patient relations representatives, bilingual advocates, interpreters and facilitators.

“Cultural competency should not be a separate department, but should be embedded in all the organization’s operations.”

Dinah Surh

- Strengthening efforts with active health education and outreach programs.
- Developing videos, films and other media resources that reflect the ethnic backgrounds of patients. Making readily available printed materials that take into account the literacy levels of clients served.
- Conducting periodic monitoring and evaluation to ensure that the initiative is on course and achieving its intended outcomes.

Lutheran Health Centers also launched a successful Asian Initiative, which served as a model for subsequent

programs. At its onset, community-based studies were conducted to assess population changes and needs. Community partners included the Brooklyn Chinese American Association and the Chinatown Health Clinic. Bilingual staff were hired, bilingual signage and written materials were posted, and marketing through ethnic media groups at community-based sites was undertaken. A Community Representative was also appointed to the Health Council.

“Cultural competence makes good sense from a business perspective. It keeps the organization close to the market; enables the organization to respond quickly to market changes; increases market share; enhances the ability to enter niche markets; and increases the likelihood of success with funding partners. Cultural competency also reduces health disparities, improves quality and outcomes, maximizes resources; minimizes waste; reduces risks of medical errors and malpractice; improves patient compliance, improves patient/enrollee/employee satisfaction; increases prevention and primary care utilization, and reduces emergency room use.”

Dinah Surh

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Lessons Learned from the Lutheran Family Health Center's Model

- A self-assessment of the organization should be conducted, and the results should be shared with staff.
- Cultural competence should be incorporated into the vision/mission statement and established as an organizational priority. A strategic plan should be developed with specific goals and objectives.
- Policies and procedures should be reviewed to ensure they incorporate practices that promote cultural and linguistic competency.
- The executive team of the organization must provide strong leadership for the initiative. The initiative's management team must be diverse. It should create a cultural access task force to guide the effort.
- Resources should be allocated to support the initiative.
- Support of staff for the initiative must be secured, through staff involvement, new employee orientation, job description/performance evaluation, staff training, and education for cross-cultural issues.
- The environment should be adjusted to fit the needs of patients and provide a welcoming feeling. Diversity should be celebrated.
- All communiqués should be written in the patient's language of origin. Educational materials and forms should be translated into the language of the patient. Special cultural needs and tastes should be accommodated.
- Bilingual-bicultural staff and/or personnel and volunteers skilled in the provision of medical interpretations should be utilized during encounters with patients.
- Community collaborations and partnerships should be cultivated and nurtured. An organization should sustain and expand partnerships with community leaders, which would facilitate hiring of bi-lingual, bi-cultural staff, cross referrals, marketing, outreach and educational strategies, and seeking outside grants and partnership opportunities.
- Monitoring and evaluation of cultural competency is critical to ensure patient/client satisfaction. Surveys about cultural access questions should be made, and report cards used to measure utilization and outcomes.
- Staff should intervene in an appropriate manner when other staff members engage in a culturally insensitive manner or demonstrate racial biases or prejudice.

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Following in the footsteps of the Asian Initiative, the Lutheran Center subsequently launched the Caribbean Initiative in partnership with the Caribbean Women's Health Association. With additional funding, the Caribbean American Health Center opened with a staff from Caribbean and Latin American countries. Outreach and health education efforts were conducted through an ethnic radio station, involving Ms. Universe and the Consulate of Trinidad and Tobago. The Caribbean American Health Center has experienced dramatic growth since it opened two years ago.

4.2. An Organization Embedded in & Targeted to the Immigrant Community: The African Service Committee Model

The African Services Committee is a community-based organization that has been providing services to African immigrants in New York City for twenty years. As discussed by Mazza Seyoum, the Committee heads a community outreach program that provides HIV testing and support services for HIV-positive patients. It also provides housing and educational programs.

To relate effectively to its community, the African Services Committee:

- Maintains an overwhelmingly African staff. Currently, 25 of 30 staff members are Africans who have experienced the same issues their clients currently

face. For example, many were undocumented immigrants seeking access to a wide range of services.

- Collaborates with local hospitals, where outreach staff members conduct educational sessions for African women and providers at hospital sites.
- Conducts an HIV prevention program for the African community, where leaders from the community are trained as health educators. These leaders serve as bridges to the community.
- Reaches women in their own environment, wherever they are. Trainings are often conducted in immigrant women's homes on

“We can print pamphlets in the languages spoken by immigrant women, but if the women are illiterate in their language, then the use of word of mouth, ethnic media outlets or graphics are the alternatives.”

Maaza Seyoum

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Lessons Learned from the African Services Committee Model

- Acquire in depth knowledge about the community and its needs.
- Tap into the social/community groups. Hire staff from the community who are grounded in the culture, understand the experiences/barriers of women, and who can effectively reach them wherever they are.
- Conduct trainings and programs to suit the schedule of those who are served. Flexibility of operations is critical to success.
- Be innovative and think in non-traditional terms as you devise ways of reaching women in the community.

on weekends to provide a comfortable space and to the weekends to provide a comfortable space accessible to women who might be secluded and restricted to the home.

- Uses ethnic media (radio) and word of mouth to publicize services.

4.3. An Immigrant Organization as a Bridge Builder

The Women's Health Initiative at Sakhi for South Asian Women serves as a bridge between the South Asian communities and South Asian and mainstream health providers.

According to Zerena Khan, the Women's Health Initiative:

- Develops a core network of South Asian healthcare providers trained to serve the needs of the South Asian community.
- Trains mainstream providers on the particular needs of the South Asian community.
- Sponsors educational activities to raise awareness in the South Asian community about violence against women.
- Conducts regular surveys of South Asian survivors of violence against women.
- Is developing a model for training South Asian professionals to speak about domestic violence.

"In our outreach efforts, we staged a march through Jackson Heights, Queens, where there is a large South Asian community. We sang different anti-violence messages in different languages and attracted a lot of attention."

Zerena Khan

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5. Producing Culturally-Competent Outreach Materials

5.1. The Cancer Institute’s Model

Claudia Ayash explained that the Cancer Institute at New York University serves a large immigrant population with limited English proficiency (LEP). The Institute has recognized the fact that many women patients arrive at the clinic with late stages of cancer, indicating an absence of preventive care, which could have made early detection possible.

The Institute developed an educational video targeted to Hispanic women (both foreign and US born) with the hopes of illustrating the value of preventive care and its role in increasing the likelihood of survival.

“In the development of the video, we reached out to different community partners such as the Center for Immigrant Health and the Institute of Urban & Global Health. We found these partnerships to be critical to success.”

Claudia Ayash

To guide the development of the script and presentation, the Institute

created both a medical board and a focus group composed of people from the community. Both groups ensured that the contents of the video were culturally competent as well as accommodating to different literacy levels and different dialects. The focus group deliberated on the choice of words. The video utilized dialogue, symbols, and diagrams to present a combination of visual and audio messages.

The video, which was shown on cable TV, invited women to seek health services and ensured confidentiality to undocumented women. It also stressed that services would be provided free of charge. After the release of the video, the Institute experienced a dramatic increase in patients accessing their services.

5.2. The New York Immigration Coalition Model

Adam Gurvitch reviewed how the New York Immigration Coalition uses a multifaceted approach in producing culturally competent materials. The Coalition considers a large range of questions, concerns, and issues with which immigrants must wrestle. Materials are designed to provide reassuring, accurate and comprehensive messages.

Importantly, the materials address the range of risks that a patient may be subjected to when seeking services. Such risks include the financial and legal implications of service access for immigrants of varying immigration status. The importance of addressing patients’ fears of risk, as well as the risks themselves, was shared.

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Participants were challenged to design programs that offer and provide confidentiality.

6. Overcoming Language Barriers to Accessing and Providing Services

“ Why are language services important in the health care setting? Because it’s the law, and because it affects quality and cost of care.”

Mara Youdelman

6.1. Why Provide Language Services?

Mara Youdelman of the National Health Law Center emphasized that language services are critical in a health care setting for the following reasons:

1) It’s the law.

Title VI of the Civil Rights Act of 1964 states that “no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” 42 U.S.C. § 2000d. National origin is interpreted as including individuals with limited English proficiency.

All public and private entities receiving federal financial assistance are covered by Title VI, including state, county, and local health and welfare agencies; hospitals and clinics; managed care organizations; nursing homes; mental health centers; senior citizen centers, and other programs that receive federal financial assistance.

To comply with Title VI, these “covered entities” must provide language assistance to persons with limited English proficiency to ensure meaningful access to programs and services. They must assess language needs, describe language assistance measures (e.g., types of services available/needed, how linguistic access will be secured), train staff, notify persons with limited proficiency of available language assistance, and monitor/update their plan.

In August 2003, the Office of Civil Rights (OCR) republished its Guidance on Linguistic Access, which clarified “covered entities,” and set out a framework for compliance. The Guidance states that providers must notify LEP persons of the availability of free interpretation and must not require friends, family or minors to interpret. It also stipulates that interpreters must be competent in medical terminology and in understanding of issues of confidentiality, impartiality and their roles as interpreters in English and the non-English language.

The Guidance also states that written materials must be translated routinely in

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regularly encountered languages. "Vital documents" that affect legal rights or

obligations must also be translated or communicated.

2) It affects quality of care.

Language barriers lead to:

- Denial of needed benefits and services.
- Delay in delivery of services.
- Receipt of the wrong benefits or services.
- Provision of ineffective or less effective/inferior quality of services.
- Poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision making, or ethical compromises (e.g. difficulty obtaining informed consent.)
- Medical errors. The rate of medical errors incurred as a result of encounters using professional interpreters was 12%, significantly less than errors incurred at encounters using no interpreters (20%).

3) It impacts cost of care.

Language barriers lead to increased costs and inefficiencies related to

practices such as unnecessary diagnostic testing. These barriers also open the door for potential liability issues such as lack of informed consent, malpractice, and negligence.

6.2. Models for Providing Language Interpretation

Exciting models of state policy and health care programs are emerging throughout the country:

- Massachusetts Emergency Room Interpreter Law and Rhode Island licensure law.
- Gouverneur Hospital in NYC- simultaneous translation; cultural competency training for providers.
- California's Alameda Alliance for Health pays stipend to providers for appropriate use of interpreters as part of the risk-sharing incentives (end of year risk pool/share.)
- Louisiana Care Health Plan – pilot interpreter training program will provide training free to any staff, including those from various health plans and providers.
- Wisconsin – eight health care facilities collaborate to provide interpreter services.
- South Carolina – Department of Social Services (DSS) contracts with the University of South Carolina, which recruits returning, Spanish-speaking

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returning Peace Corps volunteers to enter the Masters of Social Work program; students get scholarships to work part-time as interpreters and translate for DSS workers.

- Massachusetts – Cambridge Health Alliance helped develop a 3-semester medical interpreter-training program with a community college and a neighborhood job development agency.
- Illinois – community clinic developed self-study program to train recent immigrants as medical interpreters; interpreters “pay back” cost of course by interpreting at the clinic.
- Texas Project Link provides information and training to health care providers regarding interpreter services and provides translation assistance.
- Tennessee Rural Medical Services uses bilingual providers/staff to provide interpreters on- and off- site at specialty care appointments, hospitals, and health department visits.
- North Carolina's Harvest Family Health Center provides interpreter services to patients; has instituted a priority-hiring program to increase bilingual providers; and offers Spanish-language health education.
- North Carolina's Catawba Centering Model is testing ways

to provide prenatal care to Latina pregnant women. Offers education and one-on-one health visits with the goals of reducing transportation costs, increasing trust in the health care system, and enhancing community support.

- North Carolina- Duke University's International Patient

Office is providing interpreter services to the hospital and individual providers working in 17 outlying clinics.

6.3. Paying for Language Services

Youdelman also outlined some of the sources of funding available for providing linguistic access:

- Federal reimbursement is available for language assistance including translation and interpretation for Medicaid/SCHIP enrollees. States can draw down federal funds at either their administrative match rate (50%) or their “covered service” match rate depending on how they choose to provide language services.
- Department of Health and Human Services Office of Refugee Resettlement.
- State Departments of Health and Social Services
- County Departments of Health and Social Services.
- Local foundations.
- Nonprofit organizations.

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6.4 Model Programs Providing Direct Reimbursement Using Federal Matching Funds to Pay for Language Services

- Language service agencies:

Hawaii, Washington, and Utah contract with interpreter organizations; providers schedule interpreters who bill the state. Washington offers testing and certification. Hawaii and Utah are reimbursed as “covered service.”

- Provider reimbursement:

Maine and Minnesota require providers to pay for interpreters and then reimburse providers. Providers choose whom to hire. In Maine, interpreters must sign code of ethics, and providers cannot use family and friends of the patient.

- Payments to interpreters:

New Hampshire requires interpreters to become Medicaid providers. Interpreters submit bills directly to the state.

- Language line:

Kansas pays for a telephone language line that service providers can access for Medicaid/SCHIP patients. Providers receive a code for access.

“In developing an action plan for your state, the following issues must be considered: how can providers work with advocates and policy makers to improve language access and funding; what model would be most appropriate for your state; what data can providers collect to augment advocacy for improved language access and funding; is legislative and/or administrative action needed; what are actual costs and estimated cost savings; and how do we improve the workforce – number of, and training for, interpreters?”

Mara Youdelman

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7. The Complexity of Being Undocumented

7.1. The Intersection of Public Benefits & Immigration Status

Reflecting on a real life story of an undocumented immigrant who was a victim of domestic violence and confronted with a life threatening reproductive health problem, Hilary Seo highlighted the formidable challenges of being an undocumented immigrant in the United States. For this particular woman who was experiencing pain from an intrauterine device, a simple life-saving trip to a health care provider was an extremely risky proposition that had to be weighed carefully. Some of the questions she had to ask were: how would she tell her abusive partner that she was using an IUD without his knowledge? How was she to navigate the health care system without speaking English? How could she pay for medical expenses when she had no money? Would the doctor report that she had bruises on her body? Would the doctor turn her in when he/she discovered she was undocumented? What if her partner found out she saw a male doctor? How would she overcome the fear and shame she felt being a victim of assault? How would she shatter this wall of silence and isolation? Would that trip to the doctor actually save her life or would it endanger it further? What were the implications of her decision on her newborn son? What should she do?

Seo stressed the critical need for providers to arm themselves with the knowledge that will equip them to serve effectively undocumented immigrant women, especially those who are victims of domestic violence.

To shed light on the labyrinth of the immigration system, Seo described a spectrum model where on one end sits the lawful Permanent Resident status, and on the opposite end hangs the “without status” category. In between those two poles, there is a wide gray zone that includes different types of immigration status, each of which may affect eligibility for medical assistance. These categories are fluid, and individuals can fall in and out of status categories easily.

The intersection of public benefits and immigration status is complex, and it is critical that providers analyze each situation carefully in light of the immigrant woman's needs. In New York State, the following immigration categories are eligible for medical coverage:

- Lawful Permanent Residents.
- Persons Residing Under the Color of Law (PRUCOL). Category includes individuals who are undocumented but who have been living in the US with the knowledge of Department of Citizenship and Immigration Services (DCIS). These are individuals whom immigration authorities know about but have decided not to act against. PRUCOL is “in the eye of the beholder.” It is a gray area. It is a conceptual definition that was developed based on case law

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and needs to be argued before the court.

- Asylees who suffered persecution in their countries of origin.
- Temporary Protected Status. Granted to individuals from certain countries in turmoil. Once the protection period ends, the individual must either leave the country or apply for a renewal of status.
- VAWA Self-Petitioner. Created under the Violence against Women Act for women who are married to US citizens or Lawful Permanent Residents and have been subjected to cruelty by their partners. They can self-petition to receive their own immigration status.
- Children under 19 years of age, regardless of documentation.
- All undocumented immigrants are eligible for emergency Medicaid.
- Pregnant women regardless of status are eligible for Emergency Medicaid and PCAP.

“The intersection of public benefits and immigration status is seriously complicated.”

Hilary Seo

7.2. New York State Public Insurance Programs Available to Undocumented Immigrants

Alice Berger described four public insurance programs available to undocumented immigrant women:

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Pre-Natal Care Assistance Program (PCAP/MA)

Eligibility

- Offers coverage for pregnancy and health care services to pregnant women up to 200% Federal Poverty Level (FPL).
- Covers women up to 60 days postpartum and newborns up to one year of age.

Enrollment

- Clients can enroll at local Medicaid office.
- Onsite screening also provided by many family planning and PCAP providers.
- Clients can attest to their own income and can apply as independent households.
- Pregnant women who obtain PCAP/MA during first or second trimester may be enrolled in a managed care plan.
- Women who get PCAP/MA at six to nine months are exempt from managed care.

Covered Services

- 0% - 100% FPL: Comprehensive Medicaid coverage, including all family planning services and abortion.
- 100% - 200% FPL: Pregnancy-related services only, including all family planning services – not abortion.

Accessing Services

- Under PCAP/MA managed care, OB services are in-network only. Clients must use in-network providers.
- If client already has a provider, clients should be advised on which plans provider has contract with.
- Patients not enrolled in managed care can access services at any Medicaid provider.

Medicaid Family Planning Extension Program (FPEP)

Eligibility

- Provides family planning benefits to women who lose their Medicaid eligibility at the end of their pregnancy and have no other health insurance coverage.
- Client must have had full PCAP/MA coverage when pregnancy ended, and must have been pregnant within the past 2 years.

Enrollment

- Clients must register with a NYSDOH funded family planning provider and return to the same provider for services for duration of coverage.
- No automatic enrollment from PCAP/MA.
- To obtain full 24 months coverage, client must register for FPEP as soon as she loses her PCAP/MA (60 days postpartum). No re-certification.
- Client needs the following documentation:
 - Inactive Medicaid card **OR** inactive Medicaid client identification number (CIN)
- OR**
 - Letter of discontinuance from local Medicaid office, AND
 - Proof of pregnancy (Clients may self-attest to pregnancy.)

Covered Services

- Provides up to 24 months of coverage for a full range of family planning services; including GYN care; birth control; emergency contraception; pregnancy testing; STD counseling, testing and treatment; HIV counseling and colposcopy.

Accessing Services

- Client returns to same family planning provider for duration of FPEP coverage.

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Child Health Plus (CHP B)

Eligibility

-Provides comprehensive health care for children age one month to 19 years, who are not eligible for Medicaid.

-No premium for family incomes 160% - 250% Federal Poverty Level (FPL).

-Premium subsidized for family incomes 160%-250% FPL.

-Full premium for family incomes above 250% FPL.

Enrollment

-Enrollment done by managed care plans and facilitated enrollers.

-Minors, unless emancipated, cannot enroll in CHPB on their own.

Covered Services

-CHPB covers all types of birth control, emergency contraception, pregnancy testing and counseling, sterilization, abortion (medical and surgical), STD counseling, testing and treatment, HIV counseling and testing; cervical cancer, pelvic problems, breast disease, anemia, and high blood pressure.

Accessing Services

-Services provided only through managed care plans.
-All health services accessed through in network providers only.

-In choosing a health plan, families should be advised which plans their children's providers have contracts with.

-Patients can access reproductive health services at least twice per year without a PCP referral or prior authorization.

NYS Breast & Cervical Cancer Early Detection & Screening Program

Eligibility

-Provides New York State residents with free screenings for breast and cervical cancer and pre-cancerous conditions, diagnostic and case management services.

-Income up to 250%. Women 18 years of age and over who are asymptomatic for breast and cervical cancer.

Enrollment

-Screening is done by designated staff at each of the sites in a Healthy Women Partnership.

- Each county in NYS has a Healthy Women Partnership.

Covered Services

-For women 18-40: Annual pap smear and pelvic exam, annual clinical breast exam, colposcopy, ultrasound and other diagnostic testing, and annual mammogram if personal or first-degree family history of breast cancer.

-For women 40-64: Comprehensive breast and cervical cancer screenings and diagnostic testing.

-For women 65+: Comprehensive breast and cancer screenings and diagnostic testing if ineligible for or doesn't enroll in Medicare Part B.

Accessing Services

-All Services are provided through Healthy Women Partnership sites throughout New York State.

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“The system is extremely fragmented, and enrollment in programs is not an automatic process.”

Alice Berger

In addition to these four programs, the following resources are available to undocumented immigrants:

- Health and Hospitals Corporation (HHC) Plus. This is not an insurance program. It is based on HHC's reduced fee scale program. Services are available at all of New York City's HHC facilities (except Coney Island.) Outpatient clinic services only. Cost is \$15 per clinic visit, and \$10 for prescriptions, no matter how many.
- CHCs: Community Health Centers provide no- and low-cost health services to undocumented immigrants.
- Adolescents and reproductive health services: All minor enrollees have access to a full range of services regardless of

age. Services are confidential, and no parental consent is required for reproductive, emergency and mental health services, as well as alcohol and substance abuse counseling.

Immigrant women with satisfactory immigration status are eligible for all of the programs as well as the following programs: Medicaid and Child Health Plus A; Family Health Plus; Medicaid Family Planning Benefit Programs; and NYS Breast and Cervical Cancer Treatment Program.

“Under New York State Law, managed care enrollees can obtain reproductive health services from any provider in their plan twice per year without a referral from the primary care provider and without authorization from the plan. These include reproductive health visits, treatment and follow up visits. This Direct Access Law applies to Medicaid managed care, Child Health Plus, Family Health Plus, and commercial insurance plans.”

Alice Berger

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8. Closing Circle

Participants gathered in a circle to reflect on what they learned throughout the day and to renew their commitment to work with, and for, immigrant women. Many participants expressed a sense of empowerment gained by coming together with others who are also on the front lines and facing the same challenges. They conveyed a sense that although the task ahead is daunting, it is not insurmountable.

to hear participants praise the opportunity to meet potential new partners at the Regional Forums, often for the first time, it was clear that new structures for formal and ongoing local collaboration need to be developed both upstate and downstate to address the complex challenges of reaching the state's very diverse immigrant communities.

9. Next Steps

Family planning providers and immigrant-serving programs have underscored the dire need to strengthen collaboration at the local level, and to create models of mutual assistance that will actually bring reproductive health care into the worlds of immigrant women across the state. While it was exciting

“There is a need to continue to streamline the health care system to make it less bureaucratic with less forms to fill. There is also a critical need for culturally-sensitized frontline workers, and for a more humane health care system that does not treat patients as if they were in a factory.”

Bhaswati Bhattacharya

Appendices



WORKING TOGETHER TO INCREASE IMMIGRANT WOMEN'S ACCESS TO REPRODUCTIVE HEALTH CARE

Regional Forum Agenda

**Thursday, October 23, 2003
8:30 AM-4:30 PM**

**YWCA
610 Lexington Avenue @ 53rd Street
New York City**
SUBWAYS: E,V (Lexington & 53rd St.) and #6 (Lexington & 51st St.)
BUSES: M101, M102 and M103

Sponsored By:

Center for Women in Government & Civil Society
University at Albany
135 Western Avenue
Albany, New York 12222
(P) 518-442-3887
(F) 518-442-3877
www.cwlg.albany.edu

Family Planning Advocates of
New York State, Inc.
17 Elk Street
Albany, New York 12207
(P) 518- 436-8408
(F) 518-436-0004
www.fpaofnys.org

**WORKING TOGETHER TO INCREASE IMMIGRANT WOMEN'S ACCESS TO
REPRODUCTIVE HEALTH CARE**

Agenda
Thursday, October 23, 2003

- 8:30 – 9:00** **Registration**
- 9:00 – 9:30** **Welcome, Introductions & Objectives of the Day**
- Maud Easter, Center for Women in Government & Civil Society
 - Karen Anderson, Family Planning Advocates of New York State
- 9:30 – 10:45** **Cultural Influences of Different Immigrant Communities on
Reproductive Health**
- Moderator: Marianne Yoshioka, School of Social Work, Columbia University*
- Maria Uribelarrea, MIC-Women's Health Services/MHRA
 - Zeinab Eyega, Research Action & Information Network for Bodily Integrity of Women (RAINBO, African Immigrant Program)
 - Rashidah Abdul-Khabeer, Circle of Care, Philadelphia
- 10:45 – 11:00** **Coffee Break**
- 11:00 – 12:30** **Promising Models in Reaching & Serving Immigrant Women**
- Moderator: Silvia Henriquez, National Latina Institute for Reproductive Health*
- Maaza Seyoum, Health Programs, African Services Committee, New York City
 - Dinah Surh, Lutheran Family Health Centers
 - Zerena Khan, Sakhi for South Asian Women
- 12:30 – 1:30** **Networking Lunch**

WORKING TOGETHER TO INCREASE IMMIGRANT WOMEN'S ACCESS TO REPRODUCTIVE HEALTH CARE

- 1:30 – 2:45** **Workshops**
- Workshop A** **Producing Culturally-Competent Outreach Materials**
- Moderator: Mala Desai, Northern Queens Health Coalition*
- Claudia Ayash, Cancer Institute, New York University
 - Adam Gurvitch, New York Immigration Coalition
- Workshop B** **Overcoming Language Barriers to Accessing and Providing Services**
- Moderator: Linda Gonzalez, Planned Parenthood Federation of America*
- Mara Youdelman, National Health Law Program (NHeLP)
- 2:45 –3:00** **Coffee Break**
- 3:00 – 4:15** **Plenary Session: The Complexity of Being Undocumented**
- Moderator: Dina Refki, Center for Women in Government & Civil Society*
- Hilary Seo, Center for Battered Immigrant Women's Legal Services
 - Alice Berger, Planned Parenthood of New York City
- 4:15 – 4:30** **Closing Circle**
- 4:30** **Adjourn**

Working Together to Increase Immigrant Women's Access to Reproductive Health Care

New York City Regional Meeting
October 23, 2003

FEATURED SPEAKERS & MODERATORS

Rashidah Abdul-Khabeer, R.N., M.H.S.,

DEPUTY DIRECTOR, CIRCLE OF CARE OF FAMILY PLANNING COUNCIL

Rashidah Abdul-Khabeer is currently the Deputy Director for the Circle of Care, a program of the Family Planning Council that provides HIV-related education and services for women, children, and their families. Ms. Abdul-Khabeer has administrative responsibilities for its Clinical and Support Services and the Perinatal HIV Transmission Prevention Program. As a consultant and trainer, Ms. Abdul-Khabeer has pioneered HIV prevention education and services for African-American and other communities of color since 1983. In 1985, she founded BEBASHI, Blacks Educating Blacks About Sexual Health Issues, a Philadelphia community-based organization providing sexual health education, case management, and support services. She is a founding member of the Philadelphia AIDS Consortium, the Minority AIDS Project of Philadelphia, and the National Minority AIDS Council in Washington, DC.

Ms. Abdul-Khabeer has served as guest lecturer and faculty for several educational programs. She received her nursing education from the Medical College of Pennsylvania, and her Master in Human Services from Lincoln University, Pennsylvania. She has also been a practicing Muslim for more than 20 years and is currently pursuing an undergraduate degree in Islamic Studies from the American Open University in Virginia. She has taught Islamic studies in the Madrassah of Masjid-u-llah and the United Muslim Masjid as well as Islamic studies for women throughout the Philadelphia area. She is the co-Founder of the Islamic Association for the Betterment of Human Life, a nonprofit organization providing human services to the Muslim communities of Philadelphia and the surrounding counties.

Claudia Ayash, M.P.H

MANAGER, COMMUNITY EDUCATION AND OUTREACH PROGRAM OF NYU
CANCER INSTITUTE

Claudia Ayash is currently the manager of New York University Cancer Institute's Community Education and Outreach program. In conjunction with the outreach team and members of key organizations, Ms. Ayash designs programs and

materials to increase the presence of the Cancer Institute in the community, to enhance oncology services for underserved individuals (through association with Bellevue Hospital Center), and to improve public awareness about the prevention and warning signs of cancer. Ms. Ayash was previously a health educator at the Community Health Resources department of Saint Vincent's Hospital where she implemented awareness and screening programs for the public. She graduated from New York University with a Master of Public Health in 1996.

Alice Berger, R.N., M.P.H

DIRECTOR OF HEALTH CARE PLANNING AND MANAGED CARE INITIATIVES,
PLANNED PARENTHOOD OF NYC

Alice Berger is Director of Health Care Planning and Managed Care Initiatives at Planned Parenthood of New York City. Ms. Berger is responsible for managed care policy and its impact on clinical and advocacy issues. As a consultant to The Door, Ms. Berger formulates policy and contractual strategies for collaboration with the managed care environment. She has worked extensively with ensuring comprehensive primary care to at-risk families through her work at MHRA as Director of the Infant Child Health Assessment Program. Prior to that, she directed the Prenatal Care and Assistance Program at St. Vincent Hospital and Medical Center.

Ms. Berger was a founding member and co-chair of the New York State Assembly Health Committee/Perinatal Advisory Committee and presently Chairs the Family Health Issues Committee that focuses on a wide array of adolescent health issues. In addition, Ms. Berger was instrumental in crafting the policy and operational methods of the new Medicaid Family Planning Benefit Program. Ms. Berger was recently awarded the National Family Planning and Reproductive Health Association (NFPRHA) Advocacy and Public Affairs Award.

Mala Desai, M.S.W., M.S.

EXECUTIVE DIRECTOR, NORTHERN QUEENS HEALTH COALITION

Mala Desai is the Executive Director of the Northern Queens Health Coalition, which has over 55 member agencies providing direct services to the residents of Queens. As the Executive Director, Ms. Desai has facilitated the development of several key projects for membership in response to improving community health needs. Some of these projects include the Caregiver Support Services Partnership for Queens Region 11, the Queens Community-Oriented Palliative Care Initiative, and the Access to and Quality of Maternal and Infant Health Care Program.

Ms. Desai is also the Founder and Chairperson of Pragati, Inc., which is an organization dedicated to empowering South Asian women by addressing the

need for economic self-reliance and independence. The organization has provided services to over 5,000 South Asian women and families since its inception in 1984. Ms. Desai is also Founder, Director, and Teacher of “Mala’s School of Odissi Dance®,” which teaches the Indian classical dance style of Odissi.

Previously, Ms. Desai worked as the Program Director for the New York Immigration Coalition where her responsibilities included managing the project, “Transforming Education for New York’s Newest” for the Donors’ Education Collaborative. Ms. Desai completed her undergraduate degree in Psychology from the University of Delhi, where she also received her Master of Social Work. She holds a Master of Science from the New School for Social Research.

Zeinab Eyega, M.S.

PROGRAM DIRECTOR, AFRICAN IMMIGRANT PROGRAM (RAINBO)

Zeinab Eyega is the Director of the African Immigrant Program at Research, Action and Information Network for Bodily Integrity of Women (RAINBO) and has been with the organization since its creation. In 1995, Ms. Eyega started the immigrant program through a pilot project that examined the needs of circumcised women and girls in New York City. Since then, the pilot project has expanded into a program that addresses reproductive, sexual health, and rights of African immigrants and refugee women in the United States. Her published works include, "Facts and Fiction Regarding Female Circumcision/Female Genital Mutilation: A Pilot Study in New York City," which was published in the Journal of American Medical Women’s Association. Ms. Eyega has contributed to the development of RAINBO’s technical manual for healthcare providers entitled, *Caring for Women with Circumcision: A Technical Manual for Health Care Providers* and to the soon-to-be released book, *Female Genital Mutilation: A Guide to Worldwide Laws and Policies*.

In addition to teaching and public speaking, Ms. Eyega has facilitated numerous cross-cultural competency workshops for health care providers and reproductive health promotion seminars for African immigrant and refugee communities throughout the United States. Ms. Eyega is from southern Sudan and holds a Master of Science in International Health Policy from the New School University.

Linda Gonzalez, J.D., M.A.

VICE PRESIDENT OF DIVERSITY, PLANNED PARENTHOOD FEDERATION OF AMERICA

Linda Gonzalez, Vice President of Diversity, provides overall leadership for the Diversity Initiative. Ms. Gonzalez works with the management and staff of the

national organization and its affiliates in establishing and implementing programs to meet diversity objectives. Additionally, she works with the national board of directors and its affiliate boards and volunteers.

Ms. Gonzalez's previous positions have included working as a public interest attorney, social worker, and Diversity Trainer and Consultant with the TODOS-Sherover/Simms Alliance Building Institute. As a diversity consultant and trainer, she developed and conducted training programs for schools, non-profit organizations, and government agencies to promote collaboration and alliance building among culturally diverse groups and individuals. As a consultant, Ms. Gonzalez provided guidance to organizations in meeting their short and long-term goals.

Ms. Gonzalez completed her undergraduate work at UCLA where she earned a degree in Sociology. She is a graduate of San Jose State University where she earned a Masters of Arts degree and graduated from New College of California with a Juris Doctor degree.

Adam Gurvitch, M.A.

DIRECTOR OF HEALTH ADVOCACY, NEW YORK IMMIGRATION COALITION

Adam Gurvitch is the Director of Health Advocacy for the New York Immigration Coalition, a nonprofit immigrants' rights network representing more than 150 groups. Mr. Gurvitch leads organizing and advocacy to improve immigrants' access to affordable health care and insurance coverage and works at the city, state, and federal levels to achieve policy reform. Previously, Mr. Gurvitch established a national HIV/AIDS education program in Hungary, where he lived for three years. His first job in public health was with the American National Red Cross, where he worked in program development and the evaluation of community-based HIV-prevention programs. He holds a Masters degree from the Milano Graduate School of Management and Urban Policy, at New School University.

Silvia Henriquez, M.A.

EXECUTIVE DIRECTOR, NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

Silvia Henriquez is the Executive Director of the National Latina Institute for Reproductive Health, an organization dedicated to ensure the fundamental human right to reproductive health for Latinas, their families, and their communities through education, advocacy, and coalition building. Ms. Henriquez provides the type of cutting edge, dynamic leadership necessary to advance a national, Latina movement that will help to improve access to reproductive health services and defend the reproductive freedom of Latinas. She has extensive policy advocacy experience and recently co-authored, *Our Health, Our Rights: Reproductive Justice for Latinas in California*, during her tenure as a health policy

analyst for the Latino Issues Forum. Previously, Ms. Henriquez worked as the outreach director of the National Abortion Federation (NAF), developing strategies to increase reproductive health access for women of color across the nation. Prior to her work at NAF, Ms. Henriquez worked as an organizer, and thereafter, the coordinator of the National Campus Organizing program of the Feminist Majority Foundation.

Zerena Khan, R.N.

SAKHI FOR SOUTH ASIAN WOMEN

Zerena Khan is a member of Sakhi for South Asian Women, which is a community-based organization in the New York metropolitan area committed to ending the exploitation and violence against women of South Asian origin. Recognizing oppression based on class, immigration status, religion, and sexual orientation, Sakhi works to empower women, particularly survivors of domestic violence. Sakhi strives to create a voice and safe environment for all South Asian women through outreach, advocacy, leadership development, and organizing.

Ms. Khan is also a registered nurse and clinical nurse administrator at the MIC-Women's Health Services in Astoria, Queens.

Hilary Sunghee Seo, J.D.

CO-DIRECTOR, COMMUNITY LIAISON PROJECT AT SANCTUARY FOR FAMILIES' CENTER FOR BATTERED WOMEN'S LEGAL SERVICES

Hilary Sunghee Seo is Co-Director of the Community Liaison Project at Sanctuary For Families' Center For Battered Women's Legal Services, where she focuses on conducting community outreach, public education, and advocacy on issues concerning gender-based violence and providing direct legal representation to immigrant domestic violence victims. Ms. Seo's clients are survivors of a wide-range of gender-based violence, including rape, battering, trafficking/prostitution, honor-killing and female genital mutilation. The Community Liaison Project reaches out to the Arabic, Bengali, Cantonese, Fujianese, Hindi, Korean, Mandarin, Spanish, Urdu, and Vietnamese-speaking communities in the Metropolitan New York area through close collaboration with community-based social service organizations already serving domestic violence victims in these communities.

Prior to joining Sanctuary For Families, Ms. Seo was an associate at Wachtell, Lipton, Rosen & Katz and clerked for Judge Eugene H. Nickerson of the U.S. District Court for the Eastern District of New York. Ms. Seo received her Juris Doctor from Columbia Law School, where she was an Articles Editor of the Columbia Law Review, and her Bachelor of Arts from Harvard University.

Maaza Seyoum, M.P.H.

ASSISTANT DIRECTOR, HEALTH PROGRAMS, AFRICAN SERVICES COMMITTEE

Maaza Seyoum joined the African Services Committee (ASC) as the Assistant Director of Health Programs in September 2002. Ms. Seyoum is responsible for the supervision and oversight of health programs, monitoring and evaluation, data-analysis, report writing, and managing program staff. She also coordinates the volunteer/intern program at African Services.

Prior to joining ASC, Ms. Seyoum participated in the development and implementation of multi-sectoral programs for Save the Children in Mali and the World Health Organization's Regional Office for Africa. Her primary interests include the links between health, health behavior, and socio-economic status, particularly among women and adolescents. Ms. Seyoum is actively assisting ASC to develop its international capacity. She holds a BA in Sociology from Pitzer College and a Masters in Public Health from Columbia University. Ms. Seyoum is Ethiopian and was raised in Cote d'Ivoire. She is fluent in both English and French.

Dinah Surh, M.P.H.

VICE PRESIDENT/ADMINISTRATOR, LUTHERAN FAMILY HEALTH CENTERS

Dinah Surh is Vice President/Administrator of Lutheran Family Health Centers in Brooklyn, New York, one of the largest community health center networks in the country.

Having over twenty years of experience in direct senior ambulatory care management for both hospitals and community-based primary care networks, Ms. Surh has created and implemented many innovative primary care programs in the ethnically diverse neighborhoods of New York City. Ms. Surh was instrumental in developing cultural initiatives to ensure cultural competence throughout Lutheran Family Health Centers, including facility design, signage, creating patient relations representative roles, instituting staff training in customer service, cultural diversity, medical interpretation and translation skills and team building, utilizing new telephone technology for translation, producing a multilingual website and monitoring quality activities system-wide to ensure patient safety and satisfaction.

She is currently an officer on the Board of Directors of the New York Association for Ambulatory Care, a member of the National Center for Cultural Competence Advisory Committee based in Georgetown University in Washington, DC, Office of Minority and Women's Health, DHHS, and was a member of the Cultural and Linguistic Appropriate Services (CLAS) Standards National Advisory Committee, Office of Minority Health, DHHS. Ms. Surh holds a B.A. in Sociology from Barnard College/Columbia University and a Masters in Public Health in Hospital

Administration from the School of Public Health at the University of California at Berkeley.

Maria Uribelarrea, R.N.

DIRECTOR, MIC-WOMEN'S HEALTH SERVICES/MHRA

Maria Uribelarrea, is Executive Director for MIC-Women's Health Services, a service division of MHRA that provides prenatal, family planning, and medical abortion services to New York City's underserved communities through a network of eight centers located in Brooklyn, Manhattan, Bronx, and Queens. With over 30 years of experience delivering health care to women and families in medically underserved communities, Ms. Uribelarrea has been instrumental in creating a culturally sensitive and diverse environment for the women, 65% of whom are immigrants, visiting the centers. Under her supervision, MIC-Women's Health Services recently finished conducting a focus group study of Mexican, Ecuadorian, Pakistani, and Bengali women to understand their differing views on birth control and method choice.

Ms. Uribelarrea is a firm proponent of women and families' right to access health care that is coordinated through a provider with whom they develop a special and on-going relationship of trust. Senior positions at Planned Parenthood of NYC and the NYC Health and Hospitals Corporation have honed her leadership and organizational skills while her clinical experience, from fourteen years as a nurse practitioner in an innovative practice, has sensitized her to client and provider needs. Ms. Uribelarrea's own experience as an immigrant from Argentina helped her view cultural diversity as an asset and an enriching experience for all.

Marianne R. Yoshioka, Ph.D., M.S.W.

ASSOCIATE PROFESSOR, COLUMBIA UNIVERSITY SCHOOL OF SOCIAL WORK

Marianne Yoshioka is an Associate Professor of Professional Practice at the Columbia University School of Social Work. She teaches in the areas of clinical practice, advanced research methods, and practice with battered women. Dr. Yoshioka's professional and research interests include domestic violence among immigrant populations, HIV prevention, substance abuse, and the design of culturally appropriate intervention. She has received funding from the National Institute of Mental Health and private foundations to conduct research in these areas. Dr. Yoshioka's current work focuses on the development of a model to explain the ways in which the cultural context shapes the experience of partner abuse. She has worked as a social worker in the area of addictions and marriage and family therapy.

Mara Youdelman, J.D., LL.M.

ATTORNEY, NATIONAL HEALTH LAW PROGRAM

Mara Youdelman has worked at the National Health Law Program (NHeLP) since August 2000 on issues including Medicaid, racial and ethnic disparities, reproductive health, and immigrants' issues. Ms. Youdelman is the co-author of a Field Report from The Commonwealth Fund, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*. With The Access Project, she has co-developed the *Language Services Action Kit* on funding reimbursement in Medicaid/SCHIP (the State Children's Health Insurance Program) for language services. She is also co-author of *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. Ms. Youdelman recently completed work on a joint report with the Summit Health Institute for Research and Education, also funded by The Commonwealth Fund, entitled *Racial, Ethnic and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*.

Ms. Youdelman also participates as a member of the Office of Minority Health's National Project Advisory Committee to develop national healthcare interpreter standards. Prior to joining NHeLP, she completed a teaching fellowship at Georgetown University Law Center's Federal Legislation Clinic and two years litigating for the Administration for Children's Services in New York City on child abuse and neglect cases. Ms. Youdelman earned her Juris Doctor from Boston University School of Law and her Master of Laws in Advocacy from Georgetown University Law Center.

**Working Together to Increase Immigrant Women's Access to
Reproductive Health Care**

**New York City Regional Meeting
October 23, 2003**

PARTICIPANTS

Catherine M. Abate

Community Healthcare Network
79 Madison Avenue, 6th Flr.
New York, NY 10016
Phone: (212) 366-4500, ext. 262
cabate@chnnyc.org

Rashidah Abdul-Khabeer

Circle of Care
Suite 1000
260 S. Broad St.
Philadelphia, PA 19102
Phone: 215 985- 2606
Fax: 215 732
Rashidah@familyplanning.org

Hamra Ahmed

My Sisters' Place
45 Ludlow St. Suite 310
Yonkers, New York 10705
Phone: (914) 963-6701
hahmad@mysistersplaceny.org

Judy Ah-Yune

Chinese American Planning Council
365 Broadway
New York, NY 10013
Phone: (212) 941-0030
cpc365judy@hotmail.com

Karen Anderson

Family Planning Advocates
17 Elk Street, Suite #3
Albany, NY 12207
Phone: (518) 436-8408
Fax: (518) 436-0004
Karen@fpaofnys.org

Claudia Ayash

Community Education & Outreach Program
NYU Cancer Institute
550 First Avenue
New York, NY 10016
Claudia.ayash@med.edu.nyu.edu

Tamar Bauer

Child Health Forum
New York Academy of Medicine
1216 5th Avenue
New York, NY 10029
Phone: (212) 822-7275
tbauer@nyam.org

Carmina Bernardo

Planned Parenthood New York City
Margaret Sanger Square
26 Bleecker Street
New York, NY 10012-2413
Phone: (212) 274-7201
Carmina.bernardo@ppnyc.org

Alice Berger

Planned Parenthood New York City
Margaret Sanger Square
26 Bleecker Street
New York, NY 10012-2413
Phone: (212) 274-7373
Alice.berger@ppnyc.org

Bhaswati Bhattacharya

SAKHI for South Asian Women
P.O. Box 20208
Greeley Square Station
New York, NY 10001
Phone: (212) 645-6745
bhaswati@aol.com

Susan Chamlin

State Senator Liz Kruger
211 East 43rd Street
New York, NY 10017
Phone: (212) 490-9535
Susanchamlin@aol.com

Anindita Chatterjee Bhamik

Sanctuary for Families
67 Wall Street
Suite 2211
New York, NY 10005-3198
Phone: (212) 349-6009
Anindita@sffny.org

Pat Churchill
DVCAT
750 Astor Ave.
Bronx, NY 10467
Office: (718) 882-5000
PHILLS61@aol.com

Mala Desai
Northern Queens Health Coalition
39-01 main Street, Suite 611
Flushing, NY 11354
Phone: (718) 661-9313
NQHC@aol.com

Anh Doh
Asian & Pacific Islander Coalition on AIDS
150 Lafayette Street, 6th Floor
New York, NY 10013
Phone: (212) 334-7940
anhdo@apicha.org

Maud Easter
Center for Women in Government &
Civil Society
135 Western Ave.
Albany, NY 12222
Phone: (518) 442-3887
Fax: (518) 442-3877
easter@albany.edu

Zeinab Eyega
RAINBO, African Immigrant Program
915 Broadway, Suite #1109
New York, NY 10010-7108
Phone: (212) 477-3318
Fax: (212) 477-4154

Jan Figueria
Planned Parenthood Nassau
540 Fulton Ave.
Hempstead, NY 11550
Office: (516) 750-2600
jan.figueria@ppfa.org

Carol Galan

Carla Goldstein
Planned Parenthood New York City
26 Bleecker St.
New York, NY 10012
Phone: (212) 274-7292
carla.goldstein@ppnyc.org

Linda Gonzalez
Planned Parenthood Federation of America
434 W. 33rd St.
New York, NY 10001
Phone: (212) 261-4646
Linda.gonzalez@ppfa.org

Raycenth Green

Adam Gurvitch
New York Immigration Coalition
275 7th Ave., 9th Floor
New York, NY 10001
Phone: (212) 627-2227, ext. 222
Fax: (212) 627-9314
agurvitch@thenyic.org

Silvia C. Henriquez
National Latina Institute for Reproductive
Health
162 Montague St., 3rd Flr.
Brooklyn, NY 11201
Phone: 718.260.8811
Fax: 718.260.9941
silvia@latinainstitute.org

Elizabeth Howell
Community Healthcare Network
79 Madison Ave., 6th Flr.
New York, NY 10016
Phone: (212) 366-4500
ehowell@chnnyc.org

Carine Jocelyn
Haitian Women's Program
464-466
Brooklyn, NY 11217
Phone: (718) 399-0200
info@haitainwomensprogram.org

Anne Keenan
Planned Parenthood New York City
26 Bleecker Street
New York, NY 10012
Phone: (212) 274-7377
anne.keenan@ppnyc.org

Zerena Khan
SAKHI for South Asian Women
P.O. Box 20208
Greeley Square Station
New York, NY 10001
Phone: (212) 714-9153
Fax: (212) 564-8745

Nyanda Labor

Bureau of Maternal Infant and Reproductive Health
NYC Dept. of Health & Mental Hygiene
Phone: (212) 442-1755
nlabor@health.nyc.gov

LeeChe P. Leong

Teen Health Initiative
New York Civil Liberties Union
125 Broad Street, 17th Floor
New York, NY 10004
Phone: (212) 344-3005 x241
Fax: (212) 344-3318
lleong@nyclu.org

Kathleen Lopez

Community Healthcare Network
79 Madison Ave., 6th Flr.
New York, NY 10016
Phone: (212) 366-4500
klopez@chnnyc.org

Eileen Meltzer**Alexandra Milonas**

Service Program Management
Medical and Health Research Association of New York City
40 Worth Street, Suite 720
New York, NY 10013
Phone: (212) 285-0220, ext. 114
amilonas@mhra.org

Bridget Money Penny

MIC-Women's Health Services/MHRA
225 Broadway, 17th Flr.
New York, NY 10007
Phone: (212) 267-0900, ext. 242
Fax: (212) 212-571-5641
bmoneypenny@mic-mhra.org

Haydee Morales

Planned Parenthood New York City
26 Bleecker Street
New York, NY 10012
Phone: (212) 274-7320
Haydee.morales@ppnyc.org

Tammy Nazarko

Bureau of Women's Health
New York State Dept. of Health
Corning Tower, Room #1805
Albany, NY 12237
tnno2@health.state.ny.us

Anum Nyako

Planned Parenthood New York City
26 Bleecker Street
New York, NY 10012
Phone: (212) 274-7323
Anum.nyako@ppnyc.org

Beth Pollack

Planned Parenthood Hudson Peconic
4 Skyline Drive
Hawthorne, NY 10532
Phone: (914) 467-7300
beth.Pollack@ppfa.org

Jaya Ramji

ACLU Reproductive Freedom Project
125 Broad Street, 18th Floor
New York, NY 10004
Phone: (202) 549-2631
jramji@aclu.org

Gemma Pujadas Ribeiro

Kings County District Attorney's Office
Domestic Violence Bureau
350 Jay Street
Brooklyn, NY 11201
Phone: (718) 250-2080
gpujadas@juno.com

Dina Refki

Center for Women in Government & Civil Society
135 Western Ave.
Albany, NY 12222
Phone: (518) 442-5127
Fax: (518) 442-3877
drefki@albany.edu

Sandra Romain

Haitian-American United for Progress
221-05 Linden Blvd.
Cambria Heights, NY 11411
Phone: (718) 527-3776
Sromain@haupinc.org

Nelly Santiago-Rivera

Planned Parenthood of Nassau County
Boro Hall Center
40 Court Street, 6th Floor
Brooklyn, NY 11201
Phone: (212) 965-7125
Fax: (212) 965-7181
Nellie.Santiago-Rivera@ppnyc.org

Hilary Sunghee Seo

Community Liaison Project Sanctuary for
Families' Center for Battered Women's
Legal Services
P.O. Box 1406
Wall Street Station
New York, NY 10268-1406
Phone: (212) 349-6009
Fax: (212) 349-6810

Maaza Seyoum

African Services Committee, Inc.
429 West 127 Street
New York, NY 10027
Phone: (212) 222-3882 x 122
maazas@africanservices.org

Kruti Shastri

SAKHI for South Asian Women
P.O. Box 20208
Greeley Square Station
New York, NY 10001
Phone: (212) 714-9153
Fax: (212) 564-8745
kruti311@yahoo.com

Charli Summers

Planned Parenthood Hudson Peconic
4 Skyline Drive
Hawthorne, NY 10532
Phone: (914) 467-7310
charli.summers@ppfa.org

Dinah Surh

Lutheran Medical Center/Lutheran Family
Health Centers
150 55th Street, Station 20, LFHC
Administration
Brooklyn, NY 11220
Phone: 718-630-7215
Fax: 718-630-6828
dsurh@lmcmc.com

Rebecca Sze

Charles B. Wang Community Health Center
268 Canal Street,
New York, NY 10013
Phone: (212) 966-0228 Ext. 105
rsze@cbwchc.org

Connie Tse

New York Asian Women's Center
39 Bowery, PMB 375
New York, NY 10002
Phone: (212) 732-5230
Ctse@nyawc.org

Maria Uribelarrea

MIC-Women's Health Services/MHRA
225 Broadway, 17th Flr.
New York, NY 10007
Phone: (212) 267-0900
Muribelarrea@mic-mhra.org

Lois Uttley

Education Fund of Family Planning
Advocates
17 Elk Street, Suite #3
Albany, NY 12207
Phone: (518) 436-8408
Fax: (518) 436-1048
lois@mergerwatch.org

Jessica F. Vasquez

National Latino Alliance for the Elimination
of Domestic Violence
P.O. Box 672
Triborough Station
New York, NY 10035
Phone: (646) 672-1404
Fax: (646) 672-0360
jvasquez@dvalianza.org

Wilma E. Waithe

Office of Minority Health
New York State Department of Health
ESP-Corning Tower Building, Rm. 780
Albany, NY 12237
Phone: (518) 474-2180
Wew01@health.state.ny.us

Sang Hee Won

Education Fund of Family Planning
Advocates
17 Elk Street, Suite #3
Albany, NY 12207
Phone: (518) 436-8408
Fax: (518) 436-1048
sanghee@mergerwatch.org

Ada Wong

Coordinator of Women's Health
Charles B. Wang Community Health Center
268 Canal Street,
New York, NY 10013
Phone: (212) 966-0228 Ext. 105
awong@cbwchc.org

Mara Youdelman

National Health Law Program
1101 14th Street, NW, Suite #405
Washington, D.C. 20005
Phone: (202) 289-7661
Fax: (202) 289-7724
youdelman@healthlaw.org

Marianne Yoshioka

School of Social Work
Columbia University
McVickar Hall
622 West 113th St.
New York, NY 10025
Phone: (212) 854-5669
mry5@columbia.edu

Jenny Zhang

Charles B. Wang Community Health Center
268 Canal Street,
New York, NY 10013
Phone: (212) 966-0228 Ext. 105
jzhang@cbwchc.org

Appendix D: Evaluations

1. Participants and Responses:

- Number of participants: 55
- Number of Responses: 27

2. Content and Format:

Figures below show number of responses for each category.

	Excellent	Good	Average	Fair	Poor	Blank
Morning Panel: <i>Cultural Influences of Different Immigrant Communities on Reproductive Health</i>	21	5	1	0	0	0
Mid-Morning Panel: <i>Promising Models in Reaching & Serving Immigrant Women</i>	15	10	2	0	0	0
Workshop A: <i>Producing Culturally-Competent Outreach Materials</i>	8	9	7	1	0	2
Workshop B: <i>Overcoming Language Barriers to Accessing & Providing Services</i>	9	15	0	0	0	3
Plenary: <i>Complexity of Being Undocumented</i>	10	10	2	0	0	5
Overall Experience	13	14	0	0	0	0
Overall Organization	15	7	3	0	0	2

3. Themes:

Most useful aspects of the meeting:

- Hearing about models and examples of success
- Networking time and opportunities
- Hand-outs and organizational resources
- Discussion about the role of men

- Question and Answer sessions
- Morning Panel
- Workshop B
- Legal requirements and clarifications for undocumented clients
- Awareness of African and Muslim countries
- Lay-out of the room
- Plenary session
- Participant list
- Use of PowerPoint
- Learning about various referrals for clients

Least useful aspects of the meeting:

- Micro-focused discussions given the larger institutionalized problems
- Lay-out of the room
- Lack of discussion on how problematic the existing systems is
- Information at particular providers

Most relevant aspects for participants' work:

- Ideas for program development and improvement
- Clarification on the unique issues facing immigrant women
- Networking opportunities
- Suggestions on how to improve communication with organizations
- Overcoming language barriers
- Cultural influences
- Producing culturally-competent materials
- Concrete ideas for promising models
- Implications on child health
- Clinical initiatives to produce change
- Initiatives to educate health care professionals
- Title VI information

15 participants completing the survey stated that receiving technical assistance would be useful to develop a local collaboration between immigrant community-based and family planning agencies.

- Of the 15, 12 said they would like assistance in identifying partners
- Of the 15, 8 said they would like a strategy for organizing initial meeting of collaborating partners
- Of the 15, 12 said they would like resources on collaboration