

# **The Bronx Health Link 2011 Annual Forum**



**Pregnancy, Childbirth, and Baby Care Across  
Cultures: Understanding, Respecting, and  
Serving Immigrants in the Bronx**

## **About The Bronx Perinatal Information Forum**

*The Bronx Perinatal Information Network (PIN)*, a project of The Bronx Health Link, is funded by the New York State Department of Health, Bureau of Women's Health. It is part of the statewide *Comprehensive Prenatal-Perinatal Services Network Program (CPPSN)* established in 1987. The mission of the Bronx PIN is to identify and organize information about the healthcare and social services system in the Bronx in order to improve the prenatal and perinatal health of women, their children, and their families.

## **About The Bronx Health Link, Inc.**

The Bronx Health Link (TBHL) is a clearinghouse of health care information for providers and consumers in the Bronx. TBHL coordinates the Bronx Perinatal Information Network and the Infant Mortality Reduction Initiative in the Bronx. The agency provides:

- Referrals
- Educational workshops for consumers and providers,
- Health information and promotion and materials for women and their families located throughout the community.

TBHL also works to improve community health by:

- identifying, organizing and sharing information with providers and consumers on services and resources in the community
- Identifying emerging community health issues
- Addressing gaps in services by fostering opportunities for collaboration and cooperation to maximize the availability of quality services

## **Acknowledgements**

The creation of this report was a collaborative effort. Thanks to the staff of The Bronx Health Link — Jessica Robles had the original idea for the theme of the conference, Gillian Saunders wrote much of the text of these proceedings, Joann Casado and Robert Lederer wrote other parts, and Joann Casado edited the final report.

Esperanza de los Santos, Luisa Solis, Noel Marrero, and Jessica Robles provided staff support for the conference itself.

We would also like to thank the conference sponsor, the New York State Department of Health through the Comprehensive Perinatal-Prenatal Services Network.

## Introduction

On May 10, 2011, the Bronx Perinatal Network sponsored its Annual Forum at Lehman College on the theme of *Pregnancy, Childbirth, and Baby Care Across Cultures: Understanding, Respecting, and Serving Immigrants in the Bronx*.

Recent census data indicates that the Bronx is experiencing increased numbers of immigrants who make this borough their home. It is now home to communities including a recent influx from Mexico, the Dominican Republic, Senegal, Mali, Ghana, Bangladesh, India, Vietnam, Thailand, and many other countries.

This forum looked at those changing demographics with an emphasis on some of the pregnancy, childbirth and postpartum baby care practices of the different cultures that now reside in the Bronx. As health educator Rosmer Arzola, one of the conference speakers, said, “When people immigrate, they bring with them their traditional beliefs, values and practices. Personal acculturation [how much the individual has adopted U.S. cultural practices] and economic status affects an immigrant woman’s pregnancy and childbirth experience in New York City.” So the conference also examined how care providers can increase their ability to serve people from those cultures with respect, awareness, and knowledge of services and programs available to them. Speakers included care providers and health educators from the various nationalities and cultures who serve mothers and children, as well as academics and advocates with important knowledge of the issues facing these communities.

The goals of the conference were to help participants gain an understanding of:

- the cultural practices of several major cultural/national groups that live in the Bronx with regard to pregnancy, childbirth, and postpartum baby care.
- the best methods to increase cultural competence and provide interpretation in the needed languages
- the ways to help immigrants – both documented and undocumented -- obtain all the medical coverage and services available to them.

Similarly, this report seeks to bring to a larger audience the knowledge and insights shared by the presenters at the conference. In addition, we are offering our recommendations to both individual care providers and organizations providing pregnancy and baby care and health education as to how to increase cultural competence and greater access to these services for immigrants in the Bronx.

We hope that providers, as well as health and human service agencies, will use this report to increase their knowledge and awareness of these pressing issues, and will advocate for institutional change that can lead to better, more sensitive and appropriate care for this growing segment of the Bronx community.

**Copies of this report – and of a CD containing other documents with more information about these communities and issues -- can be obtained by calling The Bronx Health Link at (718) 590-2648 or emailing [bob@bronxhealthlink.org](mailto:bob@bronxhealthlink.org).**

**Forum Program:**  
***Pregnancy, Childbirth, and Baby Care Across Cultures:  
Understanding, Respecting, and Serving Immigrants in the Bronx***

9:00 – 9:20 Welcome, Introduction, Overview

9:20 – 11:20 **Panel One – Community Perspectives: Cultural Traditions in Pregnancy, Childbirth and Postpartum care**

Speakers from:

- Dominican community (Rosmer Arzola)
- Mexican community (Alyshia Gálvez)
- Bangladeshi community (Mahbooba Akhter Kabita)
- West African community (Rosamond Bankole)

11:20 – 11:30 Break

11:30 – 12:50 **Panel Two – Provider Perspectives: How to Provide Culturally and Linguistically Appropriate Care; Issues of Coverage and Rights**

Addressing:

- Achieving cultural competency
- Reaching immigrant communities
- Language access: Translation and interpretation
- Coverage and rights for immigrants - documented and undocumented

Speakers:

- Deborah Pelto
- Judy Wessler
- Marija Sajkas
- Rosmer Arzola

12:50 – 1:00 Closure and evaluation

## **Overview: Understanding, Respecting and Serving Immigrants in the Bronx: An Overview of Immigration in the Bronx**

Joann Casado, Executive Director, The Bronx Health Link

The central question to consider is: What does diversity mean for provision of care?

**Changing Demographics:** Between 1990 and 2010, the number of foreign-born U.S. residents almost doubled from 20 million to 40 million, while the U.S. population rose from 250 million to 310 million. Thus, immigration directly contributed to one-third of U.S. population growth, and with U.S. born-children and grandchildren of immigrants, immigration contributed to half of the U.S. population. An unauthorized (aka undocumented or “illegal”) immigrant is a person who *resides* in the U.S. but is **not** a U.S. citizen and has **not** been admitted for permanent residence.

As to immigrants in New York City, 44% or 2.7 million of the adult population are foreign-born. As a result, NYC's health is increasingly characterized by the health of the foreign-born. Research has shown that the longer immigrants are here in the U.S., the more they pick up the habits of this country – which are certainly not all good.

In the Bronx, 31% of the borough's almost 1.4 million residents are foreign-born, making the Bronx one of the top-10 most diverse cities in the United States according to the U.S. Census Bureau's 2007 American Community Survey. The Bronx's Hispanic and Latino population is the largest of any borough, with 702,073 people, or 51% of the borough's total population. Some 55% of Bronx residents speak a language other than English at home - including 46% who speak Spanish. There are blocks in the South Bronx where nearly everyone speaks Spanish.

**Implications for Cultural Competence:** So what does the new wave of immigration mean in the Bronx? What does cultural competence really mean and what do providers have to do to provide it? Medical institutions need to train their staffs to understand cultural realities. For example, there are important differences in birth practices between Dominican and Puerto Rican mothers. Translation services must be available – reliance on staff for ad hoc translation is not enough. Also, cultural competence does not simply mean providing Spanish translation, because the Bronx has a multitude of ethnic communities.

Immigrants and the native-born use health care resources differently, with immigrants typically accessing them less frequently. The majority of health care received by undocumented immigrants comes through emergency departments (EDs), while most of the remaining care is obtained through public clinics and community health centers. It is important to discuss the fact that undocumented immigrants were completely excluded from the health care reform law passed last year.

We must work with the immigrant community – they have a voice that must be heard.

## **Pregnancy, Childbirth and Baby Care Practices among the Dominican Culture**

Rosmer Arzola, Health Educator, Morris Heights Health Center

In recent years, there has been a rapid growth of the Dominican population in the Bronx, largely due to the gentrification of Washington Heights. Pregnancy in the Dominican Republic (DR) is considered a normal process of life that involves the entire family. Age is respected and there is trust in extended family. So healthcare messages must be delivered to more than just the mother. Many Dominicans still engage in some traditional practices. Women in the Bronx who are now of childbearing age have grown up with many mixed messages (between traditional DR and “modern” U.S. perspectives) about proper practices for pregnancy and childbirth. Dominican women will listen to what providers say and are afraid to disagree with given advice. They are also usually afraid to share the traditional practices they are using. This can lead to dangerous mixing of medications. But also, providers’ lack of respect for traditional practices can cause friction. Healthcare is often sought late due to undocumented immigration status (and thus fear of deportation) and such social stresses as isolation, child care, and work requirements. Other obstacles to care include language barriers, lack of health insurance, and low income. Healthcare providers need to take the following traditions into consideration when treating patients:

### **Pregnancy:**

- If a pregnant woman’s cravings are not fulfilled, the baby could be lost in the first trimester or born with a birthmark.
- If a pregnant woman is holding a baby and the fetus kicks, it is the opposite sex of the child being held.
- If a pregnant woman passes over the father while he is asleep, he will get morning sickness.
- During the last week of the pregnancy, the woman should walk a lot.
- Baby items (especially the crib) should not be purchased until after the baby is born.
- The baby bag should be filled with yellow and white clothing

### **Childbirth:**

- Natural childbirth is believed to be better and the family is included.
- Homebirth was common in DR until the 1960s.

### **Postpartum Care:**

- The mother is supposed to have a 40-day postpartum rest period (*cuarentena*) to adjust to her new baby. During this time, she cannot: be outside after 6 PM; use chemicals (hair products, nail polish, and cleaning products); and wash her hair; and is encouraged to use vaginal douches.
- Breastfeeding is encouraged for at least 6 weeks. The mother is given salt fish to increase milk production.
- The mother’s own mother, grandmother and siblings teach parenting skills and “tell her what to do.” It is hard for her to make her own decisions. If she goes against them, she is said to be “Americanized.”
- The baby is dressed with a cross-shaped stretch band (*faja*) and a black or red talisman (*azabache*) to ward off evil spirits, and a hat for the first 9 days. S/he is also: not bathed until 24 hours after birth, and then only in the morning; given special spices to ease sleep; and taken out to get some sun.
- Baby remedies include special spices to ease sleep and a strand of the mother’s hair on the forehead to stop hiccups.

## **Mexican Mothers, Public Prenatal Care and the Birth-weight Paradox in New York City**

Alyshia Gálvez, Assistant Professor of Latin American and Puerto Rican Studies, Lehman College

The “**Hispanic paradox**” is a mystery associated with two related phenomena: 1) the relatively good health indicators of Latino immigrants, especially Mexicans, despite lower socioeconomic indicators and lower levels of healthcare coverage; and 2) the second and third generations of Latino immigrants showing a progressively smaller “advantage” over similar socioeconomic and ethnic groups than first-generation and recent immigrants, and finally showing worse than average health indicators. In sum: The accepted standard -- the more money you have, the healthier you are -- is not the whole story.

**Study of Mexican Cultural Practices:** A study of this question was performed in prenatal clinics in NYC and the states Oaxaca and Puebla. Interviews were conducted with 100 women. The average number of years in the U.S. was 6.5; and said they wanted small families (averaging 2.6 children), contradicting the myth that Mexican immigrants want to have a lot of babies.

**Pregnancy:** Mexicans generally believe that women are equipped to have healthy pregnancies without medical intervention. The women in the study provided a few simple “secrets,” such as pregnant women should eat well and not too much. Their diet is mainly natural foods taken from the ground, with fruit as a staple. Women are encouraged to walk a lot during the pregnancy and even to the hospital for delivery, and during labor. They believe that the more you walk, the better the child’s positioning for delivery. They also believe that if a woman lies down too much, the baby will not have the energy that life requires. Pregnant women are also discouraged from lifting and carrying, and are encouraged to rest and avoid stress and strife. During pregnancy the husband tells the woman to stop working. Mexican women brag about their husband’s care for them, viewing it as a romantic gesture.

Contrary to these customs, U.S. hospitals force women to lie down and submit to fetal monitoring. This diminishes their confidence and tells them they are not capable of birthing their babies. This in turn makes them more accepting of further interventions, such as induction, use of forceps, and C-section, which they would have preferred to avoid.

Mexicans in the U.S. have greater housing insecurity, pay more for rent per capita, and have less income than other groups. As a survival necessity, there is much overcrowding -- people often live one family per bedroom. Though this creates far from an optimal living condition, it does allow pregnant women who stay home to cook and do childcare for the entire household while everyone else works.

**Childbirth and Postpartum Care:** Forty days of postpartum rest is customary in Mexico. But in NYC, a woman does not usually have her family around to take care of her and provide support. Her husband may be the only family she has and although he is often willing to help out, he spends most of his day at work.

Mexican women try to reconstruct their healing traditions. Massage therapists (*sobados*) are able to apply deep-tissue massage to turn a breech baby head-down. Postpartum, an elastic band (*faja*) is used to help restore the uterus to its original size and shape. The woman is also given herbal steam baths intended to aid in healing. These special herbs are not available in NYC, so women have them sent from home. Unfortunately, not all women have that option, so they are excluded from the tradition.

## **Bangladeshi Traditions in Pregnancy, Childbirth, and Postpartum Care**

Mahbooba Akhter Kabita, Consultant to non-profit organizations

Since 2000, the population of Bangladeshis in the Bronx has increased. In Bangladesh, people speak Bengali, and 90% of the people are Muslim. Marriage signifies socially-sanctioned sexual relations. As such, pregnancy is only socially acceptable in the context of marriage and most women do not know how to use a condom. IUDs, the pill, and injectables are viewed as unacceptable methods of birth control.

**Pregnancy:** Pregnancy is usually viewed as a normal event that does not require any intervention by healthcare professionals. Women believe they have little or no control over their pregnancies. In the beginning of pregnancy, “hot” foods are viewed as harmful and “cold” foods are beneficial. Some women believe that excessive eating during pregnancy may result in a large fetus and difficult labor. Pregnant women are supposed to maintain certain restrictions based on religious-cultural codes and social norms. Women are told when, where and how to do everything, including how to dress, talk, and move around. Sons are often preferred over daughters. Family members may decide to terminate the pregnancy if they believe the fetus is female. Twins are considered bad luck. Elder women are the guards for inappropriate behavior. They also support the mother and family in birth preparedness and observe certain rituals to facilitate the delivery.

**Childbirth:** During labor, a woman is expected to bear her pain in silence. If she talks about it, she will make the labor longer. Many women continue to work as they go through labor. Laboring women are isolated due to birth-related pollution beliefs. Profuse bleeding after delivery may be viewed as a good sign linked to the purification of the uterus.

**Postpartum Care:** Just after the baby is born, a fire is lit to drive the evil spirits away. The child’s first food is honey, as colostrums are considered polluted or too thick to digest. On the seventh day, the baby’s hair must be shaved or the family will not take care of him/her. For the mother, a hot compress is applied to her lower abdomen and external genital areas to help her uterus retract and to heal the womb. During this period, they are not allowed to perform any religious duty. Women normally wait three days before they begin breastfeeding. Both Muslims and Hindus consider the women and babies to be polluted as long as the mother’s postpartum bleeding continues. Thus both mom and infant stay isolated from family members in the birthing room.

**Bengali Women and U.S. Healthcare:** In NYC, Bengali women have no experience with navigating a healthcare system and are lost when they are forced to participate. They are unsure what information is proper to share with the provider. When birthing in the hospital, they generally follow the provider’s directions, although they would be more comfortable at home with their family. Not knowing what to expect, they are filled with frustration and fear. In Bangladesh, they would be surrounded by family, but here they feel isolated. Similarly, Bengali women are reluctant to take their children to the pediatrician because they don’t think it is necessary. If the baby has a problem, they often address it with traditional massage. Bangladesh is a patriarchal society. The gender norms continue as they live in the U.S. The man is in control of the woman. Often, at doctor’s appointments the man will speak for her. This is a sign of control. If she speaks up for herself, she may be punished when she returns home. She is not allowed to leave the house without his permission. Not having family around, she has no one with whom to share her troubles.



## **West African Cultural Traditions in Pregnancy, Childbirth, and Postpartum Care**

Rosamond Bankola, Health Educator from Sierra Leone

Africa is a continent where there are more than 200 languages spoken and a wide variety of beliefs and traditions. A woman in Africa has a 1 in 16 chance of dying in pregnancy or childbirth. The main causes of death are hemorrhaging (34%), infection (10%), pre-eclampsia (9%), and obstruction during birth (4%). Only 42% of births in Africa are attended by skilled personnel. Over the next 10 years in Africa, the World Bank estimates that there will be 2.5 million maternal deaths, 49 million maternal disabilities, and 2.5 million child deaths. In my culture, talking about birth control and birth spacing is taboo. Most women do not use birth control. They don't like to rely on any medications at all. They do consider breastfeeding a form of birth control.

**Pregnancy:** Pregnancy is acknowledged but not celebrated. A woman will not advertise her pregnancy and will often deny it if asked. She fears that if people know someone will bewitch her baby. Pregnancy out of wedlock is taboo and results in the woman being disowned by her family. Prenatal care and childbirth services are underutilized since women do not believe in using hospitals and prefer to use midwives. During the pregnancy, women are isolated, excluded from many social events, including funerals. Going to a funeral may result in the loss of a child.

**Childbirth:** Men are not allowed to be present during labor because they are too controlling. The emphasis is on midwives (older women of the community) rather than clinics. To ease labor, the midwives feed the women fattening foods, including okra and tomatoes (to make the baby come out smoothly and clean, respectively). During labor, mothers are beaten to desensitize them to pain and because it is thought that the sudden shock of the slap induces birth. The beating continues until the baby is delivered. This practice, while common in my homeland, is less so here, since most births take place in a hospital setting. Men are scared they will be arrested if they hit their wives. Many women in Sierra Leone are circumcised and this contributes to the increased incidence of fistulas (severe conditions in which a hole develops between the rectum and vagina, leading to incontinence and often infections).

The placenta and umbilical cord are buried to restore the woman's fertility and help heal her womb. If the placenta is not buried, it is cooked and given to a sick community member to aid in his healing. If twins are born, one child is killed. If the choice is between a boy and a girl, the boy will be chosen to live.

**Postpartum Care:** Women of Sierra Leone don't have a baby shower until after the baby is born. The newborn's head is shaved and boys are circumcised after one week. The new baby's nails are never trimmed. Trimming the nails is considered bad luck and may lead to the child becoming a thief. The postpartum rest period is traditionally two months, during which the woman is provided with iron-rich foods like sweet potato leaves. The grandmother has primary responsibility for the child. The mother must refrain from sexual activity until after she stops breastfeeding. It is believed that if she doesn't, the baby won't survive. Since breastfeeding can last for years, it is necessary for men to have more than one wife.

There is a culture of breastfeeding in my country. However, women fear passing the medications given in childbirth to the new baby. That issue needs to be addressed with them. They also need more support once they go home.

## **Sexuality and Sexual Health of Mexicans in New York City**

Debra Peltó, MPH, MPhil, Doctoral Candidate, Mailman School of Public Health, Columbia University

A study was done about the family planning and communication practices of Mexican men and women in NYC. Goals included learning how Mexicans' cultures interact with the NYC health care system and strategizing about how healthcare systems and providers can increase access to quality care. Among the methods used were participant observation; interviews with healthcare providers and patients; and a literature review. A key finding was that there is disconnect between health messages provided and how people live their lives.

**Background on Mexicans:** Mexico is an extremely diverse country with many ethnic groups. Some indigenous groups have maintained customs from before the European invasion. About 80% of the Mexicans who now reside in NYC are from the state of Puebla. In the U.S., Mexican men have the lowest income yet the highest level of work participation; Mexican women have the lowest income and the lowest level of work participation.

**Study Findings:** The majority of Mexican couples discuss childbearing goals and aim for an average family size of 2-3. Though they are highly influenced by religious teachings, they use birth control because they don't want to have more children than they can sustain. Many of those not receiving birth control rely on the withdrawal method.

**Healthcare Barriers:** Barriers to healthcare access in NYC include inadequate income, lack of health insurance, inconvenient clinic hours, social marginalization, different ethnicity from the providers, and reluctance to discuss sexual matters with strangers. Many immigrants are unaware of programs and aid at their disposal, so they do not access the care. One woman described her experience as "feeling isolated despite liberty. Being in a foreign country is limiting." Because of work or childcare issues, many cannot keep appointments. Most employers of Mexicans don't offer health insurance or pay enough for the employees to purchase it privately. Also, they do not allow their employees enough flexibility to be able to make healthcare appointments. No sick or personal days are provided, so if you miss a day (or even part of a day), you are docked a full day's pay. In their need for care, many Mexicans resort to drugs sent from Mexico or complementary and alternative therapies.

It is crucial to offer information about sexuality and family planning methods in a respectful way. Because many Mexicans in NYC did not have much formal education, they may need additional time for explanations and questions. Providers often make insulting and insensitive remarks that discourage patients from returning to them for follow-up care. Also, when speaking with the Mexican community, it is recommended to use the formal *usted* as opposed to the informal *tu*. The use of *tu* is reserved for close friends and family; otherwise it insinuates social inferiority and can cause great insult. Medical terminology around birth control can be confusing for those who speak Spanish. For instance, an IUD is often referred to as a "T." Someone not familiar with birth control methods here but more familiar with traditional Mexican practices would take this to mean a medicinal drink. Literature needs to be language and culturally-appropriate. Many Mexicans in the U.S. are reluctant to use available medical services even if they have a green card and Medicaid for a number of reasons. These include: fear that its use will affect their chances of gaining citizenship, and fear that one day they or their children will be asked to pay the money back. The result is that they do not seek out preventive care and wait until the need becomes extreme.

## **Cultural Competence – Lessons from Morris Heights Health Center**

Rosmer Arzola, Health Educator, Morris Heights Health Center

Morris Heights Health Center is a community-based organization, located at 85 Burnside Avenue that provides women's health services and houses the only birthing center in NYC. Services provided include pediatric, dental, behavioral health, and social services, as well as school-based health centers. As a Title X provider, Morris Heights provides family planning services, including for undocumented people. The center also takes over when Medicaid's coverage of pregnant and postpartum women ends, and provides services for mothers for up to two years after delivery. A new clinic called Harrison Circle provides housing for elders at two locations and houses special units for cardiology and physical therapy.

Health educators at Morris Heights connect with community women and build trust. If the women don't receive the services they seek or don't feel understood, they may isolate themselves and never seek care again.

Everyone in the Dominican community considers themselves a doctor and medications are often shared.

More than language skills are needed - cultural competency is also essential. Without competency there is no connection. It must also be understood that there are cultures within cultures. Just because people speak the same language doesn't mean they share the same thoughts.

Talking about sex is taboo in Dominican families. When they come for family planning, they are uncomfortable using medical terms and use acronyms instead. What's most important is that they understand the message. That means meeting them where they are at.

## **Cultural Competence - Striving for Equal Access to Quality Healthcare Services**

Judy Wessler, Director, Commission on the Public's Health System

Four years ago, the Commission on the Public's Health System brought together a coalition to celebrate the 100<sup>th</sup> anniversary of NYC's Child Health Clinics (The Bronx Health Link led the effort in the Bronx.). The coalition did a survey of community parents around the city concerning their children's healthcare status and access to care. One of the main findings of this effort was that cultural and language barriers to healthcare are overwhelming and make access to care difficult.

In a follow-up study done jointly with The Bronx Health Link and Brooklyn Perinatal Network, researchers assessed cultural and language competency by health providers. The two terms were not predefined, with the goal to determine what would make people feel more comfortable in receiving healthcare. 117 patients were surveyed in four languages at community-based organizations (not healthcare providers) around the city. An advisory group of health policy advocates was established to convert the survey data into a checklist for characteristics of cultural competence and to recommend culturally competent providers for interviews. Key points on the checklist were knowledge of the community and established relationships with community organizations. The healthcare providers were interviewed at 9 facilities and 11 networks across the city (in the Bronx, Montefiore Family Health Center, Urban Health Plan and Webster Houses Child Health Clinic) to find out what they considered the key elements of cultural competence, and the checklist was reviewed with each of them. They were also asked what they considered **best practices**. Among the common themes were:

**Community/Patient Interaction:** community assessment to identify the patient population, those not seeking care, and new communities; outreach to community and programs for particular populations/illnesses; and involving the patient and family in decision-making about care.

**Accessibility:** sliding fee scale for uninsured patients; evening and/or weekend hours; staff people who speak the languages of the patient, or have interpreters available or provide access to a language line; and access to interpreter services for the blind, hearing-impaired, and disabled.

**Cultural Competence:** a diverse staff at all levels, reflective of and hired from the community; many staff who are bicultural/bilingual; providers and staff who have learned to listen to patients and are open to addressing cultural differences; acknowledgement that patients are attracted when the race/ethnicity/language of providers reflect the community; recognition of and methods to address problems facing new immigrants; friendly and respectful treatment of all patients; inclusion of pictures/paintings/colors of walls that reflect community cultures; and signs, posters, information translated into the common languages in the community.

Note: The full report, published in 2010, can be downloaded at

[http://www.bronxhealthlink.org/bronxhealthlink/bronxhealthlink/reports/culturally\\_competent\\_care\\_so\\_me\\_exampl/](http://www.bronxhealthlink.org/bronxhealthlink/bronxhealthlink/reports/culturally_competent_care_so_me_exampl/)

A key aspect of cultural competence is what relationship the healthcare facility has with community-based organizations. One example: Montefiore Family Health Center had to be sued for not providing translating services to its Asian population. As a result, it now has an advisory committee, staff members who speak Cambodian and Vietnamese and are making a full effort to be culturally competent.

## **Immigrant Access to Health Care and Coverage in New York State**

Marija Sajkas, Health Advocacy Associate, New York Immigration Coalition

There are approximately 4.2 million immigrants in New York State, of whom between 600,000 and 900,000 are undocumented. Noncitizens are three times more likely to lack health insurance than citizens. The barriers to health care and insurance include: language /cultural barriers; fears about confidentiality of immigration status information and reporting; concerns about effect on the immigration process; concerns of their sponsor; type of employment; legal restrictions to (public) insurance; agency failures; and massive confusion about rights and available services. As a result, immigrants: are less likely to go to doctor, seek preventive care, and have a regular doctor; are more likely to delay care until it is more serious and costly; tend to seek alternative care; and often seek care and medications from their home country. But a 2010 study of uninsured immigrants in NYC found that most want to keep themselves and their family healthy, understand value of insurance, are in favor of cost sharing, and are willing to pay affordable prices.

**Rights to Medical Care:** All New Yorkers, regardless of their immigration status and ability to pay, have the following legal rights:

- **Right to emergency treatment at all public and private hospitals** (U.S. Emergency Medical Treatment and Active Labor Act or EMTALA of 1986). This includes the rights to emergency medical transportation and to be examined to determine if s/he has a medical emergency. If determined to be an emergency, the hospital must treat and stabilize the patient.
- **Right to services in a language the patient can understand** (regulations under 2006 NYS Hospital Communications Assistance Law – aka Public Health Law § 2803, Title VI of U.S. Civil Rights Act of 1964). Language is the biggest barrier to accessing quality healthcare for people with limited English proficiency. All NYS hospitals are required to: identify a patient’s preferred language; provide *free, skilled* interpreting services for a patient’s *entire* visit; post signs in all public areas and offer information about free interpreting services; provide interpreter services even when family members or friends accompany patient; and translate *all* significant forms for patient.
- **Right to apply for financial assistance at any hospital** (NYS Hospital Financial Assistance Law of 2006 – aka NYS Public Health Law § 2807-k). Hospitals must offer discounts to low-income (below 300% of federal poverty level), uninsured NYS residents for any service. In a non-emergency situation, uninsured patients can access free or low-cost care at all public and private hospitals and satellite clinics in NY State.

**Healthcare and health insurance are safe for undocumented immigrants to use.** Hospitals, ambulances and clinics are **not** supposed to ask or report immigration status to the United States Immigration and Customs Enforcement (ICE) or Immigration and Citizenship Services (ICS). As to specific benefit programs, Medicaid, Child Health Plus, food stamps (now called “SNAP”), WIC (Women, Infant, Children Nutrition Assistance), and housing assistance are safe to use. Cash assistance, long-term care from Medicare and SSI are not safe to use – that is, undocumented immigrants are ineligible. There are several payment options for immigrants regardless of immigration status. They include: Emergency Medicaid & other public insurance programs, financial assistance and sliding-fee scale, HHC Options (only at HHC), free public health services (tests for TB, HIV & sexually transmitted diseases, vaccinations, mental health and cancer screening).

**Private insurance:** Currently, there are no immigration status restrictions for private insurance.

For more information, contact the New York Immigration Coalition at 212-627-2227 x223 or x226 or visit [www.thenyic.org](http://www.thenyic.org).

## **Taking Action**

The Bronx Health Link strongly believes that achieving true cultural competence in healthcare in this borough, city, and state requires concerted action by government at all levels, healthcare institutions, and community-based organizations. We must work with the immigrant community – they have a voice that must be heard. The presentations at this forum made clear that the following steps are essential to address the cultural, linguistic and navigational barriers confronting immigrants:

### **Healthcare providers must:**

- consider the cultural traditions of patients when treating them – especially regarding sensitive topics such as sexuality and family planning
- understand that there are cultures within cultures, so that even immigrants from the same country may have very different traditions, beliefs, and languages
- use language that is culturally appropriate, including in choice of pronouns, and
- adopt the “best practices” for care of immigrants listed on page 12.

### **Government must:**

- exercise leadership in cultural competency mandates
- provide funding for workforce diversity and medical education opportunity
- enforce existing language access rules
- enforce civil rights laws about nondiscrimination in healthcare
- improve support of community-based outreach, education, and navigation programs, and
- ensure the preservation and strengthening of robust hospitals and community health clinics, where the majority of low-income uninsured residents seek care.

## Biographies of Presenters

### Panel One

**Rosmer Arzola** is a young woman of color of Dominican descent. A graduate of Lehman College, she has 7 years of work experience working with underserved communities in Washington Heights, Harlem and the South and Central Bronx. Ms. Arzola is currently a health educator at the Morris Heights Health Center, where she works primarily with women who are pregnant, providing them with health education, support services and assistance.

**Alyshia Gálvez** is Assistant Professor of Latin American and Puerto Rican Studies at Lehman College. She was previously an assistant professor and faculty fellow at New York University, and earlier taught at Seton Hall University, where she also directed the Joseph A. Unanue Latino Institute. A cultural anthropologist, her areas of specialization include Latin America, Latinos in the United States, religion, migration, performance, citizenship, and medical anthropology. She is currently conducting a two-year study examining the interaction between Mexican immigrants and the public health system in New York City during pregnancy and childbirth.

**Mahbooba Akhter Kabita**, who was born in Bangladesh, is the former Executive Director of the Westchester Square Partnership, whose mission is to foster coordination of social and health services and work for social justice in the South Asian community in New York City.

**Rosamond Bankole** was born and raised in the little West African country of Sierra Leone. A poverty-stricken childhood and a civil war were the unfortunate highlights of her life. She says that the war was the single most important influence in her life and it has continued to shape her academic and professional desires to this day. She arrived in the United States as a refugee in 1998. Starting in high school, the dream of obtaining a degree in Public Health was deeply entrenched in her heart. She says that her experiences in Sierra Leone have been the fuel pushing her forward.

### Panel Two

**Debra Pelto** is a medical anthropologist with an MPH from Columbia University, who is currently a PhD Candidate at Columbia. Her dissertation research examines the meanings, communications, negotiations, and activities around sexuality and sexual health among adult Mexican women and men in New York City.

**Judy Wessler** is Director of the Commission on the Public's Health System and a longtime committed advocate for universal access to health care and a system of health care based on community needs with a particular focus on the underserved.

**Marija Sajkas** has 20 years of experience working as a journalist and editor with a focus on minority reporting, and as a communication specialist for the International Committee of the Red Cross and UN Stabilization Forces. Mrs. Sajkas is also an experienced public health advocate focusing on the work with immigrants and victims of domestic violence, previously working for the Family Justice Center in Queens. In her current role as the NY Immigration Coalition's health advocacy associate, Mrs. Sajkas coordinates work of 10 community-based health advocates, and she advocates for immigrants' inclusion in health care.

# **The Bronx Health Link**

**851 Grand Concourse, Room 914**

**Bronx, NY 10451**

**(718) 590-2648**

**Visit our website: [www.bronxhealthlink.org](http://www.bronxhealthlink.org)**

**For free downloadable copies of this report, as well as:**

- **Information on our maternal and child health promotion programs**
  - **Free consumer information**
- **Background on Bronx health issues - research, policy and advocacy**
  - **Free daily health e-newsletter**
  - **Health events calendar**