REGION I TITLE X

INTEGRATING HIV PREVENTION AND FAMILY PLANNING SERVICES

Organizational Self-Assessment Manual

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Introduction
Introduction

Purpose and Approach of the Manual

In 2002, with funding from the Office of Population Affairs, the Region I Title X Family Planning Training Center (RTC) conducted a needs assessment to identify training needs related to the integration of HIV services into family planning care. Examining the findings from this needs assessment, the RTC perceived a role for an innovative, lasting training product that would supplement trainings and technical assistance provided through the Training Center and support clinic-level HIV integration activities. This was the impetus for this manual, entitled Integrating HIV Prevention and Family Planning Services: Organizational Self-Assessment Manual.

With their expertise in reproductive health, their dedication to prevention and their commitment to providing care to underserved populations, Title X family planning providers are uniquely positioned to provide essential HIV prevention services to young women, a group increasingly at risk for HIV infection. Title X providers in Region I are committed to HIV integration and, increasingly, are providing a variety of HIV services to their family planning clients, both female and male. This manual is designed to assist clinic managers to strategically work through how to provide integrated HIV services in the context of the clinic’s organizational structure and resources. In keeping with the training focus of the RTC, the manual emphasizes measures that managers can take to enhance family planning staff capacity to provide integrated HIV services.

In developing this manual we have sought to bring some of the rich resources of the HIV “world” to practitioners in the family planning “world.” We have consulted federal and state technical assistance publications, models of care, evidence-based standards of practice and training curricula to extract guidelines and principles to assist clinic managers as they move forward with the process of integrating HIV prevention and family planning services.

It is important to reiterate that the manual is rooted in the Region I Title X HIV Integration Needs Assessment. While the manual’s chapters are organized around specific HIV service components, the choice of topics to address within each chapter has been guided by the relevant findings of the Needs Assessment which are summarized in the introduction to the chapter.

The integration of HIV prevention and family planning services is a broad and complex undertaking. There are a number of aspects of HIV/FP integration that are beyond the scope of this manual, including outreach to client populations at risk, and provision of reproductive health care services to women who are HIV positive.
How to Use the Manual

Users of the manual may choose to work through it progressively, chapter by chapter, or they can concentrate on individual chapters. Recognizing the many demands on clinic managers’ time, each chapter is designed to stand alone so that clinics may focus in on the topics most relevant to the configuration of HIV services they currently provide.

- **Chapter I: Destination Integration**, provides a working definition of HIV/family planning integration and an overview of the rationale, potential and challenges of integrated service delivery. A client-centered approach to care is proposed as the model of care best suited to achieving the promise of HIV integration while avoiding some of the pitfalls.

- **Chapter II: Providing HIV Risk Assessment and Prevention Counseling Services**, is designed to help family planning clinics incorporate effective HIV risk assessment and prevention counseling practices into the family planning encounter.

- **Chapter III: Linkage to HIV Testing Services**, provides guidelines concerning when, where and how to refer clients for HIV testing, for those clinic settings that do not offer such testing directly. For family planning programs that do provide HIV testing, this chapter offers a training outline and resources to facilitate the development of “in house” training programs for staff, and to enable the appraisal of training programs offered by other agencies.

- **Chapter IV: Developing Referral Networks and Procedures**, provides guidance in establishing, developing and maintaining strong referral networks with HIV/AIDS service providers and other associated services (e.g. substance abuse services).

*Chapters I through IV* each include a Work Plan that lists key tasks involved in bringing about a more effective and complete integration of particular HIV services into family planning care. The Work Plan prompts clinic management teams to assess the clinic’s current status with regard to each task, to identify steps to be taken to move forward, and to assign staff and a timeframe for their accomplishment.

**Special Section on Cultural Competence**

Title X clinics in Region I serve ethnically and racially diverse populations, and continually strive to find ways to better serve these diverse communities. A key finding of the *Region I Title X HIV Integration Needs Assessment* was the expressed need for training to support the development of culturally competent services in the HIV area. This was one of the top five training needs identified by providers at the regional level.
In response to this need, this manual includes a Special Section on Cultural Competence. This section provides a framework and tools to assist clinic managers in engaging their staffs in the ongoing process of strengthening cultural competence on both the provider and the institutional levels, in order to better meet the needs of the diverse populations served by Title X programs.

**The CD-ROM**

The contents of this manual are based on key technical scientific, technical assistance and policy documents emanating from both the HIV and family planning arenas. The essential documents and resources underlying each chapter are listed at the end of that chapter so that users may refer to them for further information and more detail as needed.

The manual is accompanied by a CD-ROM which enables the user to access many of these sources and resources in their entirety. The CD-ROM opens with an annotated listing of its contents, organized by manual chapter; each entry includes a direct link to the referenced document or website along with a brief description of what will be found there to assist the user in deciding which links to investigate further.
Integrating HIV Prevention and Family Planning Services
Chapter 1

Destination Integration: Guiding Principles/Model of Care
Introduction

As shown in the Region I Title X Needs Assessment, family planning providers throughout the region are committed to HIV integration to better serve their clients, and have taken a variety of steps and paths to achieve it. Exactly what integration means at the implementation level, however, is not always clearly understood. While the term “HIV integration” is freely used, family planning providers may have widely differing conceptions of its implications for service delivery, as well as its benefits and drawbacks.

As family planning programs work toward HIV/family planning integration it may help to take a step back and consider the broader picture of the destination—what integration might look like in practice and what it is intended to accomplish.

This chapter offers a working definition of HIV integration, something to look back to as an agency takes steps to include HIV services in family planning care. The goals of integration as revealed in its public health rationale and its great potential benefits for clients are presented. The challenges and obstacles encountered by family planning providers on the road to integrated care are also discussed. Finally, the basic elements of a client-centered orientation to care are offered as a framework for the effective delivery of integrated HIV/family planning services.

To assist family planning agencies in taking a strategic look at how HIV integration can continue to take shape in their setting this chapter provides the following units:

- Rationale for HIV Integration in Family Planning
- Defining HIV Integration
- HIV Integration Challenges
- Providing Integrated Care: A Client-Centered Approach
- Resources
Women represent a growing segment of persons with HIV/AIDS in the United States. Women of color have been disproportionately affected. Adolescents and younger women are also at increasing risk. The figures in the box below illustrate the increasing impact of the epidemic among populations traditionally served by family planning programs.

**HIV/AIDS Among Women in the U.S.**

- From 1985 to 2002, the proportion of adult/adolescent AIDS cases in the United States reported in women increased from 7% to 26%.
- African American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths of AIDS cases reported to date.
- Of new infections among women, the CDC estimates that approximately 75% of women were infected through heterosexual sex and 25% through injection drug use.
- Of approximately 40,000 persons newly infected with HIV in the U.S. about half are younger than 25 years of age.
- Nearly half of all women, ages 18 – 49, report never having discussed HIV/AIDS or other STDs with a health care provider.

*Source: Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. (References 2 – 5).*

**BOX 1**

As noted by the Family Planning Councils of America (FPCA), given that heterosexual contact is the primary mode of HIV infection in young women, family planning programs are uniquely positioned to provide preventive HIV services to this population. Additional reasons why family planning clinics are an ideal venue for providing HIV services include:
Family planning providers are skilled at talking with patients about sexuality and reproductive health. Family planning providers already discuss with clients sexual behavior, STD risk, condom negotiation, dual protection and partner issues. Clients come to the family planning visit expecting to disclose some sexual history to the provider.

Title X clinics are a trusted provider of health services for women. The level of trust already established may help to ease the discomfort many women feel about discussing HIV and AIDS. Title X providers are particularly attuned to the needs of adolescents and women of color; populations increasingly at risk for HIV infection.

Title X clinics are often the only place where economically disadvantaged young women have access to or contact with the health care system. For this reason they may be the only place where these women are offered HIV services.

Most family planning clinics already provide diagnosis and treatment of STDs. Infection with a STD is a risk factor for HIV infection, and treatment of STDs has been shown to reduce the risk of HIV infection and transmission.

Family planning providers are dedicated to prevention. A hallmark of family planning is the promotion of responsible decision-making and prevention of disease to achieve reproductive health.

Family planning providers play a critical role in connecting women to essential services at the beginning of their pregnancies. HIV prevention efforts directed toward women of reproductive age also play a critical role in the prevention of perinatal transmission of HIV. Family planning providers informing the client of a pregnancy can direct them to testing and other services that reduce mother-to-child transmission of HIV in women at risk.

The integration of HIV services into family planning increases access to these services among women who need them. The fundamental importance of HIV-family planning integration is succinctly stated in a 2003 OPA-funded report entitled Examining HIV Prevention Activities in the Title X Family Planning Program:

“Since heterosexual contact is the leading means of infection in women, family planning programs can provide invaluable prevention and education interventions among the populations at highest risk of infection. Located in areas and environments that women often find accessible, family planning clinics are a principal source of health care for many adolescent and young adult women. Family planning programs offer the opportunity for women to seek and receive information about HIV in a nonjudgmental environment, sometimes providing the only contact healthy individuals have with medical professionals during the years in which their risk of HIV infection is likely to be highest. As a source of confidential, inexpensive and culturally appropriate care, these programs provide an important venue for the delivery of HIV prevention services.”
The rationale for integration of HIV services into family planning is a compelling one, but what exactly does HIV integration entail? Here are four different but complementary definitions. Each provides a useful perspective on the meaning of HIV integration.

**HIV Integration in Theory**

The International Planned Parenthood Federation describes HIV integration “in theory” as the incorporation of the prevention, detection and treatment of HIV into sexual and reproductive health services. HIV integration “make[s] explicit the connection between sexuality, contraceptive choice and STI/HIV prevention and harness[es] the inherent synergy between preventing unwanted pregnancy and preventing STI/HIV.”

**A Functional Definition of HIV Integration**

A commentary published in *International Family Planning Perspectives* (June 2002) on integration of STD and HIV services into family planning defines integration in this way:

“Any two services can be considered to be integrated when they are offered at the same facility during the same operating hours, and the provider of one service actively encourages clients to consider using the other service during that visit. According to this definition, integrated services may or may not be offered in the same physical location within the facility and may or may not be offered by the same service provider.”

This definition reflects the reality as seen in Region I that different organizations take different routes and pursue different strategies to reach the goal of service integration. In some family planning settings integration is operationalized as the co-location of distinct family planning and HIV services that are available to all clients. In other settings the services are provided in the same encounter by cross-trained staff. Or a combination of these approaches may be used.
Provider’s Eye View of Integrated Care

Perhaps the most user-friendly and experience-based definition of HIV integration comes from providers themselves. A group of Region I family planning providers, HIV specialists, and Regional Training Center staff were asked: “What does integrated care mean to you?” Here are their answers. Note that their responses highlight both the promise and challenges of HIV integration.

- “One-stop shopping”
- “Bringing services to where the clients are”
- “Attaching a ‘new’ service to an ‘old’, trusted, provider”
- “Leading in from a more accepted service to one that is a ‘harder sell’”
- “Bringing together services for problems that have common causes and common solutions”
- “Bridging the gap between prevention and care”
- “Providing services that address the whole person; client-centered care”
- “Offering a constellation of services, both on site and by referral”
- “Information overload”
- “Being asked to do more with less”
- “A good sounding goal but tough to achieve”

The Components of HIV Integration

A very concrete way to define HIV integration is to look at its components, the specific HIV-related services to be incorporated into family planning encounters. This listing of services from information provision to referral for HIV care is sometimes referred to as the “HIV integration continuum”.

- **Providing HIV education:** The provision of clear, understandable factual information on what HIV/AIDS is, factors that increase a person’s risk of acquiring HIV, how HIV is transmitted, how it can be prevented, the availability of HIV testing, the importance of early diagnosis and entry into medical care, and the availability of treatment for HIV infection.

- **HIV risk assessment:** A confidential process that asks question about past history, behaviors and practices that may place a client at risk for HIV infection. The objectives of risk HIV risk assessment are to provide a basis for prevention (risk reduction) counseling, to identify clients to be offered HIV testing, and to refer clients to needed services.

- **HIV prevention counseling:** HIV prevention counseling is a client-centered exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV.
HIV testing: The provision of laboratory or rapid testing to detect HIV infection along with pre- and posttest counseling, and referral to medical and support services.

Referral to HIV medical care and other needed services: Provision of any of the HIV services noted above will likely reveal specific client needs for medical and social services that are not offered within the family planning agency. A cornerstone of successful HIV/family planning integration is a network of strong referral relationships with a broad spectrum of community-based service organizations.

Providing reproductive health care to HIV-positive clients: The provision of contraception, routine gynecological services, STD diagnosis and treatment and other sexual health services according to service protocols that recognize the particular medical needs of women with HIV infection.

OPA provides guidelines for Title X family planning programs regarding the provision of the services included in the HIV integration continuum. Title X clinics are required to provide education/information about HIV and AIDS, information on risks and infection prevention, and referral services. In addition, clients must receive counseling on STDs/HIV that consists of “an individualized dialogue” in which there is a discussion of personal risks for infection and steps to be taken to reduce risk. It is optional for family planning clinics to provide HIV risk assessment and HIV counseling and testing (C&T) services, but these services must be provided by “specially trained” staff.

The CD-ROM includes a link to the OPA Program Guidelines.
Integration of HIV and family planning services yields critically important benefits for family planning clients. However, as reported in the Region I Needs Assessment, family planning clinics face a number of challenges as they work to integrate HIV services. The aforementioned OPA-funded study which interviewed staff from family planning clinics throughout the country identified similar challenges and barriers to HIV integration. These challenges, along with initial steps that can be taken to meet them, are summarized here.

**Challenge: Provider Burden/Time Crunch**

The Region I Needs Assessment found that offering HIV risk assessment and prevention services in the timeframe generally allocated for the family planning visit is a major challenge for providers throughout the region. Clinic managers felt that time constraints were the greatest barrier hindering their staffs’ ability to discuss HIV issues with clients, and providers identified “longer sessions”—something very hard to come by—as a key factor that would enable them to integrate HIV services into family planning.

In the OPA-funded study, respondents emphasized that staff “buy-in” is critical to the success of HIV integration efforts, but may not always be present. Providers may feel they are being asked to jam additional issues into already rushed visits, or that HIV counseling takes time away from discussion of the family planning concerns that bring clients to the clinic. Given the societal stigma surrounding HIV, providers may feel uncomfortable discussing HIV, or raising the issues with clients, particularly those perceived to be at low risk.

**Initial Action Steps**

To encourage the development of a common vision and goals concerning HIV integration in a particular family planning clinic, managers, supervisors and clinic staff could devote a staff meeting to the consideration of the following questions: 1) What does HIV integrated mean to us as family planning providers? 2) What are the potential benefits of HIV integration for our clients? and 3) What are the benefits and drawbacks of HIV integration for us as individual providers, and for our Title X program?

More concrete steps that clinics can take to facilitate staff acceptance of and commitment to the integration of HIV services into family planning include: involving staff in the planning for these activities, building such activities into the organization’s mission statement, job descriptions and service
protocols, and seeking out training opportunities to enhance providers’ level of comfort and skill in delivering HIV-related services. Managers and staff can review clinic flow and scheduling practices to identify ways to increase efficiencies and ease the time pressures on providers.

**Challenge: Intensive and Ongoing Needs for Training**

To effectively deliver integrated HIV services, family planning providers must possess a considerable body of knowledge, and a skill set that is somewhat different from, although complementary to, that required for delivery of basic family planning services. Ongoing training is essential to develop providers’ knowledge, skills and comfort levels to address HIV.

In the **knowledge** arena, providers require up-to-date information on HIV and AIDS, modes of transmission, methods of prevention, STD and HIV linkages, substance abuse and HIV linkages, methods of testing for HIV infection, as well as basic information on available treatments for HIV. In addition, providers may need to increase their understanding of the stigma surrounding HIV which contributes to clients’ and providers’ reluctance to confront it.

In the **skills** arena, providers may need training in HIV risk assessment, evidence-based methods for risk reduction counseling, counseling related to the HIV testing decision, delivery of HIV test results to clients, and addressing HIV issues in a culturally sensitive manner.

While training needs are considerable, ensuring that staff receive such training is problematic. Time required for training is time taken away from service delivery, and programs have encountered difficulties accessing training resources. Most of the grantees in Region I involved with HIV counseling and testing have depended on the state to provide training in this area. In some states, however, family planning clients have been seen as being at lower risk for HIV, and family planning providers have not been given priority to be trained. With state funding for HIV C&T services precarious in all six New England states, this source of training may become even less available to family planning providers in the Region. In addition, family planning agencies may have unique training needs that are not fully addressed in the HIV training that states generally offer.

**Initial Action Steps**

Assessing HIV integration training needs at the grantees and clinic levels is essential in order to address the unique needs of individual clinic sites. Family planning programs can examine the findings from the **Region I Title X HIV Integration Needs Assessment and Training Plan** to help identify key staff training needs related to the provision of HIV services. Programs can also conduct their own training needs assessment among their staff. To meet the training needs identified, clinic managers can seek out alternative training opportunities, including those offered by the Title X Regional Training Centers (RTC), the HRSA-funded AIDS Education Training Centers (AETC), and the CDC-funded STD/HIV Prevention Training Centers. As noted in the OPA-funded report, participation in HRSA and CDC training activities would help to facilitate the incorporation of family planning issues into training for HIV providers as well. Programs can also experiment with developing and providing HIV integration training in-house, as some Region I clinics are currently doing.
The CD-ROM includes links to resources and tools to assist program managers in doing all of these things.

**Challenge: Scarce Funding Resources**

Mirroring the national situation, family planning providers in Region I are being asked to do more with their limited resources. At the same time that severe cutbacks in state and federal funding make it difficult to provide basic family planning services, the provision of HIV-related services may result in higher overall costs for clinics. In addition, the current economic downturn has resulted in a greater demand for services. As in much of the nation, the Region is beginning to see an increase in the number of uninsured, and family planning clinics expect an upsurge in the need for subsidized or free family planning and other reproductive health services.

While the provision of integrated care is endorsed as the standard of practice in both family planning and HIV/AIDS policy, funding streams for the two sets of services remain largely separate. Categorical funding of HIV and family planning services presents an operational barrier to truly integrated care.

**Initial Action Steps**

Family planning programs can learn more about HIV funding sources. The CD-ROM includes a document entitled *Federal HIV Funding* which describes and includes links to agencies that provide funding for various types of HIV services.

**Challenge: HIV Prevention Not a Priority for Clients**

Both clinic managers and family planning counselors in Region I report that many of their clients do not see HIV prevention as a personally relevant issue when they come in for family planning services. Providers noted the “perception of invincibility” to HIV among clients, despite STDs, multiple sex partners and substance abuse. This tendency among young women to underestimate their risk of HIV infection is borne out by a number of research studies, in which women report their personal HIV risk as minimal regardless of the frequency of engaging in unprotected sex.12,13

While this lack of urgency around HIV on the part of family planning clients may make it more difficult to raise the issue in the family planning visit, it underscores both the need and importance of doing so.

**Initial Action Steps**

Family planning programs can take steps to raise the visibility of HIV as a serious risk for young women and men. Educational materials such as posters, pamphlets or waiting room videos can be displayed and made available throughout the clinic. This may also help to “normalize” HIV issues and make them easier to bring up during the family planning visit, for both providers and clients. In addition, staff should be given up-to-date data on rates of HIV and AIDS for the local area, so that both they and their clients can become better aware of the actual levels of risk.
With a guiding principle of “informed choice,” family planning providers have a long tradition of encouraging client involvement in decision-making. As family planning programs work to integrate HIV services, a re dedication to the principles of client-centered care can help clinics to achieve the promise of integrated care, while avoiding some of the pitfalls.

Client-Centered Care Facilitates Integration

Client-centered care focuses on meeting the needs of the client and involves the client as an active partner in the development of a therapeutic plan. There is ample evidence that clients are better served when the content of clinical interactions is guided by the client’s needs rather than a standardized “one size fits all” model. This has been demonstrated by research studies in both the family planning and HIV prevention fields.16-18

• In the family planning arena, client-centered care is associated with more effective use of family planning methods, method continuation and greater satisfaction with care.

  Client-centered counseling may result in the selection of a method that best fits the client’s life circumstances and abilities, contributing to better adherence, better outcomes and greater likelihood of remaining in care.

• In the HIV prevention arena, client-centered care is associated with lower rates of STD infection, higher rates of return for test results and greater satisfaction with care.

  Research and experience confirm that clients are more likely to take risk reduction steps when they have self-identified the behavior that puts them at risk and participated in the development of a risk reduction plan, than when they are simply told what to do or not do.

• A client-centered approach to care may also help to ease some of the burdens of integration, including time constraints and provider overload.

  A CDC-funded intervention in Region VI that focused on helping Title X agencies to develop a client-centered culture found that a client orientation enabled staff to individualize services to client needs and to provide more appropriate HIV prevention messages. Other benefits included decreased client waiting times, increased staff morale, and improved client satisfaction.
If client-centered care yields better outcomes in both family planning and HIV prevention counseling, and helps to lessen the burden on providers, a client-centered approach may be the “key ingredient” of successful efforts to integrate HIV and family planning services.

**Client-Centered Care at the Organizational Level**

An organization that is committed to client-centered care provides services that both meet medical standards of quality and treat clients as they want to be treated, with respect, understanding and fairness. The collective experiences of Title X providers, confirmed by the findings of numerous studies in family planning settings, have identified the following essential aspects of an organizational approach to client-centered care. 18, 19
### Key Elements of Client-Centered Reproductive Health Care

- **Programs are knowledgeable about key demographic and health status indicators within the community served.** Service provision is informed by up-to-date data on population diversity and prevalence of STDs, HIV and other health status indicators in the program's service area.

- **Facilities are accessible, clean, and inviting.** Well-cared-for facilities are physically accessible to all clients. Amenities (e.g., a children's play area), and attractive, culturally relevant decorations show that clients' needs are appreciated.

- **Clients' convenience and privacy are respected.** Services are offered at convenient times and places. Client flow systems avoid long waits for appointments, during visits, and for testing and results. There is adequate privacy for examinations and counseling.

- **Clients are genuinely welcomed and assisted.** Staff in all areas welcome every client with respect, helpfulness, and friendliness, and demonstrate concern and willingness to listen.

- **Clients' needs and opinions are important.** The clinic gathers information from clients to design appropriate services. Client surveys, focus groups, and interviews are used to determine clients' expectations and satisfaction with services.

- **Counseling is interactive and client-focused.** Staff help clients identify their own health needs and risk behaviors, and commit to health-promoting actions that are personally achievable.

- **Staff development and training supports client-centered services.** All staff receive skills training in client-centered care and cultural sensitivity.

- **Staff receive management support for client-centered care provision.** Policies, job descriptions, and reward systems support client-centered practice. Systems are in place for obtaining staff input and feedback on services and needs.

- **Clinic staff build collaborative relationships in the community.** Collaboration with other organizations that serve the client population increases staff knowledge about the community and forms the basis for a comprehensive referral network.

**BOX 2**
Client-Centered Care at the Client-Provider Level

A provider offering client-centered care recognizes the client as the expert on her own situation, life circumstances, feelings and preferences, all of which may affect her ability to follow particular medical, contraceptive and behavioral advice. By understanding “where the client is coming from” the provider can recommend treatments, courses of action and risk reduction practices that are safe, appropriate and feasible for the individual.

This understanding can be achieved through a process of client-centered counseling that:

- Approaches each client as an individual
- Establishes a dialog with the client using open-ended questions and active listening skills
- Elicits the client’s needs, concerns and preferences, in addition to medical history
- Maintains a caring, nonjudgmental attitude
- Offers options, not directives
- Recognizes that responsibility to decide and to act rests with the client

Box 3 details the specific steps and actions involved in providing client-centered counseling.
The Provider’s Role in Client-Centered Counseling

Client-centered counseling requires providers, building on their personal communication skills, to achieve interactions with clients that:

1. **Establish rapport:**
   - Assure privacy and confidentiality
   - Be positive and encouraging
   - Encourage clients to ask questions and share information
   - Listen to what clients say and observe what clients do
   - Use a friendly tone of voice and attentive body language to convey warmth, interest and respect

2. **Focus on the individual:**
   - Respond to the client’s stated need, interest or questions
   - Explore the client’s lifestyle, life stage, goals and preferences
   - Help the client understand how these might influence family planning and other reproductive choices
   - Respond to the client’s concerns, including myths, respectfully

3. **Communicate medical information clearly:**
   - Use simple, non-technical language
   - Avoid irrelevant information or too much information at once
   - Let clients see and touch samples and models
   - Encourage questions
   - Check that the client understands
   - Know own biases about methods/treatments and compensate for them

4. **Give clients their choice:**
   - Let clients know they have options and that the choice belongs to them
   - Offer to help clients think through options
   - Help clients weigh the pros and cons
   - Ask clients to confirm their decisions

5. **Plan next steps:**
   - Help clients plan how to carry out their decisions
   - Anticipate problems and ways to overcome them
   - Give clients informational materials they can refer to at home
   - Invite clients to call or return if they have questions, concerns or doubts
   - Schedule next visit or referral appointment, if appropriate

*Source: from Population Reports, Series Q, No. 1, 2003*
Initial Action Steps

As Title X clinics in Region I move forward in their efforts to integrate HIV and family planning services, it may be a useful exercise for clinic managers, supervisors and staff to revisit the concept of client-centered care, perhaps devoting a staff meeting to a group discussion of the following: What does client-centered reproductive health care look like from the perspectives of 1) the client, 2) the provider, and 3) the clinic or program?

Cultural Competence and Client-Centered Care

Sensitivity to and understanding of a client’s cultural background is a key component of providing client-centered care. Attitudes and beliefs concerning health and disease, reproduction, sexual behavior; gender roles, and personal power differ greatly across cultures. Family planning providers are well aware of the great impact of sociocultural norms and religious beliefs on decision making around family planning choices. Cultural factors play an equally important role in clients’ perceptions of personal risk of HIV, and their willingness and ability to take specific risk reduction actions.

In Region I, although grantee organizations vary in their aggregate levels of client diversity, each grantee has important ethnically, racially and culturally diverse populations who seek Title X services. In the needs assessment site visits, contacts at all grantee agencies expressed the ongoing need for developing culturally competent services in the HIV area. Training on “HIV and cultural issues” was one of the top five training needs identified by family planning providers responding to the needs assessment survey.

In response to this stated need, this manual includes a Special Section on Cultural Competence which provides a framework for looking at cultural competence, guidelines to follow in working towards it, organizational assessment tools and training resources. The CD-ROM also includes links to a number of excellent resources to assist family planning providers in their ongoing efforts to provide culturally competent care.
Here is an annotated listing of key resources, many of which are referenced in this chapter. Links to these resources may be found under Introduction and Chapter I on the CD-ROM.

- **Region I Title X HIV Integration Needs Assessment and Training Plan: Final Report**
  JSI Research & Training Institute, Inc.
  [http://www.famplan.org/docs/combined_needs_assess.pdf](http://www.famplan.org/docs/combined_needs_assess.pdf)
  The need for this manual grew out of information gathered from this needs assessment, conducted with family planning providers in Region I.

- **Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics**
  Alan Guttmacher Institute
  This article documents the successes and roles of family planning and Title X. The provided framework gives readers an extensive background of family planning and the need to continue services in the United States.

- **Program Guidelines for Project Grants for Family Planning Services**
  (Complete Document)
  Office of Population Affairs, Department of Health and Human Services
  This document has been developed to assist current and prospective grantees in understanding and utilizing the family planning services grant program authorized by the Title X Public Health Service Act, 42 U.S.C. 300, et seq.

- **Region I Title X Family Planning Training Center**
  JSI Research and Training Institute, Inc.
  [www.famplan.org](http://www.famplan.org)
  The Region I Title X Family Planning Training Center web site provides reproductive health providers with online training registration, breaking news, data maps, a loaning library, and other useful resources. Providers can also access information about other JSI projects and training opportunities.
Preventing HIV/AIDS in Women, Adolescents and Infants: The Critical Role of the Title X Family Planning Program
Family Planning Councils of America, Inc.
http://www.fpcai.org/brochures/fpca_HIVAIDS.pdf

A compilation of information addressing the needs, reasons and suggestions for integrating HIV/AIDS services into Title X Family Planning Clinics. Contains a form for ordering copies of the brochure for clinics.

Examining HIV Prevention Activities in the Title X Family Planning Program
http://www.opa.osophs.dhhs.gov/pubs/eval/03may.pdf

This research study was conducted to help the Office of Family Planning (OFP) identify and assess the types of HIV prevention activities Title X programs are providing, identify gaps in current programs and highlight innovative strategies and promising practices.

Federal HIV Funding
Information compiled by JSI Research & Training Institute, Inc.

This document describes the major funders of HIV prevention and care services. Learning about the various HIV funding streams can help family planning programs identify sources of support for new programs, including HIV integration initiatives.

Assessment Tools:

HIV Integration Checklist
International Planned Parenthood Federation/Western Hemisphere Region, Inc.

A self-evaluation tool to explore if and to what degree gender-sensitive STD/HIV prevention strategies have been integrated into sexual and reproductive health (SRH) programs on the organizational, programmatic and service-delivery levels. The checklist is a user-friendly evaluation instrument that can initially be applied to assess the degree of STD/HIV integration and then used as a tool to monitor progress toward achieving integration.

Client-Centered Care Organizational Assessment: How Well Does your Agency Provide Client-Centered Services?
Center for Health Training (Region VI)
http://centerforhealthtraining.org/materials.html#howwell

A one-page self-assessment that can be completed by your entire staff or your management team to begin a dialogue about how client-centered your services and systems really are.
HIV/AIDS Surveillance Data and Other Demographic Data:

- **State Health Facts Online**
  
  http://www.statehealthfacts.kff.org/

  Kaiser Family Foundation

  Allows users to find data for each state and compare it with national statistics. It includes HIV/AIDS data, testing rates, AIDS cases, CDC funding and other useful resources.

- **CDC National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention**
  
  http://www.cdc.gov/hiv/stats/hasrlink.htm

  HIV/AIDS Surveillance Report, published annually, contains tabular and graphic information on AIDS and HIV case reports with many measures, including data by metropolitan statistical area, mode of exposure, vital status, and case definition category.

- **HIV Surveillance Data from Region I State Health Departments**

  Levels of detail vary by state, but can include data by community and region. Some states’ data is available online; other states provide a phone number for requesting surveillance data.

  - Connecticut Department of Public Health – HIV/AIDS Surveillance Program
  - Maine Department of Human Services, Bureau of Health, HIV/STD Program
  - Massachusetts Department of Public Health, HIV/AIDS Surveillance Program
  - New Hampshire Department of Health and Human Services, Bureau of Communicable Disease Control and Surveillance
  - Rhode Island Department of Health
  - Vermont Department of Health


<table>
<thead>
<tr>
<th>TASKS</th>
<th>CURRENT STATUS</th>
<th>STEPS TO BE TAKEN</th>
<th>STAFF RESPONSIBLE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community profile, including demographic info and HIV surveillance data, developed for clinic’s service area</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
<tr>
<td>Staff provided with current information on HIV prevalence/trends in local service area</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
<tr>
<td>Staff meeting(s) scheduled to envision integrated HIV/FP care from perspective of clients, staff and organization</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
<tr>
<td>HIV integration defined and included in clinic’s mission statement</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
<tr>
<td>HIV integration activities (provision of HIV prevention services) included in staff job descriptions</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
<tr>
<td>HIV integration activities (provision of HIV prevention services) included in clinic’s service and clinical protocols</td>
<td>1  2  3  4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
<td></td>
</tr>
</tbody>
</table>
### HIV/FP Integration Work Plan

**Laying the Groundwork for Integrated HIV Prevention and Family Planning Services**

<table>
<thead>
<tr>
<th>TASKS</th>
<th>CURRENT STATUS</th>
<th>STEPS TO BE TAKEN</th>
<th>STAFF RESPONSIBLE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic flow and scheduling practices reviewed with inclusion of HIV integration activities (provision of HIV prevention services) in mind</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Just</td>
<td>Fully</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Beginning</td>
<td>Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic self-assessment conducted of commitment to and ability to provide client-centered services, including review of available client satisfaction and community survey data</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Just</td>
<td>Fully</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beginning</td>
<td>Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training needs around HIV/FP integration identified through both external and internal needs assessment processes</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Just</td>
<td>Fully</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Beginning</td>
<td>Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External HIV/FP integration training opportunities for staff explored, identified and assessed</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Just</td>
<td>Fully</td>
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<tr>
<td></td>
<td>Beginning</td>
<td>Accomplished</td>
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<td></td>
</tr>
<tr>
<td>Online HIV/FP integration training opportunities for staff explored, identified and assessed</td>
<td>1 2 3 4</td>
<td></td>
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<td></td>
<td>Just</td>
<td>Fully</td>
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</table>
Integrating HIV Prevention and Family Planning Services
### HIV/FP Integration Work Plan

**Laying the Groundwork for Integrated HIV Prevention and Family Planning Services**

<table>
<thead>
<tr>
<th>TASKS</th>
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<th>STEPS TO BE TAKEN</th>
<th>STAFF RESPONSIBLE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda/plan put together for development of in-house training on HIV/FP integration</td>
<td><strong>1</strong> Just Beginning</td>
<td>3 Fully Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning funding sources that may be used to support HIV/FP integration identified</td>
<td><strong>1</strong> Just Beginning</td>
<td>3 Fully Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific staff assigned to explore HIV/AIDS funding sources that could be used to support the integration of HIV prevention and family planning services</td>
<td><strong>1</strong> Just Beginning</td>
<td>3 Fully Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culturally appropriate HIV/AIDS educational and awareness-raising materials obtained</td>
<td><strong>1</strong> Just Beginning</td>
<td>3 Fully Accomplished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Display and dissemination procedures for HIV/AIDS educational materials specified</td>
<td><strong>1</strong> Just Beginning</td>
<td>3 Fully Accomplished</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter II

Providing HIV Risk Assessment and Prevention Counseling Services
While great strides have been made in the care and treatment of people living with HIV, prevention remains the greatest hope for stemming the spread of the epidemic, and reducing the burden of human suffering caused by the disease. Successful HIV prevention consists largely of helping individuals to adopt and maintain safer sexual behaviors. Family planning providers are uniquely positioned to advance the cause of HIV prevention. They are dedicated to disease prevention and the promotion of reproductive health, accustomed to discussing sexual behavior; skilled in counseling techniques, and trusted by their clients.

The Region I Title X HIV Integration Needs Assessment found that HIV risk assessment and prevention counseling were universally being conducted in clinics throughout the region, indicating a high degree of integration of these essential HIV services. However, there was wide reported variability in the scope of risk assessment, and in the prevention counseling approach or model used by clinics. In addition, the majority of clinic staff providing these services expressed the need for more opportunities to develop their HIV risk assessment and prevention counseling knowledge base and skills.

Years of experience on the part of providers, counselors and case managers in health care and public health settings, as well a large body of community-based research, have demonstrated that some approaches simply work better than others in helping clients to adopt and maintain safer behaviors. This chapter draws upon many sources to summarize what is known about “best practice” methods to assist clients in understanding their own individual risks for HIV, and in taking steps to reduce that risk, including consistent use of condoms, and being tested for STDs and HIV.

To help family planning clinics incorporate effective risk assessment and prevention counseling techniques into the family planning encounter, this chapter provides the following units:

- Client-Centered HIV Risk Assessment
- Evidence-Based HIV Prevention Counseling Approaches
- Developing a Protocol for HIV Risk Assessment and Prevention Counseling
- Enhancing Staff Capacity to Provide Effective HIV Risk Assessment and Prevention Counseling
- Resources
Although in HIV service settings risk assessment and prevention counseling are intertwined with HIV testing, please note that in this manual HIV testing, is discussed in a separate chapter. This is because a significant portion of family planning clinics in Region I do not directly provide HIV testing services.
HIV risk assessment is the foundation upon which HIV prevention counseling is conducted. To facilitate effective prevention counseling, HIV risk assessment must be client-centered, that is, tailored to the behaviors, circumstances and needs of the individual client. Delivery of client-centered risk assessment services requires commitment to a comprehensive risk assessment model on the part of both clinic managers and staff.

**Risk Assessment Definition and Goals**

Stated broadly, the goals of HIV risk assessment are:

- To provide a basis for working with the client to develop a personal risk reduction plan,
- To identify clients to be offered (referred for) HIV testing,
- To link clients to needed services

To be effective in reaching these goals, risk assessment must be more than a series of yes/no questions. A cogent definition of the “ideal” in risk assessment may be found in Asking the Hard Questions: A Reproductive Health Provider's Guide to Client-Centered HIV Risk Assessment:

> **“HIV risk assessment is an interactive exchange between a provider and a client in which the provider asks open-ended questions designed to elicit responses and reflection that can raise a client’s self-perception of risk.”**

In order to serve as the foundation for individualized prevention counseling, HIV risk assessment must “raise a client’s self-perception of risk”—that is, encourage the client to identify and acknowledge the behaviors and circumstances that increase personal risk for HIV. The HIV risk assessment process should help clients to “discover for themselves” what is putting them at risk.

To achieve this goal, risk assessment must be an **“interactive exchange”**, a dialogue or conversation between provider and client, in which the client feels safe enough to discuss, with some specificity, behaviors and life events that are not often talked about. Key topic areas to cover in this conversation, and ways to set the stage so that clients feel supported in what may be an uncomfortable process are discussed next.
Key Topic areas for HIV Risk Assessment

HIV risk assessment should focus on the range of behaviors and circumstances that may place a client at risk for HIV infection, encompassing substance use, partner behaviors, and STD history as well as the client’s own sexual history and practices. While many of the components of an HIV risk assessment may be covered in the intake and history protocols family planning providers already use, certain aspects of HIV risk assessment may be less familiar to family planning providers. The Region I Title X Needs Assessment found, for example, that providers were more likely to conduct sexual risk assessments than to ask about substance abuse, and that risk assessment protocols in many clinics did not include risk factors such as coerced sex or partner’s incarceration.

A comprehensive HIV risk assessment should cover the topic areas listed below.

- **Sexual history, including number of partners, gender of partners, types of sexual behavior, and use of condoms**
- **History of sexually transmitted infections**
- **Pregnancy intentions**
- **Substance use history**
- **Sexual assault/abuse and domestic violence**
- **Partner factors including substance use, incarceration, and other partner behaviors of concern to client**
- **Previous actions taken to reduce HIV risk**
- **Other HIV related risks, e.g. tattooing, body piercing**

There are many ways to ask about these issues, as shown in Boxes 1, 2 and 3 in this section. While the list of topic areas may seem somewhat daunting, dialogue around HIV risks encompasses almost all of the factors affecting other aspects of reproductive health such as contraception and STDs. Because of the large amount of overlap in issues related both to general reproductive health and HIV prevention, comprehensive HIV risk assessment need not take an inordinate amount of extra time in the family planning visit. This has been borne out by the experience of HIV integration grantees in Region I.

Communication Guidelines for HIV Risk Assessment

As described above, HIV risk assessment is a “minefield” of very personal topics that may be emotionally loaded and difficult to discuss. Sensitivity to difficult issues and counseling skill are hallmarks of family planning service delivery; and the guidelines stated below are well-engrained practices for many family planning providers. But they bear repeating here because they are essential for establishing trust with the client and creating a safe environment for the risk assessment dialogue.
Provide assurances of confidentiality.
Maintain a nonjudgmental attitude.
Use clear, understandable, non-offensive language.
Show respect for the person, cultural context, values and beliefs.
Express caring and compassion for the client.
Recognize the client's life circumstances and obstacles faced.
Be aware of body language, both the client's and one's own.
Allow clients time to respond.

Providers experienced in HIV risk assessment suggest these additional communication techniques to facilitate a successful risk assessment conversation.¹³

“Normalize” the risk assessment process.
To reduce embarrassment and anxiety, emphasize that these questions are asked of all clients. Explain that the goal of these questions is to be able to provide the best reproductive health care for the client.

Use open-ended questions to encourage a more in-depth response.
To serve as a good basis for HIV prevention counseling, it is essential that the risk assessment process helps clients to talk about their risky behaviors with specificity. Close-ended (yes/no) questions cut the conversation short. Open-ended questions encourage clients to talk and respond more fully. Box 1, taken from CDC's Revised Guidelines for HIV Counseling, Testing and Referral, provides examples of how to ask about key HIV risk factors in an open-ended manner.

Provide written information about HIV.
Written information lessens the burden of factual information to be conveyed during the visit and preserves precious counseling time for risk assessment and risk reduction discussions.

Please note that an excellent HIV risk assessment training resource is available to family planning clinics in Region I. Asking the Hard Questions: A Reproductive Health Providers' Guide to Client-Centered HIV Risk Assessment is designed to help reproductive health care providers enhance their sexual history taking and HIV risk assessment skills. It addresses providers' concerns and contains sample counseling dialogues, risk assessment tips, and practice activities. A companion guide, Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors, helps clinic administrators to facilitate the development of provider skills in HIV risk assessment. Both guides are accessible via www.famplan.org, the web site of the Region I Family Planning Training Center, and via the CD-ROM.
### Examples of Closed-Ended Versus Open-Ended Questions

<table>
<thead>
<tr>
<th>Close-ended questions, which might interfere with client-centered human immunodeficiency virus (HIV) prevention counseling</th>
<th>Open-ended questions, which promote client-centered HIV prevention counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever injected drugs? OR Have you (for a male client) ever had sex with a man? OR Have you (for a female client) ever had sex with a bisexual man?</td>
<td>What are you doing that you think may be putting you at risk for HIV infection? What are the riskiest things that you are doing?</td>
</tr>
<tr>
<td>If your test comes back positive, how do you think you may have become infected?</td>
<td>When was the last time you put yourself at risk for HIV? What was happening then?</td>
</tr>
<tr>
<td>Have you ever had sex when you were under the influence of alcohol or drugs?</td>
<td>How often do you use drugs or alcohol? How do you think drugs or alcohol influence your HIV risk?</td>
</tr>
<tr>
<td>Do you (always) use condoms when you have sex? OR Can you always use condoms when you have sex?</td>
<td>How often do you use condoms when you have sex? When/with whom do you have sex without a condom? When with a condom? What are you currently doing to protect yourself from HIV? How is that working? What kinds of things do you do to protect you partner from getting infected with HIV? (for HIV-infected clients) Tell me about specific situations when you have reduced your HIV risk. What was going on that made that possible?</td>
</tr>
<tr>
<td>Can you always use clean works (i.e., needles, syringes, cottons, or cookers*) when you inject? *Cottons are filters use to draw up the drug solution. Cookers include bottle caps, spoons, to other containers used to dissolve drugs.</td>
<td>How risky are your sex/needle-sharing partners? For example, have they been recently tested for HIV?</td>
</tr>
</tbody>
</table>

**Source:** Centers for Disease Control and Prevention. Revised Guidelines for HIV Counseling, Testing, and Referral and Recommendations for HIV Screening of Pregnant Women. MMWR 2001/Vol.50/No.RR19.

**BOX 1**
Risk Assessment Tools

There is no one perfect tool for HIV risk assessment, though a number have been developed. Two are offered here and others may be found in the resources included under Chapter II on the CD-ROM.

**Question Guides**

An HIV risk assessment question guide can be a very helpful support to family planning providers. Individual providers will develop their own ways of phrasing HIV risk assessment questions, and those practicing a client-centered approach will tailor the emphasis and ordering of questions to the client’s situation. But a risk assessment “cheat sheet” like the one below can help to guide and structure the risk assessment conversation. Bulleted items are issues to “probe” or ask more about, depending on the client’s answers to the opening questions.

<table>
<thead>
<tr>
<th>Question Guide for HIV Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Behaviors</strong></td>
</tr>
<tr>
<td>Tell me about your current sexual relationship.</td>
</tr>
<tr>
<td>Tell me about your sexual activity in the past.</td>
</tr>
<tr>
<td>• Number of partners in the past 10 years</td>
</tr>
<tr>
<td>• Gender of partners</td>
</tr>
<tr>
<td>• Types of intercourse—vaginal, oral, anal</td>
</tr>
<tr>
<td>What do you know about the sexual activity of your current partner or partners you were with in the past?</td>
</tr>
<tr>
<td>How often do you use condoms—all the time, most of the time, hardly ever or never?</td>
</tr>
<tr>
<td>How satisfied are you with your sexual relationship?</td>
</tr>
<tr>
<td><strong>HIV/STI Risk</strong></td>
</tr>
<tr>
<td>Have you ever had a sexually transmitted infection—such as chlamydia, “trich”, herpes, HPV or warts, gonorrhea, or syphilis?</td>
</tr>
<tr>
<td>Have you ever been tested for HIV? What led you to be tested? What were the results?</td>
</tr>
<tr>
<td>What are you doing now to protect yourself from HIV/AIDS and other sexually transmitted infections? How about in the past?</td>
</tr>
<tr>
<td><strong>Pregnancy Intentions</strong></td>
</tr>
<tr>
<td>Are you pregnant now, or think you may be?</td>
</tr>
<tr>
<td>What are you doing to avoid an unplanned pregnancy?</td>
</tr>
<tr>
<td><strong>Substance Use History</strong></td>
</tr>
<tr>
<td>What have you heard about the connection between alcohol and drug use and HIV?</td>
</tr>
<tr>
<td>Have you ever felt that alcohol or drugs were a problem for you?</td>
</tr>
<tr>
<td>How often have you used alcohol or drugs? What about injection drug use?</td>
</tr>
<tr>
<td>• sharing needles or “works”</td>
</tr>
<tr>
<td>To your knowledge, have any of your sexual partners injected drugs?</td>
</tr>
<tr>
<td>How has drinking or using drugs affected your sexual behavior?</td>
</tr>
<tr>
<td><strong>Domestic Violence/ Sexual Assault or Abuse</strong></td>
</tr>
<tr>
<td>Have you ever been forced to have sex when you didn’t want to?</td>
</tr>
<tr>
<td><strong>Other HIV-Related Risks</strong></td>
</tr>
<tr>
<td>Is there anything else you are concerned about now or in the past that might be increasing your HIV risk?</td>
</tr>
<tr>
<td>• Blood transfusion since 1997</td>
</tr>
<tr>
<td>• Hemophilia</td>
</tr>
<tr>
<td>• Use of shared equipment for tattooing, body piercing</td>
</tr>
<tr>
<td>Have you or any of your sex partners ever been in prison?</td>
</tr>
</tbody>
</table>

**BOX 2**

Other Tools
Some clinics may opt to use a self-administered risk screening questionnaire. An advantage of this is that clients may find it easier to answer questions in writing than out loud. However, if a self-administered form is used, providers should always review it with the client, and discuss any responses that raise questions or concerns. The essence of HIV risk assessment is a dialogue between clients and providers that enables clients to take a real look at their own risk. Only on the basis of such a conversation can prevention counseling, as described in the next section, take place.

An alternative to a self-administered risk assessment form is an awareness raising questionnaire (See Box 3). The client is given the form to read, but no answers need be recorded. The purpose of the questionnaire is not to gather information, but rather to raise the client’s awareness of the factors that affect HIV risk and to encourage the client to express her questions and concerns during the family planning visit. If such a questionnaire is used by a clinic, it is very important that providers bring it up and discuss it with the client during the visit; otherwise anxiety rather than awareness may be raised. Again, this discussion is critical as a basis for prevention/risk reduction counseling.

A Word About HIV Risk Perceptions
As family planning providers work to integrate HIV risk assessment into the family planning visit, it is important to sound a cautionary note about the tendency to underestimate HIV risk. As noted in Chapter I, respondents to the Region I Title X HIV Integration Needs Assessment Survey reported that many family planning clients do not see HIV prevention as a personally relevant issue; providers noted the “perception of invincibility” to HIV among clients, even in the presence of risk factors such as STD infection, multiple sex partners and drug use. Many research studies have documented this propensity among adolescent and young adult women to view their personal risk of HIV as minimal, even as they engage in risky behaviors, and even though they may see the HIV risk of their peers as high.6-7 Clients may also perceive themselves to be “safe” from HIV when they are in a monogamous relationship; this perception may or may not be accurate depending on the presence of other risk factors. At times family planning providers may share this tendency to underestimate HIV risk among their clients; family planning clients as a whole are often described as a “low risk population”, even though HIV infection rates are rising in many of the population groups served by Title X clinics (see Chapter I, Box 1).

The very essence of HIV risk assessment is to bring about a realistic estimation of risk so that appropriate preventive actions can be taken. As clinics prepare to include HIV risk assessment among their services offered, it may be worthwhile for clinic managers and staff to discuss the issues related to perceptions of HIV risk.
Personal Questionnaire

This questionnaire is to let you know what kinds of activities might expose you to HIV, the virus that causes AIDS. Please read this over while waiting for your visit. You will have a chance to discuss any questions or concerns with a counselor or clinician today.

**THIS IS FOR YOUR INFORMATION ONLY. YOU DON'T NEED TO WRITE ANYTHING DOWN.**

1. Have I had more than one sexual partner in the last ten years?
2. Have I ever been with a sexual partner who had had other sexual partners?
3. Have I ever had sex with someone who was infected with HIV?
4. Have I ever had sex without a condom (rubber), when I didn’t know whether or not my partner had any kind of infection?
5. (For men) Have I ever had sex with a man?
   (For women) Have I ever had sex with a man who also has had sex with other men?
6. Have I ever had sex with a partner whom I didn’t know very well?
   Did I have sex with that person without using a condom (rubber)?
7. Have I ever shared needles to shoot drugs?
8. Have I ever had a partner who shared needles to shoot drugs?
9. Have I ever had a sexually transmitted infection – chlamydia, trichomoniasis or “trich,” herpes, HPV or warts, gonorrhea, or syphilis?
10. Have there ever been times when my sexual behavior was affected by alcohol or other drug use?
    Is alcohol or drug use currently affecting my sexual behavior?
11. Have I ever had sex for money, drugs, or safety?

If you answered “yes” to any of the questions above, you might be at risk for infection with HIV. You might want to consider having an HIV-antibody test. The result of that test is especially important if you think you are pregnant, or want to become pregnant. And for someone who does have HIV, early testing can lead to early treatment. Your counselor or clinician can answer your questions and give you more information. Please feel free to ask any questions about HIV and AIDS, and any other sexually transmitted infection.

*Form developed by Joan Mogul Garity 1988, revised 2001*

JSI Research and Training Institute, Inc. 2002

**BOX 3**
Prevention, both of HIV and of unintended pregnancy, requires the individual to adopt and maintain "safe" behaviors, and to change risky ones. The prevention counseling approach used is critical to its effectiveness in promoting behavior change on the part of the client. While the provision of information on how HIV is transmitted is important, both experience and research have demonstrated that didactic, information-giving approaches simply don’t work when it comes to changing behavior. As clinics work to integrate HIV risk assessment and prevention counseling into family planning care, they will want to use approaches that have been shown to be effective.

The HIV prevention counseling model recommended by the Centers for Disease Control and Prevention (CDC) is based on the latest scientific research on health behavior change and on the behaviors that contribute to HIV transmission. The CDC model has been confirmed effective by Project Respect, a randomized trial evaluating the efficacy of HIV prevention counseling in changing high risk sexual behaviors and preventing new STDs and HIV. Project Respect found that clients counseled according to the CDC’s method reported significantly more condom use and had fewer new STDs in the follow-up year.

**CDC’s Client-Centered HIV Prevention Counseling Model**

In its training materials, CDC provides this definition of HIV prevention counseling:

*HIV prevention counseling is a client-centered exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV.*

There are two key components of this definition:

1. Counseling is client-centered, i.e., tailored to the client’s particular behaviors, circumstances and special needs.
2. The goal of HIV prevention counseling is risk reduction through behavior change.
The specific aims of the HIV prevention counseling process are to:

- Enhance clients’ perception of their own personal risk
- Support client-initiated changes in behavior
- Focus on small, achievable steps toward reducing personal risks.

These aims are achieved through an interactive exchange in which the provider listens to the client, helps the client to explore the circumstances in which she or he behaves in risky ways, and encourages the client to think of steps to take to reduce HIV risk. Clients are more likely to adopt a strategy they have conceived than one they have been told to do.

A critical aspect of the method is that it focuses on small, incremental steps to reduce risk rather than on global directives, such as “practice safer sex”. See Box 5 for examples of this distinction. To help the client to take the small steps, the provider and client together develop a risk reduction plan. To assure that the plan is realistic they discuss both the benefits of the plan to the client and the barriers that might stand in its way. Box 4 summarizes guidelines for providers offering HIV risk reduction counseling.

### Elements of Effective HIV Prevention Counseling

- Keep the session focused. Don’t try to eliminate all risks.
- Base the risk reduction plan on an assessment of the individual’s personal risks.
- Explore and provide support for risk reduction steps already taken.
- Negotiate a concrete, achievable behavior change step that will reduce HIV risk.
- Problem-solve with client around barriers to the risk reduction step.
- Provide skill building opportunities if possible.
- Clarify critical rather than general misconceptions. Avoid unnecessary information.


**BOX 4**
### Examples of Global Versus Specific Risk-Reduction Steps for HIV Prevention Counseling

<table>
<thead>
<tr>
<th>Global risk-reduction steps, which are unlikely to be effective in changing behavior</th>
<th>Specific risk-reduction steps, which are more likely to be effective in changing behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always use condoms.</td>
<td>Buy a condom tomorrow and try it on. Carry a condom next time I go out (e.g., to the bar/nightclub). Starting tonight, put condoms on the night stand beside the bed. Starting tonight, require my partner to use a condom next time, or I will not have vaginal (anal) sex.</td>
</tr>
<tr>
<td>Have fewer or less risky partners.</td>
<td>Stop seeing (specific partner) who is seeing other people. Break up with (specific partner) before getting together with someone new.</td>
</tr>
<tr>
<td>Have safer sex.</td>
<td>Talk honestly with (specific partner) about my HIV status and ask about his/her status. Next time I’m out with friends and may have sex, avoid getting “high” on drugs or alcohol. Only kissing, etc., with (specific partner) until we both have an HIV test. Tomorrow, ask (specific partner) if he or she has had a recent HIV test and has been tested for other sexually transmitted diseases.</td>
</tr>
<tr>
<td>Stop injecting drugs.</td>
<td>Obtain clean works (i.e., needles, syringes, cottons, or cookers*) tomorrow so I have them before I use them next time. Contact drug treatment center and make appointment.</td>
</tr>
</tbody>
</table>

*Cottons are filters used to draw up the drug solution. Cookers include bottle caps, spoons, to other containers used to dissolve drugs.

Six-Step Counseling Approach

To help providers deliver effective HIV prevention/risk reduction counseling in accordance with the standards of practice described above, CDC has developed a six-step counseling approach. This is the approach that was tested in the Project Respect randomized trial. This approach, outlined here, can be used in the family planning encounter, and is applicable to other aspects of reproductive health, including pregnancy prevention.

<table>
<thead>
<tr>
<th>Six Steps of HIV Prevention Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Introduce and orient client to the session</strong></td>
</tr>
<tr>
<td>State the goals of the session. “Normalize” the process. Provide assurances of confidentiality.</td>
</tr>
<tr>
<td>2. <strong>Identify client’s personal risk behaviors and circumstances</strong></td>
</tr>
<tr>
<td>Conduct client-centered HIV risk assessment.</td>
</tr>
<tr>
<td>3. <strong>Identify safer goal behaviors</strong></td>
</tr>
<tr>
<td>Negotiate a realistic, achievable behavior that will reduce HIV risk and that the client is willing to try.</td>
</tr>
<tr>
<td>4. <strong>Develop a client action plan</strong></td>
</tr>
<tr>
<td>Identify specific small steps to achieve the goal behavior. Discuss the benefits of the plan and factors (barriers) that could hinder taking these steps. Put the plan in writing.</td>
</tr>
<tr>
<td>5. <strong>Make referrals and provide support</strong></td>
</tr>
<tr>
<td>Discuss people in the client’s life who might be supportive of the plan. Provide referrals to HIV testing and other services as indicated.</td>
</tr>
<tr>
<td>6. <strong>Summarize and close the session</strong></td>
</tr>
<tr>
<td>Confirm action plan and follow-up steps with client.</td>
</tr>
</tbody>
</table>


BOX 6

Process of Health Behavior Change

Early on in their careers most health care providers discover that providing information about health risks is insufficient to change clients’ health behaviors. Health behavior; including sexual and substance use behavior; is influenced by many factors, and making changes, no matter how desirable, can be very difficult for the individual. A familiarity with the principal theories of health behavior change can be helpful to both family planning supervisors and counselors as they work to assist clients with making risk reduction plans. Box 7 provides an overview of some of the key behavior change that underlie effective prevention and risk reduction programs.
<table>
<thead>
<tr>
<th>Level Addressed</th>
<th>Theory/Model</th>
<th>Focus</th>
<th>Key Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theories that address how individual factors such as knowledge, attitudes, beliefs, prior experience, and personality influence behavioral choices</strong></td>
<td>Health Belief Model</td>
<td>Peoples’ perceptions of the threat of a health problem and appraisal of behavior recommended to prevent or manage problem.</td>
<td>Perceived susceptibility Perceived severity Perceived benefits of action Perceived barriers to action Cues to action Self-efficacy</td>
</tr>
<tr>
<td></td>
<td>Theory of Reasoned Action/ Theory of Planned Behavior</td>
<td>People are rational beings whose intention to perform a behavior strongly relates to its actual performance through beliefs, attitudes, subjective norms, and perceived behavioral control.</td>
<td>Behavioral intention Subjective norms Attitudes Perceived behavioral control</td>
</tr>
<tr>
<td></td>
<td>Stages of Change/ Transtheoretical Model</td>
<td>Readiness to change or attempt to change a health behavior varies among individuals and within an individual over time. Relapse is a common occurrence and part of the normal process of change.</td>
<td>Precontemplation Contemplation Preparation Action stage Maintenance Relapse</td>
</tr>
<tr>
<td><strong>Theories that address processes between the individual and primary groups that provide social identity, support, and role definition</strong></td>
<td>Social Cognitive Theory/ Social Learning Theory</td>
<td>Behavior change is explained by dynamic interaction among personal factors, environmental influences, and behavior.</td>
<td>Observational learning Reciprocal determinism Outcome expectancy Behavioral capacity Self-efficacy Reinforcement</td>
</tr>
<tr>
<td></td>
<td>Community Organization/Building</td>
<td>Processes by which community groups are helped to identify and address common problems or goals.</td>
<td>Participation and relevance Empowerment Community competence Issue selection</td>
</tr>
<tr>
<td></td>
<td>Social Marketing</td>
<td>The application of commercial marketing technologies to increase the practice of healthy behaviors in order to improve individual and collective well-being.</td>
<td>Consumer orientation Audience segmentation Communication channels analysis Voluntary exchange of goods and services</td>
</tr>
</tbody>
</table>


**BOX 7**
A formal, written protocol provides guidance to clinic staff in carrying out the complex tasks of integrated risk assessment and prevention counseling, and helps to ensure consistency in delivery of services. Presented below are the main topics and issues to consider in developing a risk assessment/prevention counseling protocol or revising one already in use. Please note that in clinic settings that provide HIV testing, HIV risk assessment and prevention counseling may be enfolded into the HIV testing protocol (see Chapter III).

Key Components of a Protocol for HIV Risk Assessment and Prevention Counseling

- Integrated Care Philosophy
  Affirms that HIV risk assessment and prevention counseling are an integral part of the family planning visit, and a basic component of the clinic’s scope of services. Reiterates the clinic’s commitment to a client-centered approach in providing these services.

- Who Can Deliver These Services/How They Are Trained
  Specifies which staff may provide HIV risk assessment and prevention counseling services in accordance with clinic policy, Title X, and local and state regulations. States types and scope of training staff must have received to be eligible to provide these services.

- Risk Assessment Approach
  States the goals of risk assessment and describes the risk assessment model used by the clinic, underscoring the importance of a client-centered approach. Describes risk assessment scope (behaviors to cover). Provides general guidelines for conducting a risk assessment. Indicates which forms and tools to use for risk assessment.

- Prevention Counseling Model
  States the goals of prevention counseling and describes the prevention counseling model/approach used by the clinic. Provides general guidelines for providing HIV prevention counseling.

- Who Receives These Services and Frequency of Administration
  Ideally directs that HIV risk assessment prevention counseling should be offered to all family planning clients, beginning with their initial visit. If resources do not permit this level of service, gives guidance as to who should be provided these services. States importance of periodically reassessing risk and specifies the interval at which HIV risk assessment/prevention counseling should be repeated.
Criteria for Referral to HIV Testing
Specifications who should be recommended HIV testing based on risk assessment findings, health status (pregnancy, STD diagnosis) or client request. If clients are to be recommended HIV testing on a routine basis (i.e., universal referral) such policy should be described here. See also Chapter III, Section 3 for key components of an HIV C&T service provision protocol.

Protection of Client Confidentiality
Reiterates the critical importance of preserving of client confidentiality and provides guidance for providers around HIPAA privacy rules and state statutes governing HIV status and related protected information.

Documentation of Risk Assessment and Counseling
Specifies where and how providers should record the delivery and results of HIV risk assessment and prevention counseling. Indicates forms to be used for recording risk information, whether HIV testing was suggested to the client, and client’s decision regarding testing.
The key to successful integration of HIV services into family planning is well-trained, committed staff. Here are some steps that clinic managers and supervisors can take to ensure that staff feel well-equipped and confident to provide client-centered risk assessment and prevention counseling services.

Identify Needs and Opportunities for Training

The Region I Family Planning Needs Assessment found that thirty to fifty percent (depending on the state) of providers in Region I wanted further training in HIV risk assessment and HIV prevention. Specialized training is essential, both to ensure a basic level of skill and to help family planning providers feel comfortable delivering HIV services.

Training opportunities, however, can be difficult to come by. Many state Departments of Health, which have traditionally provided training in HIV prevention counseling, have been forced by budget constraints to cut back on their training offerings. Clinics in some areas of Region I report that they find themselves at the bottom of waiting lists for training because they are thought to be serving a lower risk population.

In addition to state HIV/AIDS programs, clinic managers may need to look to other sources for training in HIV-related topics, including:

- **The Region I Family Planning Training Center (RTC)**
  The Region I Training Center offers multiple trainings each year in HIV-related topics, and a wealth of other HIV resources for family planning providers. Clinic managers and training coordinators in Region I are encouraged to request the kinds of training that would best meet their HIV integration needs.

- **Family Planning Training Centers in other regions of the country**
  Several have developed packaged training curricula, online training courses, and provider tools for use in family planning settings.

- **The New England AIDS Education and Training Center (NEAETC)**
  The NEAETC provides training to health care providers throughout New England in the prevention, care and treatment of HIV, focusing especially on providers serving underserved populations.
AIDS Education and Training Centers (AETCs) in other regions of the country
Other AETCs may offer packaged training materials, and other resources and tools for providers.

Local health care centers and community service organizations to which referrals are made. Cross-training or joint training of clinic staff with referral agency staff may be able to be arranged.

The Resources section at the end of this chapter lists these and other training resources, including online courses in risk assessment and prevention counseling. Links to these resources are provided on the CD-ROM.

Conduct Observation of Counseling

Direct observation of counseling sessions by a supervisor is a valuable method for quality assurance, and yields an important opportunity for staff to enhance their risk assessment and prevention counseling skills. Observation should be structured, and constructive feedback should be provided as soon as possible after observation. Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors, accessible via the CD-ROM, includes guidelines and a tool for conducting structured observation of counseling sessions.

Hold Regularly Scheduled Case Conferences

Case conferences, or other regular opportunities to discuss counseling, treatment and referral issues, enable providers to learn from each other. Such meetings provide much needed support to counselors and help to prevent discouragement and burnout. They also help supervisors to recognize specific staff needs for skill building and training, and identify other types of support that could help providers in their risk assessment and prevention counseling work.

Provide High Quality Patient Education Materials

Of the top five types of support cited by Region I providers as helpful for integrating HIV into the family planning session, the second highest priority was having available a broader range of high quality print, audio and video materials appropriate for family planning clients. While educational materials on their own are not effective in promoting health behavior change they do have an important supplemental role to play in support of interactive prevention counseling approaches. For efficiency, basic information on HIV and its transmission can be provided in a pamphlet or video rather than a face-to-face encounter with a counselor. This allows more time for the provider to focus on risk assessment and development of a personal risk reduction plan for the client. Print materials can also serve as a “take-home” for the client to reinforce what was covered in the counseling session. HIV health education materials provided should be tailored to their audience, that is, appropriate to clients’ cultural background, language, sexual orientation, age and reading ability.
Resources

Here is an annotated listing of key resources, many of which are referenced in this chapter. Links to these resources may be found under Chapter II on the CD-ROM.

- **Revised Guidelines for HIV Counseling, Testing, and Referral Services - 2001**
  Centers for Disease Control and Prevention
  These guidelines replace CDC’s 1994 guidelines, HIV Counseling, Testing, and Referral Standards and Guidelines, and contain recommendations for public- and private-sector policy makers and service providers of HIV counseling, testing and referral.

- **HIV/STI Prevention and Treatment among Youth in the US**
  Advocates for Youth
  http://www.advocatesforyouth.org/about/hivsti.htm
  This section of Advocates for Youth’s website includes strategies and resources focusing on HIV/STI prevention for youth with access to hotlines, fact sheets and printable brochures.

- **Project RESPECT**
  Centers for Disease Control and Prevention
  http://www.cdc.gov/hiv/projects/RESPECT/default.htm
  Describes methods, tools, results and other details of a national 6-year study evaluating the efficacy of interactive, client-centered HIV prevention counseling compared with information-only didactic message sessions.

**Training Resources:**

- **Asking the Hard Questions: A Reproductive Health Provider’s Guide to Client-Centered HIV Risk Assessment**
  JSI Research and Training Institute, Inc.
  This guide is designed to help reproductive health care providers enhance their sexual history and HIV risk assessment skills. Addresses providers’ concerns and contains sample counseling dialogues, risk assessment tips, and practice activities.
Section 6  Resources

- **Supporting Quality HIV Risk Assessment: A Guide for Reproductive Health Clinic Managers and Supervisors**
  JSI Research and Training Institute, Inc.
  A companion guide to Asking the Hard Questions: A Reproductive Health Provider’s Guide to Client-Centered HIV Risk Assessment, this guide is designed to help reproductive health care supervisors and managers address and improve upon HIV integration in their clinic. Key components are discussed in depth, such as organizational challenges, developing and maintaining referral systems, and working with staff around client-centered counseling skills.

- **HIV Risk Assessment in Women**
  Health Care Education and Training, Inc.
  [www.hcet.org/training/hiv.htm](http://www.hcet.org/training/hiv.htm)
  This continuing education program is designed to provide professionals who work in women’s health care settings with the information needed to address HIV within the family planning setting. The program addresses HIV epidemiology, risk assessment, and risk reduction behaviors.

- **Approach to Sexual History Taking and STD Screening: Self-Study Module One**
  STD/HIV Prevention Training Center of New England
  This is the first in a series of self-study modules on the topic of STDs. The material addresses sexual history taking and the laboratory diagnosis of STDs.

- **STD 101 In-A-Box: Ready-To-Use Presentations**
  Centers for Disease Control and Prevention
  Includes ready-to-use STD presentations, a user’s guide with suggested agendas, discussion questions, and a script for an interactive group exercise. State/local health departments, health educators, conference organizers, trainers, clinicians, or anyone needing to conduct a basic presentation on STD prevention may use STD 101 In-A-Box. Requires user to register before accessing the presentations.

- **Online STD Case Series**
  National Network of STD/HIV Prevention Training Centers and the Centers for Disease Control and Prevention
  This web-based case series is designed for practicing clinicians who diagnose, treat and manage patients with, or at risk for, sexually transmitted diseases (STDs). The series includes case presentations of common STD-related syndromes with a guided, interactive process to evaluate each case, arrive at a diagnosis and provide recommended treatment.
References


HIV/FP Integration Work Plan
Providing HIV Risk Assessment and Prevention Counseling Services

<table>
<thead>
<tr>
<th>TASKS</th>
<th>CURRENT STATUS</th>
<th>STEPS TO BE TAKEN</th>
<th>STAFF RESPONSIBLE</th>
<th>TIME FRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic managers and staff provided with information on evidence-based prevention counseling and behavioral risk reduction models</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff participation, risk assessment scope and goals defined</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff participation, risk assessment tools selected</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff participation, risk assessment protocol developed</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff participation, HIV prevention counseling approach and goals defined</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With staff participation, HIV prevention counseling protocol developed</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training needs in risk assessment and prevention counseling identified through both internal and external needs assessment processes</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TASKS</td>
<td>CURRENT STATUS</td>
<td>STEPS TO BE TAKEN</td>
<td>STAFF RESPONSIBLE</td>
<td>TIME FRAME</td>
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<tr>
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<td>------------</td>
</tr>
<tr>
<td>External training opportunities in HIV risk assessment and prevention counseling for staff explored, identified and assessed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Online training opportunities in HIV risk assessment and prevention counseling for staff explored, identified and assessed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Counseling observation program in place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Staff discussion/case conference mechanism established</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>A variety of culturally appropriate HIV/AIDS educational materials acquired</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Private rooms for counselling available</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Client feedback mechanism in place</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Chapter III

Linkage to HIV Testing Services
Introduction

Individuals who know their HIV status can avail themselves of life-enhancing treatments, take steps to avoid passing the infection to others, and make more informed decisions about other aspects of their reproductive health care. Persons at risk who test negative for HIV can take action to remain that way. In women of reproductive age, HIV testing is also a critical tool for preventing mother-to-child-transmission of HIV. Providing family planning clients a way to access HIV testing services is thus a critical component of HIV integration into family planning services.

The Region I Title X HIV Integration Needs Assessment found that Title X programs in Region I provide HIV counseling and testing services (HIV C&T) via three basic service models:

1. HIV C&T offered directly by providers as part of the family planning visit. In some sites these services were offered by clinicians, while in others they were offered by staff identified as counselors;
2. HIV C&T offered by referral to non-family planning staff or contract staff in the same agency (e.g., HIV Prevention Department within a larger agency); and
3. HIV C&T referred off-site.

In clinics that provided HIV testing directly, the needs assessment found that clinic managers were very concerned about training issues related to HIV counseling and testing. While staff must have specialized knowledge and skills to effectively provide HIV C&T services, clinic managers reported that training opportunities are becoming less and less available. Region I grantees who provide HIV C&T services have relied upon the state to provide training for their staff. However, because many states view family planning populations as at lower risk for HIV, family planning providers in some states have found themselves at the bottom of waiting lists for state-sponsored training. This predicament is worsening as states face drastic budget cuts.

This chapter is organized somewhat differently than the other chapters in the manual. Reflecting the different service models in effect for delivering HIV testing services, this chapter provides the following units:

- For Clinics That Refer Clients for HIV Testing: Guidelines for Referral
- For Clinics that Provide HIV Testing: Enhancing Staff Capacity to Provide HIV Counseling and Testing
- Resources
For family planning clinics that do not provide HIV C&T services, this chapter provides guidelines concerning when, where and how to refer clients for HIV testing.

For family planning programs in Region I that provide HIV testing directly, this chapter offers a training outline and resources to help them to develop “in house” training programs for their staff, and to evaluate the training programs offered by other agencies.
Many family planning clinics in Region I provide HIV risk assessment and prevention counseling/risk reduction services, but do not provide HIV testing. In this circumstance, the process for referring clients for HIV C&T is of critical importance. Here are some guidelines, based on CDC recommendations, to assist family planning providers in making effective referrals to HIV C&T services.

**When to Recommend (Refer for) HIV Testing**

- When client requests a test
- When risk assessment reveals:
  - past or present sexual or injection drug use risk behavior
  - sex with multiple partners
  - sex with injection drug user
  - sex with a man who has sex with men
  - sex with a person who is HIV positive
  - unprotected sex with a partner whose HIV status is unknown
  - coerced sex with a person whose HIV status is unknown
- If client is pregnant or considering pregnancy
- If client is diagnosed with a STD
- If client has a workplace injury that may result in HIV exposure
- If client received a blood transfusion or clotting factor before 1985
- If the client has infections or symptoms consistent with HIV infection
- If client has a history of incarceration

*CDC indicates routine (universally recommended) HIV testing may be beneficial in communities where seroprevalence of HIV is high (CDC offers a cutpoint of > 1% prevalence as a guideline). For information on prevalence in a particular community, consult the state Department of Health.*
Where to Refer Clients for HIV Testing

A variety of sites, both publicly funded and private, offer HIV counseling and testing (C&T) services, including community health centers, hospital emergency departments, STD clinics, substance abuse programs, AIDS service organizations, prenatal clinics and publicly funded counseling and testing sites. Family planning clinics can obtain a list of publicly funded test sites from their state’s Department of Health, HIV/AIDS office or bureau. Direct links to these offices are provided on the CD-ROM accompanying this manual. AIDS service organizations, such as a state HIV/AIDS “hotline”, will also be able to provide listings and contact information for organizations that provide HIV counseling and testing.

Clinics should keep an updated listing of publicly funded HIV C&T sites, indicating for each site: location, phone number; hours HIV testing is offered, fees charged if any, languages spoken, whether rapid testing is available at the site, and whether confidential and/or anonymous testing is offered. The list should be updated periodically as testing services are being cut back in the face of state and federal budget deficits, and as testing technologies are changing.

If anonymous testing is available in your state, it is important for providers to inform clients about this option. Some individuals will be more likely to seek HIV testing if they know they don’t have to give their name.

How to Make the Referral for HIV Testing

Many people considering HIV testing experience a great deal of uncertainty, anxiety and fear. It is important for the provider to take steps to calm the uncertainty and fear, increasing the likelihood that the client will go to be tested. Here are some recommended steps.

- **Discuss the pros and cons of testing from the client’s perspective.**
  
  This essential discussion will help providers and clients to recognize possible barriers to following through with testing and take steps to minimize them. This conversation should focus on both practical barriers (e.g. lack of transportation or childcare, inability to afford treatment) and personal concerns (e.g. fear of discrimination, dislike of counseling, anxiety about results), but should also examine the benefits of knowing one’s HIV status.

- **Be familiar with the HIV C&T sites to which clients are referred.**
  
  Providers should know the hours when testing is offered, whether a site provides anonymous or confidential testing, whether clients must pay a fee, etc., and have some understanding of the site’s capacity to provide services appropriate to the client’s cultural and linguistic background. Knowing someone to call with questions can be very helpful, and give both providers and clients more confidence in the referral.
Give clients a sense of what to expect when they go to be tested.

A verbal “walk-through” explaining what will happen when the client arrives at the site, how the test is done, how long it takes to get results, and how results will be provided may help to ease the client’s anxiety.

Assure clients that their confidentiality will be protected.

Client fears related to the stigma surrounding HIV may prevent them from seeking testing, despite wishing to know their own status. Direct and specific assurances of both the clinic’s and the testing site’s commitment and legal obligation to protect the client’s confidentiality should be given in any case, and may help to allay the client’s fears.

As a reference and support for family planning providers, guidelines for when and how to refer clients for HIV testing can be written into the clinic’s HIV risk assessment and prevention counseling protocol (see Chapter II). In addition, a listing of local HIV counseling and testing sites should be included in the clinic’s referral directory (see Chapter IV).
Providing HIV C&T is a highly skilled and emotionally demanding endeavor. Clinic managers and supervisors can help to ensure that staff feel well-equipped and confident to deliver HIV C&T services by: putting forward a clear vision of the clinic’s goals in providing these services, offering ongoing training opportunities for staff (training provided by outside agencies as well as training provided in-house), building on-the-job support systems for counselors, and developing a protocol that clearly states guidelines, standards and procedures for HIV C&T.

**Content Areas for Training Family Planning Staff in HIV Counseling and Testing**

Title X training coordinators in Region I have suggested that having a list of key content areas for an HIV C&T Training would support their efforts at developing staff trainings, and assessing the trainings offered by others. The following list of training topics comes from existing training guidelines and HIV C&T training curricula, and can be can be used by Title X programs to develop their own “in house” HIV C&T trainings. Because family planning providers receive ongoing trainings on a variety of reproductive health issues and counseling skills, it is likely that some of these topic and skill areas will be duplicative. Ideally, an HIV C&T training would build on the existing knowledge and counseling skills of providers developed through experience and past trainings. An advantage for the clinic of developing its own training is the ability to tailor information and skills to fit the context of the family planning visit as it occurs in that setting.

While a bulleted list of training content follows, highly interactive trainings incorporating role playing and experiential exercises are most effective for developing skills. A list of training resources related to HIV C&T, including online courses, downloadable curriculum materials and interactive training exercises can be found at the end of this chapter. Links to these training resources are provided on the CD-ROM.

Another way to increase HIV C&T training opportunities for staff is to collaborate with regional training organizations including the Region I Title X Family Planning Training Center; the New England AIDS Education Training Center (AETC) and the STD/HIV Prevention Training Center (PTC) of New England. AETCs are funded under the Ryan White CARE Act and conduct targeted, multi-disciplinary education and training programs for health care providers treating persons with HIV/AIDS. PTCs are funded by the CDC and dedicated to increasing the knowledge and skills of health professionals in the areas of sexual and reproductive health by providing a spectrum of state-of-the-art educational opportunities, including experiential learning with an emphasis on prevention. Links to these training centers, and their counterparts throughout the nation, are provided on the CD-ROM.
Key Content Areas to Include in HIV C&T Training for Family Planning Providers

I. HIV/AIDS Overview
   - Clinical definitions of HIV and AIDS
   - How HIV virus is transmitted from person-to-person
   - Behaviors that increase risk for HIV
   - Other HIV risk factors/indicators (e.g., STD diagnosis)
   - Overview of medical treatments for HIV
   - State and local HIV/AIDS statistics
   - Differential impact of HIV/AIDS on various population groups, including groups served by Title X

II. Intersection of HIV and Reproductive Health Issues
   - Young women and men at risk
   - Relationship of HIV, STDs, and viral hepatitis
   - Role of STD testing and treatment in HIV prevention
   - Role of birth control in HIV prevention and transmission, including dual protection
   - Mother-to-child transmission of HIV and its prevention
   - Family planning and gynecologic care for HIV-positive women

III. Risk Reduction for HIV
   - Safer sex practices including male and female condom use and “ABC” approach
   - Substance abuse treatment for drug users, and harm reduction in drug use including needle exchange, cleaning “works”
   - Antiretroviral treatment of HIV-positive mothers and newborns to prevent mother-to-child transmission
IV. **Principles of HIV C&T**
- C&T as an entry point for prevention and care
- Risk reduction counseling as an integral aspect of HIV testing
- HIV testing must be “informed, voluntary and consented”
- Define anonymous and confidential testing and their pros and cons
- Indications for HIV testing (who is recommended for HIV testing)

V. **Benefits and Challenges of HIV Testing**
- Public health rationale for screening
- Importance for HIV-positive persons of early entry into treatment
- Prevention of mother-to-child-transmission
- Pros and cons of HIV testing from client perspective
- Testing issues for specific populations (e.g. adolescents, immigrants, others)

VI. **Confidentiality and HIV**
- HIV stigma and potential for discrimination and other harms
- State and federal laws regarding HIV confidentiality, HIV status disclosure
- State HIV reporting requirements
- Anonymous vs. confidential testing

VII. **Review of HIV Testing Technologies**
- Basic testing approach: screening (HIV antibody) test followed by confirmatory test
- Review of various HIV testing methods: blood tests, oral fluid tests, urine test, rapid test, Home Access test
- Overview of rapid testing: tests available, benefits, challenges and requirements
- Sensitivity and specificity of tests, and “window period”
- Interpreting test results (negative, positive, indeterminate, or reactive, nonreactive, invalid for rapid testing)
VIII. **Basic Counseling Approach**
- Client-centered counseling approach
- Principles of evidence-based risk reduction counseling (based on behavior change science)
- Culturally competent counseling approaches

IX. **Pretest and Posttest Counseling Session**
- Pretest counseling issues to address (HIV testing process, meaning of results, test decision, confidentiality and reporting issues, client’s HIV risk and risk reduction)
- Pretest counseling recommended protocol
- Posttest counseling issues to address (delivery of test result, meaning of result, client’s emotional response. For clients testing negative: risk reduction to remain uninfected, indications for repeat testing, referrals. For clients testing positive: coping and empowerment, sources of support, treatment options and positive living, prevention of transmission to others, referrals for medical care and support services, partner notification).
- Posttest counseling recommended protocol
- Counseling with rapid tests
- Delivering negative test results
- Delivering positive or preliminary positive test results
- Delivering indeterminate test results

X. **Health Care and Support Services for People Living with HIV (PLWH)**
- Antiretroviral treatment and specialty medical care for PLWH: overview of local health care services
- Range of psychosocial support services that may be needed, including HIV case management, mental health services, substance abuse services, domestic violence services, housing, and food, legal and financial assistance
- Overview of local HIV/AIDS service system and local support services network
- Guidelines for referral to medical and support services
XI. Partner Counseling and Referral Services

- All sex partners and drug-sharing partners of an infected person should be notified of their exposure to HIV
- Voluntary process, done with consent of client and protecting client’s confidentiality
- Strategies for partner notification

Key Components of an HIV C&T Service Provision Protocol

The clinic’s HIV C&T service provision protocol describes in detail how HIV C&T will be implemented in the context of a particular family planning setting. The protocol provides essential guidance for staff providing this complex set of services and sets the standards for high quality service provision. Involving clinic staff in the development or revision of the protocol may yield a number of benefits including: giving staff an overview of the C&T process, increasing staff’s commitment to protocol elements, and identifying areas where procedures can be improved to make the process easier on both clients and providers. Presented below are the main topics and issues to consider in developing a protocol for provision of HIV C&T services or revising one already in use.

- **Goals/Model of Care for HIV C&T Services**
  The clinic’s HIV C&T service provision protocol should begin with a statement of the overarching goals and guiding principles of the program’s HIV C&T activities, including for example: a statement of the benefits of HIV testing for the individual, for couples and families and for the community at large; an assertion that HIV testing must be informed, voluntary and consented; a commitment to offering HIV C&T services in a client-centered, culturally sensitive manner; a recommendation that prevention counseling and referrals be provided even when clients decline testing. This opening statement would also indicate whether the clinic offers anonymous or confidential testing or both.

- **Protection of Client Confidentiality**
  States that informed consent must be obtained before an HIV test is given. Reiterates the critical importance of preserving patient confidentiality in the context of the stigma surrounding HIV that may result in discrimination and harm to clients. Indicates that clients should be informed of the option of anonymous testing. Explains the process for obtaining informed consent from clients. Provides guidance for providers around federal privacy rules and state statutes governing the confidentiality and transmittal of HIV status and related protected information.
Procedures for Offering HIV C&T to Clients
Explains the processes by which HIV C&T is made available to clients (e.g., on intake forms, during counseling session with provider). Lists criteria indicating that a client should be offered HIV C&T services (e.g., client request, risk behaviors, positive pregnancy test, STD diagnosis). Describes written information (posters, brochures) about HIV and HIV testing to be made available for clients in waiting and exam rooms.

Risk Assessment Approach and HIV Prevention Counseling Methods
See Chapter II for an in-depth discussion of HIV risk assessment and prevention counseling/risk reduction services, including key components of a risk assessment and prevention counseling protocol. As noted in that chapter, clinic settings that provide HIV testing will include guidelines and standards for performance of risk assessment and risk reduction counseling as part of their HIV C&T protocol.

Training Requirements for Staff Providing C&T Services
Describes in detail the knowledge, skills, experience and training a provider must have in order to deliver HIV C&T services. Designates which staff will conduct pretest counseling, administer tests and provide posttest counseling (same or different providers).

Supervision and Support for Staff Providing C&T Services
Details supervision and feedback mechanisms for staff to maintain high quality HIV C&T services. Describes other quality assurance mechanisms. Identifies support systems (both peer and supervisor support) that will be available for a counselor before and after delivering a positive test result.

HIV Testing Methods
Describes the specific HIV testing technology in use in the clinic (both antibody and confirmatory tests), and delineates steps for administering the test, handling specimens, disposing of testing materials and obtaining test results.

Pretest Counseling Session Content
Describes the key areas to address in the pretest counseling session including: basic information about HIV, risk assessment, basic information about the testing process, importance of obtaining test results and procedures for doing so, meaning of test results, confidentiality protections, and risk reduction counseling.
Posttest Counseling Session Content
Describes the key areas to address in the posttest counseling session for clients who test negative and for clients who test positive. For clients who test negative issues to address include: meaning of test results, client's feelings about result, strategies for remaining uninfected, indications for repeat HIV testing and referrals. For clients who test positive issues to address include: meaning of test results, client's emotional response, identification of sources of support for the client, treatment options and self-care, ways to avoid passing the virus to partners, prevention of mother-to-child transmission in current and future pregnancies, and referral to medical care and psychosocial support services. Referrals are a critical aspect of the posttest session for all clients. This section of the protocol should include a comprehensive list of the types of services that may be needed by clients testing positive or negative, and direct providers to the clinic's referral protocol, if available.

Documentation of HIV C&T
Delineates how informed consent for HIV testing is obtained and recorded. Specifies types of documentation of the HIV C&T encounter needed for internal, laboratory, reporting, and billing purposes. Details how records are kept secure and confidential.

HIV Reporting Requirements
Describes procedures for reporting HIV cases (confirmed positives) to state health department in accordance with state law.

Referrals to HIV-Related and Other Important Services
See Chapter IV for an in-depth discussion of referral networks and procedures that support HIV/family planning integration. The chapter includes a description of key components of a referral protocol. This section of the HIV C&T service provision protocol would also provide guidelines for the provision of partner counseling and referral services (PCRS).
Section 3  For Clinics that Provide HIV Testing: Enhancing Staff Capacity to Provide HIV C&T
Here is an annotated listing of key resources, many of which are referenced in this chapter. Links to these resources may be found under Chapter III on the CD-ROM.

- **Revised Guidelines for HIV Counseling, Testing, and Referral Services - 2001**
  Centers for Disease Control and Prevention

  These guidelines replace CDC’s 1994 guidelines, HIV Counseling, Testing, and Referral Standards and Guidelines, and contain recommendations for public- and private-sector policy makers and service providers of HIV counseling, testing and referral.

- **Revised Recommendations for HIV Screening of Pregnant Women - 2001**
  Centers for Disease Control and Prevention

  These guidelines replace CDC’s 1995 guidelines, U.S. Public Health Service Recommendations for Human Immunodeficiency Virus Counseling and Voluntary Testing for Pregnant Women, and are for public- and private-sector providers who provide health care for pregnant women.

- **Rapid HIV Testing**
  Centers for Disease Control and Prevention
  http://www.cdc.gov/hiv/rapid_testing/

  This section of the CDC website gives updated information on HIV rapid tests, research and implementation.

- **Rapid Testing for HIV**
  New York State Department of Health
  http://www.health.state.ny.us/nysdoh/hivads/rapid/index.htm

  Provides resources and training information with a particular emphasis on counseling with the HIV rapid test.

Linkage to HIV Testing Services
**Project RESPECT**
Centers for Disease Control and Prevention
http://www.cdc.gov/hiv/projects/RESPECT/default.htm
Describes methods, tools, results and other details of a national 6-year study evaluating the efficacy of interactive, client-centered HIV prevention counseling compared with information-only didactic message sessions.

**Know HIV/AIDS Testing Center Database and Hotlines**
Kaiser Family Foundation and Viacom
http://www.knowhivaids.org/prev_gettested.html#testing
Provides a national searchable database of counseling and testing centers. In addition, the link offers a directory of HIV/AIDS hotlines for counseling, testing and other resources.

### State Health Departments’ HIV/AIDS Bureaus and Divisions

Contact the following state HIV/AIDS offices for more information on HIV counseling and testing, training opportunities and location of anonymous and confidential HIV C&T sites.

- Connecticut
- Maine
- Massachusetts
- New Hampshire
- Rhode Island
- Vermont

### Training Resources

- **HIV and AIDS Online Minicourse (EngenderHealth)**
  This course is designed for reproductive health care providers, staff, planners, and managers in resource-poor settings who would like to improve their knowledge of HIV/AIDS and incorporate a focus on HIV and AIDS into their services.

- **Voluntary Counseling and Testing (VCT) Training Curriculum**
  Centers for Disease Control and Prevention (CDC), Global AIDS Program (GAP)
  http://www.womenchildrenhiv.org/wchiv?page=vc-05-02
  This curriculum was created to train counselors in developing countries to conduct an HIV prevention counseling session by following a structured VCT protocol. Many elements of the curriculum can be used to train providers practicing in reproductive health care settings in the U.S. Site offers downloadable trainer’s manual, participant’s manual, protocol cue cards, resource list and slide set.
References


**HIV/FP Integration Work Plan**

Linkage to HIV Testing Services

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<tr>
<th>TASKS</th>
<th>CURRENT STATUS</th>
<th>STEPS TO BE TAKEN</th>
<th>STAFF RESPONSIBLE</th>
<th>TIME FRAME</th>
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<tbody>
<tr>
<td>Include in clinical and service protocols specific guidelines for referral to HIV C&amp;T</td>
<td>1 2 3 4</td>
<td>Fully Accomplished</td>
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<tr>
<td>Educate all staff in HIV C&amp;T referral guidelines</td>
<td>Just Beginning</td>
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**FOR CLINICS THAT DO NOT PROVIDE HIV C&T SERVICES**

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<tr>
<td>Compile a referral directory of HIV C&amp;T sites/providers, including sites offering both confidential and anonymous HIV testing</td>
<td>1 2 3 4</td>
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<td>Establish service agreements with HIV C&amp;T sites/providers</td>
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<td>Establish means for keeping current on state and federal guidelines concerning HIV C&amp;T</td>
<td>1 2 3 4</td>
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<td>Staff training needs in HIV C&amp;T identified through both internal and external needs assessment processes</td>
<td>1 2 3 4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
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<tr>
<td>External HIV C&amp;T training opportunities for staff explored, identified and assessed</td>
<td>1 2 3 4</td>
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<td>Fully Accomplished</td>
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<tr>
<td>Online HIV C&amp;T training opportunities for staff explored, identified and assessed</td>
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<tr>
<td>Clinic’s ability and commitment to providing HIV C&amp;T training in-house assessed</td>
<td>1 2 3 4</td>
<td>Just Beginning</td>
<td>Fully Accomplished</td>
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<tr>
<td>Develop training curricula and modules using Key Content Areas outline Chapter III as a guide</td>
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Chapter IV

Developing Referral Networks and Procedures
Strong referral relationships with a broad spectrum of community-based service organizations form the cornerstone of effective HIV/family planning integration. HIV risk assessment will reveal many service needs among clients, whether or not an individual client decides to take a further step and be tested for HIV. Clients who test positive for HIV have immediate needs for specialized medical care and psychosocial support services far beyond the scope of service of family planning programs. To comprehensively serve these clients, family planning clinic staff must have ready access to numerous referrals for medical and support services. Lack of strong referral networks can leave clients without needed services, and staff daunted by the multiplicity of client needs.

The Region I Title X HIV Integration Needs Assessment found that well over two thirds of family planning clinics in the region referred clients off-site for mental health, substance abuse and domestic violence services as well as for HIV care and treatment and HIV case management services. Yet knowledge of community referral resources for these many types of services was insufficient according to survey results: Over 40% of providers reported being only somewhat or not at all knowledgeable of local community agencies that work with persons with or at risk for HIV. Having access to increased community referrals was one of the top priorities identified in terms of “support needed” by family planning providers in Region I.

Family planning clinics must continue to develop partnerships with community-based organizations in order to comprehensively serve their clients, as well as to reach out to potential new clients. Such partnerships are especially important in the face of continuing budget cuts and mounting client needs.

To help family planning clinics establish, develop and maintain strong referral networks, this chapter provides the following units:

- Overview of the HIV/AIDS Service System
- Overview of Other Services to Which Clients May Need Referral
- Forging Interagency Partnerships
- Developing a Referral Protocol and Procedures
- Enhancing Staff Capacity to Make Effective Referrals
- Making Effective Referrals: A Training Exercise
- Resources
Overview of the HIV/AIDS Service System

The HIV/AIDS service system is an entity unto itself, complex and comprehensive, multi-layered and multi-faceted. Clients identified as HIV-positive by family planning agencies need to be connected with and gain entrée to this service system. Yet many family planning providers are not fully informed about this system. A brief overview of the broad array of services potentially available to HIV-positive individuals may enhance family planning clinics’ ability to refer clients to these services. It should be noted that particular services are available to varying degrees within and across the six states that comprise Region I.

**State HIV/AIDS Program:** Housed within state Departments of Public Health or Health and Human Services, state HIV/AIDS programs (divisions, bureaus) use state and federal funds to provide HIV/AIDS-related services to reduce morbidity and mortality from HIV disease. Services typically include prevention and public education initiatives, HIV counseling and testing, partner notification services, support of HIV health care and other client services, disease surveillance and data dissemination. The state program sets policy and provides leadership in HIV/AIDS prevention and treatment initiatives, and partners with regional and local programs and providers to deliver services to populations in need throughout the state. State HIV/AIDS programs can provide information about and linkages to all of the HIV services and entities described below.

**County and City HIV/AIDS Programs:** Counties and larger cities with relatively high HIV/AIDS prevalence AIDS cases may have their own HIV/AIDS programs to serve city or county residents. Such programs may be housed within departments of health or may operate as free-standing non-profit organizations. These programs work to address the needs of individuals and families infected with and affected by HIV disease by providing information and referrals, prevention, education, advocacy, outreach and a wide variety of other services such as peer support, case management and emergency assistance. (See also HIV/AIDS Service organizations).

**HIV/AIDS Information Lines:** Telephone lines provide support, information and referral to people with questions or concerns about HIV and AIDS. Trained staff provide basic information about prevention, transmission, treatment and care of HIV, and provide referrals to counseling and testing sites, HIV/AIDS service organizations, and many other services such as substance abuse treatment, mental health care, and emergency assistance.

**HIV Counseling and Testing Sites:** Statewide networks of HIV C&T sites provide low-or no-cost anonymous and/or confidential HIV testing, pre- and posttest counseling, risk reduction education and referral to medical and support services. Some sites may also provide hepatitis education, testing and immunization, as well as STD testing.
HIV/AIDS Service Organizations (ASOs): These organizations provide a wide array of support services to people living with HIV/AIDS, their families, caregivers and significant others. Services typically include prevention, outreach, support groups, service coordination or case management services, emergency assistance, and consultation in legal matters and housing. Many of these organizations also provide education about HIV/AIDS to individuals at risk, the general public, and health care professionals. They may also conduct advocacy activities related to HIV/AIDS policy and funding at the local, state and federal levels.

HIV Medical Care and Treatment: Health centers and hospitals provide infectious disease services and primary and specialty care health care services for people living with HIV and AIDS. HIV-positive individuals who are uninsured or underinsured may be eligible for medical services covered or funded by the state. Some health care sites provide specialized care for women with HIV, including pregnant women.

AIDS Drug Assistance Programs: Required by the states and federally funded under Ryan White CARE Act Title II, the AIDS Drug Assistance Programs (ADAP) provide HIV/AIDS medications to low income individuals who have limited or no health insurance coverage. Program funds may also be used in some circumstances to purchase health insurance for eligible clients.

Ryan White Health Care Consortia: Required under Title II of the Ryan White CARE Act, a Consortium is a regional or statewide association of public and non-profit health care and other service providers that determine area-specific HIV service needs, gaps and priorities to plan for Title II funded services.

Ryan White HIV Planning Councils: Authorized under Title I of the Ryan White CARE Act, Planning Councils assess needs for service based on the size and demographics of the PLWH population, establish a plan for the delivery of HIV care and establish priorities for the use of Title I CARE Act funds. Planning Council membership includes people living with HIV, health care and social service providers (mental health, substance abuse, housing programs and others) and public health agencies.

HIV Prevention Community Planning Groups: To guide the application for and utilization of CDC HIV prevention funding, Community Planning Groups (CPGs) work with state health departments to analyze the course of the HIV epidemic in their geographic area, prioritize HIV prevention needs and identify interventions to meet them, and develop a comprehensive HIV prevention plan for their area. CPG membership includes representatives of affected populations, epidemiologists and behavioral scientists, HIV/AIDS service providers, health department staff and health care providers.

For more information on the federal entities and programs that provide core funding for many of the above listed services, see Federal HIV Funding located under Chapter 1 on the CD-Rom.
Whether or not a client opts for HIV testing, the process of HIV risk assessment, which ideally is done with most or all clients, may reveal clients’ needs for other kinds of services such as those described below. To fulfill the promise of HIV/FP integration, family planning agencies’ referral networks must include linkages to these types of services in addition to HIV-specific services. It should be noted that the different types of services noted here are available to varying degrees within the six states that comprise Region I.

**Substance abuse services:** provide treatment and support to individuals addicted to alcohol or other drugs. The spectrum of substance abuse services includes detox programs, methadone treatment, residential treatment, halfway house programs, 12-step programs, individual counseling, support groups, and needle exchange programs.

**Domestic violence services:** provide abused individuals with help and support to get out of violent home situations. The spectrum of domestic violence services includes emergency shelter; telephone crisis lines, safety planning, individual and group counseling, advocacy with social service agencies, services for children, assistance with court proceedings, and information and referral.

**Mental health services:** provide treatment and support for individuals with mental illness. The spectrum of mental health services includes psychological and psychiatric treatment, both inpatient and outpatient, counseling services, support groups, day treatment, and information and referral. Services may be located in hospitals, community health centers, community multiservice centers, and community mental health centers.

**STD screening and treatment services:** provide diagnosis and medical care for sexually transmitted diseases (other than HIV). While most family planning clinics in Region I offer these services on site, some may need to refer clients out to other publicly funded settings.

**Hepatitis screening and treatment services:** provide immunization, diagnosis and medical care for viral hepatitis (hepatitis A, B, C and other). These services may be co-located with STD services, or available in other publicly funded settings such as community health centers or public health clinics.

**Other services:** HIV risk assessment may reveal the client’s need for other services such as housing assistance, emergency food assistance, health insurance assistance, legal services, child care, transportation, etc.
Section 3
Overview of Other Services to Which Clients May Need Referral
Forging Interagency Partnerships

To comprehensively serve clients, family planning clinics must not only identify potential referral resources, but they must work to build relationships with agencies, both HIV-related agencies and others, such as domestic violence services. Effective referral networks require strong relationships between referring agencies. Family planning agencies and HIV/AIDS organizations must become better known to and conversant with each other. This section describes some basic steps Title X clinics can take to build the interagency partnerships that underlie effective referral networks.

Join the State or Local HIV Prevention Community Planning Group, Ryan White Planning Council or Ryan White Consortium

Family planning clinics need to become involved in HIV coalitions and planning groups addressing HIV, both to have their voice heard as well as to be part of developing a community-wide approach to HIV. As an active member of such a group, a family planning agency can keep abreast of trends in the HIV epidemic and in HIV/AIDS treatment, as well as changes in the HIV service system. Participation in a coalition or planning group can help the family planning agency to become familiar with the local organizations providing HIV-related services. The HIV agencies, in turn, become more aware of the services provided by Title X agencies and more understanding of the particular needs of family planning clients. Participation in a coalition or planning group requires time and effort, yet the benefits of such participation are many. The state or city HIV/AIDS office can help family planning clinics to find and connect with local HIV planning groups.

Establish Service Agreements

A key step in building referral networks and strengthening interagency collaboration is the creation of formal working agreements with a broad spectrum of agencies. Service agreements make collaboration easier by laying out clearly what is expected of each partner. They may take the form of letters of agreement or memoranda of understanding.

The service agreement may include:

- A mutually developed statement of the goals and the objectives of collaboration
- A description of the services each agency is to provide to the others’ clients
Other specifications about what each agency provides or brings to the partnership (e.g., space, equipment, training, data)

- Agreement to abide by state and federal confidentiality standards
- Description of mechanisms for information sharing
- Dates the agreement is in force

**Bring Referral Agency Staff in to Speak to Family Planning Staff**

One way to strengthen interagency linkages and to increase staff confidence in making referrals is to invite agency representatives to come in and speak to clinic staff. This enables staff to become familiar with the agencies they are making referrals to, and introduces them to a “real person” to call upon for additional information or assistance.

Some topics the representative could be asked to discuss include:

- A detailed description of services provided by the agency or program
- Requirements for accessing services, e.g., eligibility criteria, payment for services, documentation needed, etc.
- What clients can expect when they come in for their referral appointment
- Suggestions for how to make and follow up on a referral so that it proceeds smoothly
- Ability of the agency to address the needs of diverse clients, e.g., description of population currently served, languages spoken at the agency, presence of bilingual, bicultural staff, etc.
- The program’s philosophy of care

In turn, a family planning staff member could make a similar, reciprocal visit to the referral agency, further enhancing interagency understanding and communication.

**Partnering Fundamentals**

While collaboration among agencies is crucial to the provision of integrated services, and is increasingly required by both governmental and private funding sources, the establishment of effective interagency partnerships is a challenging task. The *Family Planning Linkages Innovations Research Project*, funded by OPA, examined linkages between Title X providers and community-based organizations, and came up with the following recommendations for successful collaborations.
Key Elements of Successful Interagency Partnerships

- **Structured, regular meetings:** Although meeting frequency may vary, regularly scheduled face-to-face meetings, to share information, problem-solve and plan, are critical to maintaining successful partnerships.

- **Information sharing methods:** Partners must make the effort to keep one another updated via phone, email, sharing of meeting minutes and other methods.

- **Partnership buy-in:** All partners must believe in the importance of the collaboration and share in its goals. Partners should be involved in the initial establishment of the goals, or the goals of the collaboration should parallel the goals of the agency (partner).

- **Mutual benefits/incentives to participate:** For collaboration to be successful, each potential partner agency must clearly see concrete benefits to the agency, its staff and ultimately its clients.

- **Finding overlapping areas of need:** The partnership is strengthened and needs of each agency are met when partners co-sponsor events or activities that neither could support alone, e.g., staff training, community needs assessment, grant proposal development or fund-raising.

- **Cross-training of staff:** Cross-training of staff enables agencies to better understand each other’s services, identifies opportunities for service integration, and enables agency staff to help each other in times of need.

- **Support for partner’s events:** Promoting events for partners, even when not co-sponsoring, is helpful in establishing trust among partners.

- **Acknowledging partners:** Taking the time and trouble to formally thank the partners, for example, by sending letters of appreciation to the agency’s leadership or funders, strengthens the partnership and builds goodwill among agencies.

- **Acceptance of change:** All partners must be flexible and willing to discuss changes in project administration or in service delivery. Partners must be willing to engage in open dialogue about problems so that improvements can be made.

*Source: Title X Linkages Project, Center for Health Training, Austin, TX.*

**BOX 1**
A formal, written referral protocol can help to systematize the clinic’s referral procedures and provide guidance to clinic staff by laying out a series of steps for providers to follow in making referrals. A protocol helps to ensure that essential information is given to the client, that necessary forms are completed, and that the key step of following up on referrals is taken. A written referral protocol shared with all staff also serves to underscore the importance of referral-making as a critical component of providing integrated care. Presented below are the main topics and issues to consider in developing a referral protocol or revising one already in use.

Key Components of a Referral Protocol

- **Goals/Philosophy of Referrals**
The clinic’s referral protocol should begin with a statement of the overarching goal or purpose of making referrals—to ensure and facilitate client access to comprehensive and high quality medical and social services that meet their needs. This introductory statement might also highlight the clinic’s commitment to making client-centered referrals—that is, engaging the client actively in the decision to seek a referral and making referrals to services that address the client’s perceived needs, minimize barriers for the client, and provide the client some degree of choice. Finally, this introduction should include an unequivocal declaration of the clinic’s dedication to protecting clients’ confidentiality and privacy.

- **Types of Services for Which Clients May Be Referred**
Lists the types of HIV-related services and other medical and social services outside the family planning clinic’s expertise, for which clients may be referred. This list may include the entire range of services discussed in Section 2 of this chapter.

- **List of Agencies to Which Clients Can Be Referred**
Lists the agencies with which the family planning clinic has service and confidentiality agreements. May also list other known and approved services for which service agreements are not necessary, for example HIV/AIDS information lines or other “hotlines.” Instructs providers to consult the clinic’s referral directory for comprehensive information on the agencies to which clients can be referred.
Information Provided to the Client
States that the reason for referral should be discussed with the client, and lists the information the client will need to complete the referral (e.g., agency name and address, contact person, phone number; appointment date and time). May indicate other information that ideally should be discussed with client, e.g., what to expect during the visit, eligibility requirements for service, availability of childcare, etc. May specify referral forms or appointment cards that provider should give to the client.

Release of Information
Stipulates that clients must authorize the release to the referral agency of information regarding their medical status and other aspects of their case by signing the designated release forms. The form should specify what information is being released and to whom before client signs it. The referral agency may not be contacted unless this form has been signed.

Protection of Patient Confidentiality
Reiterates the critical importance of preserving client confidentiality and provides guidance around HIPAA privacy rules and state statutes governing the transmittal of HIV status and related protected information.

Documentation of Referrals
Specifies where and how (e.g., in referral log) providers should record the referrals they have made with clients, and states the information to be recorded, (e.g., date of referral, reason for referral, agency referred to, counselor making referral, follow-up results, etc.) Indicates forms, etc., which should be copied for inclusion in the client’s chart, for example, release forms or referral forms.

Follow-up on Referrals
Instructs that steps should be taken to see whether client completes the referral, i.e., makes and keeps the appointment. Specifies how follow-up can be done (e.g., contacting client or contacting referral agency), what kinds of information should be sought when following up, and where that information should be recorded (e.g., referral log).
Compiling a Referral Directory

To help clients access the HIV-related and other services they need, clinic staff must have a comprehensive listing of agencies, programs and providers to which clients can be referred. The listing, which could be provided to clinic staff in the form of a directory, should include all of the types of services described in Sections 2 and 3 of this chapter, including:

- State, county and city HIV/AIDS programs
- HIV information lines
- HIV medical care and treatment sites
- HIV/AIDS Drug Assistance Programs (ADAP)
- HIV counseling and testing sites (HIV C&T)
- HIV/AIDS service organizations (ASOs)
- Substance abuse programs
- Mental health programs
- Domestic violence services
- STD screening and treatment programs
- Hepatitis screening, immunization and treatment programs
- Emergency assistance (food, clothing, shelter) programs
- Other services needed by the client population (legal services, housing programs)

To enable staff to better match services to client needs and to better explain to clients what they can expect when referred, it is important that the directory contain more information than simply the name, address and phone number of the agency. The sample directory page that follows shows the type of information that can help clinic staff to make smoother, more successful referrals to outside agencies.

Clinics may find it helpful to dedicate a portion of someone’s time to updating directory information on a regular basis, making sure each entry is reviewed at least twice a year.
Sample Referral Directory Page

Name and Address of Agency: ________________________________________________

Types of Services Provided: ________________________________________________

Contact Person(s):
Name: ____________________________________________________________________
Title/role: __________________________________________________________________
Phone number: __________________________ E-mail: ____________________________

Hours of Operation: __________________________________________________________________

Service Eligibility Requirements (if any): __________________________________________

Insurances Accepted/Availability of Financial Assistance or Free Care: __________________________________________________________________

Languages Spoken: __________________________________________________________________

Childcare Available: ☐ YES ☐ NO ______________________
Accessible by Public Transportation: ☐ YES ☐ NO ______________________
Other: ________________________________________________________________________

Date of Last Update: __________________________________________________________________
Just as provision of a pamphlet is not sufficient to make a client start using condoms, handing a client an appointment card does not guarantee that she or he will follow through with a referral. As with risk reduction counseling, the referral making process is more likely to be successful—that is, end up with the client receiving a needed service—if it is done in a client-centered manner.

**Client-Centered Referral**

A client-centered referral involves the active participation of the client, in discussing the kinds of services she thinks will be most helpful to her; and in thinking about things that might get in the way of obtaining a referred service. In making the referral the provider tries, when possible, to find services that will be accessible to the individual client—physically, financially, geographically and practically, as well as being culturally appropriate. Finally, a client-centered referral takes into account and tries to remove the barriers the client may face in accessing the service, including fears or reservations about using the service. The foundation of a client-centered referral is a dialogue, a conversation, between the provider and the client.

**Elements of an Effective Referral**

A referral can be considered “successful” if the client actually makes the appointment (though in some cases the family planning provider will make it for her), keeps the appointment, and receives the services to which she has been referred. As with any other health behavior, for clients to take action they must perceive that they need the referred service, and that the benefits of receiving it outweigh the costs of obtaining it. In addition they must be prepared to cope with the hurdles that they may encounter, such as payment for services or language barriers.

There are several specific steps a provider can take to increase the effectiveness, or likelihood of success of referrals, as shown in Box 2.
Elements of Effective Referrals

To make a successful referral the provider should:

- **Assess client needs.**
  In addition to conducting a formal needs or risk assessment (see *Chapter II*), the provider must make an effort to understand what kinds of services or assistance the client feels are most important to her personally. This means having a conversation with the client about what she needs and wants, and includes a recognition of cultural values, beliefs and practices that may affect the client’s utilization of a referral.

- **Identify barriers to follow-through.**
  Any time a referral is made, the provider and the client should discuss the benefits and the costs—as perceived by the client—of seeking referred services. Once again, conversation with the client is essential.

- **Be familiar with the agencies and programs to which clients are referred.**
  Providers should have fairly detailed knowledge of the services provided, eligibility requirements, hours of operation, fees, etc. as well as some understanding of the agency’s capacity to provide services appropriate to the client’s cultural and linguistic background.

- **Give clients a sense of what to expect at the appointment.**
  A verbal “walk-through” of the visit may help to quell clients’ fears and enable them to be better prepared to use referred services effectively.

- **Have a working relationship with a staff person at the referral agency.**
  Knowing someone to call with questions, or who can act as an advocate for the client at the agency, can contribute greatly to the effectiveness of a referral.

- **Assure clients that their confidentiality will be protected.**
  Especially in the case of HIV, clients’ fears about possible disclosure of their status may make them very reluctant to seek needed services. Direct and specific assurances of both the clinic’s and the provider’s commitment to protecting the client’s privacy are required. It may help to explain that the clinic has signed confidentiality agreements with the agencies to which it refers clients.

- **Strategize with clients around follow-through.**
  Talk with clients about what would help them to make and keep the appointment. If indicated, the provider can provide direct assistance like scheduling the appointment, or helping to fill out forms.

- **Follow up to see whether the referral was completed.**
  Follow-up contacts can be made with the referred provider or with the client or both, in accordance with confidentiality protections.

**BOX 2**
The following training exercise will help clinic staff to make more effective, more client-centered referrals. This training exercise was adapted from one included in *Comprehensive HIV Risk Assessment: Building Skills in Sexual and Substance Abuse History Taking, A Provider Training Manual* (Title X Region I, 2002).

**Objectives**
- To enhance the effectiveness of the referral process used by clinic staff.
- To strengthen assurance of client confidentiality in making referrals.

**Group Size**
Variable. May be used in a one-on-one session with an individual supervisor; or with a group of any size.

**Time Duration**
45 minutes for one-on-one session  
60 minutes – 1 hour, 30 minutes for group, depending on which activities are used.

**Materials and Preparation**
Have newsprint, easel stand and markers available.

Invite participants to bring any referral-related materials used by clinic staff with them to this training; for example, referral forms, referral or resource guide, protocol for referral identifying and/or updating.

**Training Activities**
- Review the objectives for this exercise.
- Facilitate a discussion of the importance of effective referral process to the quality of the services delivered by a clinic.
Ask trainees: **What are the potential referral needs that might surface during a risk assessment?** Record responses on newsprint. Listen for and confirm, adding as necessary:

- Substance abuse treatment
- Services for clients experiencing intimate partner violence
- Medical care
- Mental health diagnosis and treatment
- Housing, employment, related social services
- Harm-reduction supports for active drug users
- HIV case management services
- Other services (e.g., hepatitis diagnosis and treatment)

Ask trainees: **From the perspective of clients who have these needs, how easy do you think it is for them to gain these services?** What barriers might they perceive? Record responses. Listen for and confirm, adding as necessary:

- Many of these services are scarce and can be difficult to access, particularly by the most needy clients.
- Many chronic substance users, especially those with negative or less than successful past experiences with health and human services, are likely to feel that it’s not worth the effort.
- Clients experiencing intimate partner violence may feel that have much at stake if they try to escape the violent relationship, including shelter, economic security, their own safety and the safety and well-being of their children.
- Clients may have concerns about their confidentiality, particularly disclosure of HIV status.

Review the *Four Steps to Effective Referrals*, asking questions and facilitating discussion as outlined below:

**Step 1 – Assessing Needs**

**A. Identify client perceptions of present needs and priorities.**

Ask trainees: **What might a provider ask to assess a client’s perceptions?** Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:

- What kind of support do you think would be most helpful to you?
- What help do you most need to support your plans to protect yourself?
- Sometimes clients who have issues like yours want further support with how to talk with partners. Some want help with learning how to use drugs more safely. Some want to get into treatment. What would help you the most?
- What have been your experiences with service providers in the past?
- Which ones have worked for you and what made them work… which ones have not worked for you, and what made those not work?
B. Identify costs and benefits of seeking different services.

▷ Ask trainees: **What might a provider ask to help a client to identify the costs and benefits of acting on the referral?** Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:
  - What do you most want in a service provider?
  - What do you really dislike in a service provider?
  - What would be your biggest barrier to using to using a referral? How might that barrier be removed?

▷ Explain that just asking questions like these can make a referral seem more individualized to the client, and may increase the chance of follow-through.

**Step 2 – Making the Referral**

A. Identify a service that is likely to meet assessed needs.

▷ Ask trainees: **What factors can get in the way of identifying appropriate referrals?** Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:
  - Lack of health insurance or inadequate health insurance coverage
  - Need for child care
  - Access issues like transportation and hours of service
  - Change in personnel in referral agencies

▷ Ask trainees: **What kind of information about a referral is important for a provider to have in order to best match need to resource?** Record responses on newsprint. Listen for and confirm, adding as necessary:
  - Exact nature of service offered by resource
  - Current capacity to take on new clients
  - Sensitivities to issues of substance use, gender, age, culture, sexual orientation
  - Basic logistics about hours and location, including availability of child care
  - Service access or intake procedures
  - Financial requirements

▷ Have trainees form small groups. Ask groups to look at any referral materials trainees have brought with them, and discuss how well these materials do in covering the information described above.

▷ Facilitate a large group discussion about what steps could be taken to make any needed improvements to clinic’s referral information and procedure. Record as desired.
B. Support client follow-through

- Have trainees continue to work in their small groups. Ask groups: How can providers support client follow-through? After about 10 minutes, elicit ideas from groups. Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:
  - Clearly stating the limits and requirements, as well as the benefits of the services available, and exploring client's feelings about the limitations
  - Exploring clients' personal resources for factors such as transportation and child care
  - “Walking” the client through preparation for service access, e.g., what documents to pull together for insurance or Medicaid certification; what arrangements to make to get to the location on time; what requirements to anticipate when accessing service
  - Providing direct referral assistance – for example, setting up appointments, helping clients complete forms, arranging for required TB test at your clinic.

Step 3 – Follow-Up on Referral

- Ask trainees: What follow-up activities might providers of the agency do to enhance the effectiveness of future referrals? Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:
  - Invite feedback from and/or checking in with client about the referral.
  - Contacting the referred provider.
  - Updating referral lists with feedback about provider responsiveness.

Step 4 – Addressing Confidentiality Issues

- Ask trainees: What concerns might providers have about confidentiality in following these steps for making effective referrals? Ask trainees to discuss in small groups what procedures or strategies might be used to address those concerns. Record responses on newsprint. Listen for and confirm responses like these, adding as necessary:
  - Supervisors/clinic managers can confer with providers concerning clinic’s confidentiality policies, and federal and state statutes, including HIPAA rules, governing the transmittal of HIV status and other protected health information. Supervisors/clinic managers can also describe whatever service agreements the family planning clinic has with referral agencies.
  - Providers can explain to clients the confidentiality protections of clinic information and how those protections extend to referred providers with which the clinic has legal, written agreements.
• Providers can explain how referrals can be made anonymously and the limitations of such referrals
• A provider must obtain client’s consent to release information about substance use, HIV status or other similar data for any personalized referral.
• Any provider who becomes aware of a potential violation of confidentiality or related service laws (e.g. the Americans with Disabilities Act) should report the possibility immediately to her supervisor.

**Follow-up Activities**

- Ask trainees to outline a plan to strengthen relationships with referral agencies, and to ensure ongoing quality improvement of the referral process.
- Invite representative of referral agencies to present information about their services and how best to facilitate referrals to them.
- Have family planning staff make presentations to referral agencies, so that these agencies can better understand the needs of family planning clients.
Here is an annotated listing of key resources, many of which are referenced in this chapter. Links to these resources may be found under Chapter IV on the CD-ROM.

- **HIV Prevention Community Planning/Setting HIV Prevention Priorities**
  Academy for Educational Development and Center for Community-Based Health Strategies, funded by the CDC
  A guideline and tools to help communities set HIV prevention priorities for community planning groups.

- **HIV/AIDS Technical Assistance for HIV Prevention Community Planning Groups (CPG)**
  Center for Community-Based Health Strategies and the National Alliance of State and Territorial AIDS Directors
  [http://www.hivaidsta.org/index.htm](http://www.hivaidsta.org/index.htm)
  This site offers HIV Prevention Community Planning materials including sample polices, technical assistance materials and guides. This site is useful if you are starting a CPG or evaluating your current CPG.

- **Revised Guidelines for HIV Counseling, Testing and Referrals Services - 2001 Centers for Disease Control and Prevention**
  These guidelines replace CDC’s 1994 guidelines, HIV Counseling, Testing, and Referral Standards and Guidelines, and contain recommendations for public- and private-sector policy makers and service providers of HIV counseling, testing and referral.

- **Model State Public Health Privacy Act**
  [http://www.critpath.org/msphpa/privacy.htm](http://www.critpath.org/msphpa/privacy.htm)
  The Model State Public Health Privacy Act project is a model state law that regulates the acquisition, use, disclosure, and storage of identifiable, health-related information by public health agencies without significantly limiting the ability of agencies to use such information for legitimate public health purposes, particularly information gathered pursuant to HIV/AIDS reporting requirements.
Community ToolBox: Bringing Solutions to Light
University of Kansas and AHEC/Community Partners
http://ctb.ku.edu/index.jsp

The online ToolBox provides practical information to support your work in promoting community health and development. There are sections on leadership, strategic planning, community assessment, grant writing, community partnerships, and evaluation. Each section includes a description of the task, advantages of doing it, step-by-step guidelines, examples, checklists of points to review, and training materials.

The following federal and statewide resources are useful for identifying referral agencies and programs

Federal and State HIV/AIDS Resources

HRSA HIV/AIDS Bureau
http://hab.hrsa.gov
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Federal and State Substance Abuse Resources

SAMHSA Substance Abuse Facility Locator
http://findtreatment.samhsa.gov/facilitylocatordoc.htm
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont
Federal and State Domestic Violence Resources

- The National Women’s Health Information Center, Violence Against Women, State Resources
  http://www.4woman.gov/violence/state.cfm
  - Connecticut
  - Maine
  - Massachusetts
  - New Hampshire
  - Rhode Island
  - Vermont

Federal and State Mental Health Resources

- U.S. DHHS, Substance Abuse Mental Health Services Administration’s National Mental Health Information Center
  http://www.samhsa.gov/centers/cmhs/cmhs.html
  - Connecticut
  - Maine
  - Massachusetts
  - New Hampshire
  - Rhode Island
  - Vermont
References


Integrating HIV Prevention and Family Planning Services
### HIV/FP Integration Work Plan
### Developing Referral Networks and Procedures

<table>
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<tr>
<th>Tasks</th>
<th>Current Status</th>
<th>Steps to be Taken</th>
<th>Staff Responsible</th>
<th>Time Frame</th>
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<td>Contacts made with local HIV coalition and/or CPG</td>
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<td>Contacts made with state (and city, if applicable) substance abuse, domestic violence and mental health programs</td>
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<td>Comprehensive listing compiled of HIV/AIDS organizations and related services agencies available in local area</td>
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<td>Referral directory assembled including comprehensive information on all agencies</td>
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<td>Info exchange/planning meetings arranged with key referral partners</td>
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## HIV/FP Integration Work Plan
### Developing Referral Networks and Procedures (Page 2 of 2)

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<td>Staff trained on making effective referrals</td>
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<td>Staff trained on HIPAA requirements and protection of client confidentiality in making referrals</td>
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Special Section on Cultural Competence
Introduction

THE SIGNIFICANCE OF CULTURE

“Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions.”

National Standards for Culturally and Linguistically Appropriate Services in Health Care: Preamble.
Office of Minority Health, U.S. DHHS

A n essential element in the integration of HIV and family planning services is the development of cultural competence as a guiding principle in the clinic’s operation. Cultural competence can be seen as a binding thread woven throughout the organization – from structure, to clinic environment, to staff recruitment and training, to quality standards – that enables the seamless integration of HIV and family planning services. In the Region I Title X HIV Integration Needs Assessment, family planning clinic managers and providers at all grantee agencies identified ongoing development of culturally competent services in HIV prevention as one of their most important training needs.

Clinic managers and staff recognize that their clients at greatest risk for HIV/AIDS disproportionately represent racial and ethnic minority groups. Their experience is consistent with a well-documented pattern of racial and ethnic disparities in the incidence of illness, disease and death in the U.S. Poorer health status is evident for African-Americans, people of Hispanic origin, American Indians and some groups of Asian origin. With respect to HIV/AIDS, prevalence surveys and case surveillance data reflect its disproportionate impact on racially, ethnically and linguistically diverse groups, especially women, youth and children in those groups. While the causes of these health disparities are complex and not well understood, it is evident that poverty, discrimination in the delivery of health care and lack of culturally and linguistically competent care are indeed contributing factors.
Compelling factors for cultural competence at the client-provider level include:

- Differences among clients and among providers in perceptions of and approaches to wellness, illness and healing, sexuality and gender relationships
- Clients’ previous personal experiences of bias and stereotyping in health care
- The underrepresentation of providers from culturally diverse groups in health care
- Legislative and regulatory mandates for ensuring cultural and linguistic access to care.

“For HIV/AIDS prevention to succeed, the special needs and life contexts of vulnerable populations – those who are marginalized because of race, ethnicity, socioeconomic status, sexual orientation, age, or gender – must be sensitively addressed.”

How Does Cultural Competence Apply to HIV/AIDS, STD, and TB Prevention?

CDC National Prevention Information Network

CDC National Center for HIV, STD and TB Prevention

Clinic managers face significant challenges in addressing cultural competence in their clinic settings, among them:

- Defining what cultural competence means for their clinic and involving staff and clients in the process
- Collaborating with staff, clients and the community to set and achieve goals for increasing a clinic’s cultural competence
- Developing creative approaches for accomplishing these goals with limited resources
- Finding the resources to sustain the journey to cultural competence through ongoing staff training and other essential activities.

This Special Section on Cultural Competence is offered to provide help in meeting these challenges, with the recognition that wide differences in grantee and clinic structure throughout Region I will affect the level and extent to which a clinic manager can put policies, protocols or approaches in place.
Section Overview

Material in this section includes frameworks and definitions to lay a foundation for exploring cultural competence in a family planning clinic. Guidelines and strategies gathered from many sources can be adopted or adapted to the unique needs of the organization and community, and the appendices contain resources for applying suggested strategies. These appendices are provided for active use by clinic managers. They include materials that can be used as handouts with staff and tools for assessing a clinic’s cultural competence needs and developing approaches for addressing them. A resource list points to additional tools available from other sources. Links to web sites on the CD ROM allow deeper exploration of cultural competence and access to additional materials for use as needed. This Special Section on Cultural Competence provides the following units:

- The Rationale for Building Cultural Competence
- What Does It Mean? Defining Culture and Cultural Competence
- What Does It Take? Cultural Competence in Your Organization
  - Conduct an Organizational Assessment
  - Take a Closer Look at Clients and the Community
  - Provide Staff Development and Training in Cultural Competence
  - Integrate Cultural Competence into Mission, Policies and Practices
  - Improve Language Access for Clients with Limited English Proficiency
  - Anticipate and Address Barriers across the Organization
- Resources
- Appendices
Section 1  Introduction

Integrating HIV Prevention and Family Planning Services
The National Center for Cultural Competence, funded largely by the Health Resources and Services Administration (HRSA), has articulated a rationale for incorporating cultural competence into organizational policy. For Title X-funded family planning clinics, the following elements are most relevant:

- **To respond to current and projected demographic changes in the United States.** Immigration and significant increases in the cultural diversity of people already residing in the U.S. are resulting in more diverse perceptions, belief systems, help-seeking behaviors and experiences related to health and illness. All clinics in Region I serve target populations that are diverse and continuing to change.

- **To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.** The disproportionate impact of HIV/AIDS on different populations in the U.S. presents a stark example of racial and ethnic disparities in health status. Disproportionate rates of HIV/AIDS among African Americans and Hispanics are increasing throughout Region I.

- **To improve the quality of services and health outcomes.** A deeper understanding and respect for the cultural backgrounds of clients, their families and the environments in which they live, balanced with the ability to move away from stereotypes, preconceptions and assumptions are critical to integrating accessible, effective and cost-efficient HIV services into family planning care.

- **To meet legislative, regulatory and accreditation mandates.** Federal, state and local regulations that apply to any organization receiving federal funding require the provision of certain culturally and linguistically appropriate services. No agency receiving federal funding is exempt from the law.

**Benefits for the Organization, Staff, Clients and Community**

Improving cultural competence requires dedication and creative approaches. The investment of resources to measure and improve cultural competence may seem too expensive and time consuming in the face of limited funds, staff and time. But federally funded clinics that have developed successful practices for providing culturally appropriate care have found that these practices not only meet the needs of underserved, culturally diverse populations but also strengthen services.
through increased staff satisfaction and stronger community and agency partnerships. Culturally competent services can:

- Reduce delays in seeking care and encourage use of services by those who previously avoided treatment due to mistrust or negative experiences
- Enhance communication and clinical interaction between provider and client
- Allow the provider to obtain more specific and complete information for more appropriate diagnosis
- Facilitate the development of treatment plans that are followed by the client and supported by the client’s family and significant others
- Reduce clinic waiting time
- Enhance compatibility between Western health practices and traditional cultural health practices
- Cultivate a more diverse workplace that fosters achievement for staff from all cultures and enhances the clinic’s credibility in the community
- Increase opportunities for community collaboration to enhance service capacity and reach.

Federal agencies responsible for the health and welfare of the U.S. population have drawn clear links between quality of care and cultural competence. Box 1 highlights several federal agency initiatives that demonstrate the importance of cultural competence in addressing inequities in access to health care and health care outcomes.
Following are several federal initiatives for cultural competence that are relevant to family planning and the integration of HIV prevention services.

- **The Department of Health and Human Services’ Health Resources and Services Administration (HRSA)** has a particular interest in cultural competence because many HRSA grantees provide care to underserved and culturally and linguistically diverse populations. A HRSA-sponsored search for grantee programs that provide outstanding culturally competent care identified characteristics and goals for culturally competent health service. (See Box 2.) These programs have demonstrated that cultural competence in the delivery of services results in better health outcomes, client and staff satisfaction and cost efficiency.⁶

- **The Centers for Disease Control and Prevention (CDC),** in its Revised Guidelines for HIV Counseling, Testing, and Referral, outlines eight principles for effective HIV counseling, testing and referral. They include providing services that are responsive to client and community needs and priorities and that are appropriate to the client’s culture, language, gender; sexual orientation, age and developmental level. The CDC guidelines encourage providers to “work to remove barriers to accessing services and tailor services to individual and community needs,” and to “consider cultural factors when designing and providing HIV services to increase the likelihood of return for test results and acceptance of counseling and referral services.”⁷

- **The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS)** has issued standards, developed with public input, to help eliminate racial and ethnic health disparities and to make health services more responsive to the individual needs of all patients. The National Standards for Culturally and Linguistically Appropriate Services in Health Care (the CLAS Standards) provide a model for building culturally competent health care organizations.⁸ (The CLAS Standards and related guidelines and tools for clinic managers are discussed later in this section.)

**BOX 1**
The Influence of Culture

Culture has significant relevance in the delivery of family planning services and HIV/AIDS services. Culture shapes people’s ideas and attitudes about sexuality, risk and health. It influences how and when they seek and use health information and services.

The influence of culture applies to providers as well. In client-provider interactions, culture shapes providers’ attitudes, values, expectations and responses as much as those of clients. Perceived bias, stereotyping, or lack of cultural competence on the part of providers can greatly affect a client’s decision to seek care or adhere to treatment. It can result in undertreatment of those with HIV/AIDS and lost opportunities for HIV prevention.

All people belong to more than one cultural group and are influenced by the groups with which they identify, including:

- kinship networks
- ethnic, gender, or sexual orientation identity groups
- religious affiliations
- geographic regions
- social and economic classes
- voluntary associations and social organizations
- jobs and professions
- life experiences
- physical ability or disability.

There can be as many differences among members of the same cultural group as there are differences between cultural groups.
The Meaning of Cultural Competence

Definitions of cultural competence abound, from the narrowest – defining culture only in terms of race and ethnicity – to the broadest. They have evolved from diverse perspectives, interests and needs, and there is a lack of agreement on both definitions and approaches.

The definition offered below recognizes multiple elements of culture and encompasses cultural competence at the policy, system, service and individual levels. Further, this definition acknowledges that cultural competence is an ongoing process, not an endpoint.

A DEFINITION OF CULTURAL COMPETENCE

“Cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals. . . which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment of time.”

Maternal and Child Health Bureau, Guidance for SPRANS Grant, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1999

What Cultural Competence is Not

It can be helpful to look at cultural competence from another perspective by considering some common misunderstandings about what it is and how it is achieved.

- Culture is not defined exclusively by race and ethnicity.
- Cultural competence does not mean learning as many characteristics as possible about every culture.
- Cultural competence is not achieved simply by being the same race as some of the individuals and families served.
- Cultural competence is not an endpoint or measurable achievement.
Essential Elements of Cultural Competence

Development of cultural competence remains a great challenge in health and human services programs everywhere. Some cultural competence initiatives have focused narrowly on language access and on the patient-provider relationship without sufficient attention to the cultural competence of the system of care in which the provider functions. Incorporation of cultural competence at every level of an organization is key in creating a supportive environment for its ongoing development.

Five essential elements contribute to an organization’s ability to become more culturally competent:

1. Valuing diversity,
2. Having the capacity for cultural self-assessment,
3. Being conscious of the dynamics inherent when cultures interact,
4. Having institutionalized cultural knowledge, and
5. Having developed adaptations to service delivery that reflect an understanding of cultural diversity.

Box 2 highlights practices employed by HRSA-funded programs recognized for providing culturally competent services.
HRSA sponsored a nationwide search from 1998 to 1999 to recognize outstanding HRSA-funded programs and highlight the practices they employ to provide culturally competent care for diverse populations. HRSA found that culturally competent programs tend to:

- **Define culture broadly.** Essential to providing culturally competent care is an understanding that culture is more than race, ethnicity and language. Membership in various cultural and subcultural groups contributes to a client’s personal identity and influences how that client uses health care services.

- **Value clients’ cultural beliefs.** The extent to which program staff learn about and value their clients’ knowledge, attitudes and beliefs about health care and apply this knowledge to improve access to and quality of care demonstrates a program’s cultural competence.

- **Recognize complexity in language interpretation.** Linguistic variation within a cultural group, cultural variation within a language group and variation in literacy levels in all language groups must all be considered in providing culturally and linguistically appropriate care.

- **Facilitate learning between providers and communities.** Creating and sustaining an environment where providers learn more about the cultural context of the communities they serve and where communities learn more about how the health care delivery system works improves cultural competence and the health of individuals and communities.

- **Involve the community in defining and addressing service needs.** In programs that are truly culturally competent, clients and community members are actively involved in needs assessment and program development, implementation and evaluation.

- **Collaborate with other agencies.** A proactive combining of forces with other local agencies and organizations can expand culturally competent services.

- **Professionalize staff hiring and training.** Specific hiring qualifications and mandated training, comprehensive and replicable training curricula and allocation of budget and time for training, updates, review and testing related to cultural competence elevate cultural competence to the same level as other essential job skills.

- **Institutionalize cultural competence.** Integrating cultural competence into strategic planning at all levels and designing replicable cultural competence activities are some ways to institutionalize cultural competence.

*From Cultural Competence Works. 2001. Health Resources and Services Administration, U.S. DHHS.*

**BOX 2**
The Cultural Competence Continuum

Without exception, experts in the development of cultural competence emphasize that it is an ongoing process. Attending a workshop, reading a book or being the same race as the individuals and families a clinic serves will not bring about cultural competence. It is helpful to view cultural competence along a continuum. Clinic managers can apply the continuum model described in Box 3 in evaluating the progress of their organizations. Both individuals and agencies move along this continuum on the journey to cultural competence.\(^3\)

<table>
<thead>
<tr>
<th>A Cultural Competence Continuum</th>
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<tbody>
<tr>
<td>1. <strong>Unconscious incompetence</strong>: attitudes, policies and practices reflect an unawareness of cultural differences; are culturally “blind”</td>
</tr>
<tr>
<td>2. <strong>Conscious incompetence</strong>: aware of weaknesses and lack of knowledge or comfort in serving culturally diverse clients</td>
</tr>
<tr>
<td>3. <strong>Conscious competence</strong>: learning, verifying and striving to provide culturally relevant interventions</td>
</tr>
<tr>
<td>4. <strong>Unconscious competence</strong>: automatically provide culturally competent services, recognizing that cultural competence is a continuous process of learning and developing new approaches based on continuing assessment of community needs, demographic and economic changes and staff needs.</td>
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**BOX 3**
The following cornerstone strategies will go a long way toward strengthening a clinic’s cultural competence:

1. Conduct an organizational assessment
2. Develop a community profile
3. Provide ongoing cultural competence development and training for all staff
4. Integrate cultural competence into the organization’s mission, policies and practices
5. Improve language access for clients with limited English proficiency
6. Anticipate and address barriers across the organization

**Conduct an Organizational Assessment**

There is no one right way to approach the development of cultural competence. But a good start is to assess where the organization, its services and staff are in relation to cultural competence indicators. An organizational assessment will recognize areas of strength and discern areas that deserve attention and resources. Consider the following elements and include them in an assessment as appropriate within your organization and scope of responsibility:

- Mission and goals
- Organizational and clinical policies and practices
- Staff and leadership composition
- Hiring and staff recruitment plan and practices
- Staff development and training
- Public relations and outreach
- Physical facility
- Volunteer management practices

Set a timeline for conducting the assessment. Gather a team of dedicated, motivated individuals in and outside of the clinic who are willing to serve on a task force to help conduct the assessment, evaluate and communicate the results and assist in taking action in areas needing improvement.
Pay attention to the strengths revealed in the assessment as well, and reward and motivate staff by communicating this information inside and outside the organization as appropriate.

**Tools for Implementing This Strategy**

Few instruments for assessing organizational or agency cultural competence have been validated and most need to be tailored for family planning clinics. Appendix 1 is a comprehensive beginning tool for assessing agency, clinic and staff components of reproductive health services. Compiled from many sources, it includes indicators of cultural competence that can be relevant for family planning clinics. Appendix 2 is a tool for measuring achievement in terms of content, process and outcome components of cultural competence.

Keep in mind that assessment is not an isolated event, but a continuous process. It is as important to measure progress on the journey toward greater cultural competence as it is to measure the achievement of objectives.

**Develop a Community Profile**

Each clinic must choose and tailor strategies and practices for cultural competence in the unique context of the community it serves. A demographic, cultural and epidemiologic profile of the community is an important tool for addressing this need. The Office of Minority Health (OMH) CLAS Standards recommend that health care organizations maintain a community profile and needs assessment for services that respond to the cultural and linguistic characteristics of the community.16

Development of a community profile ideally employs both quantitative and qualitative methods to determine relevant factors about the client population, as well as the community’s resources, assets and needs related to family planning services.

It is important to go beyond a clinic’s own data, which may provide an incomplete picture of the potential client population. The community should be involved in the design and development of the profile and needs assessment. Focus groups, interviews and surveys with clients and other community members and groups with whom the clinic has relationships can provide this involvement as well as useful qualitative data for the profile. A mechanism for obtaining regular input will maintain the relevance of the community profile.

Quantitative and qualitative data regarding a clinic’s service area can be used to:

- Determine whether there are new groups moving into the service area,
- Forecast changes in the patient population,
- Estimate how well the clinic is serving the community’s population groups, and
- Determine to what extent clinic staff represent the cultures of the communities served.
**Tools for Implementing This Strategy**

*Appendix 3* outlines types of information to be included in a community profile and where to find them. *Appendix 4* lists Internet sources of demographic and health status data. Keep in mind that census data may be outdated and can be unreliable for identifying indicators such as income or ethnicity. Community service agencies and organizations may be a more reliable source for some demographic data. Regardless of the information source, recognize the limitations of the source and be careful not to overinterpret information.

**Provide Ongoing Cultural Competence Development and Training for All Staff**

Clinic managers and providers in Region I Title X clinics have documented the need for training on working with diverse clients. “HIV and culturally specific issues” was listed among the top five training needs identified by providers.

Ideally, staff development and training in cultural competence should be available for all staff, board members and volunteers. The guidelines and tools presented in this section focus mainly on cultural competence training for providers, although many can be used or adapted for others.

Key elements of cultural competence development and training include: 17,18

- **Skill building in attitude change and in awareness of self and others.** Increase awareness of racial and ethnic disparities in health, the importance of sociocultural factors on health beliefs and behaviors and the impact of race, ethnicity, culture and class on clinical decision making. Allow individual providers to determine where they are along the cultural competence continuum and to choose the next steps in their personal development.

- **Training in linguistic competence.** Ensure that bilingual staff can demonstrate bilingual proficiency, particularly with terms and concepts relevant to clinical encounters, and that they receive training in skills and ethics of interpreting. Train all providers in working effectively with professional interpreters and bilingual staff.

- **Development of competence in cross-cultural assessment, communication and negotiation.** Build providers’ skills by 1) recognizing cultural blind spots and assumptions about cultural differences between them and the client; 2) addressing their discomfort when a client’s responses or behavior differ from their own belief systems; and 3) exploring a client’s individual life experiences to find underlying causes of attitudes and behaviors such as mistrust or repeated risk-taking.

- **Training in workplace diversity.** Increase awareness of workplace diversity issues. Apply self-awareness and cross-cultural skills training to development of skills for resolving workplace disputes and improving interactions among diverse staff.
Many types of exercises are appropriate for getting the training process off the ground. Box 4 provides some examples. Any of these may lead to insights that stimulate the change process or may generate questions and issues for subsequent sessions.19

### Exercises for Building Cultural Competence Awareness and Skills

- **Cultural introductions** are small-group conversational interactions in which each participant recounts an event that suddenly made him or her aware that he or she was “different” from others in the situation. Participants describe not just what happened but how they felt and why.

- **Role plays** of brief interactions based on actual or common scenarios and involving one or two key points and characters focus attention on specific issues and questions.

- **Guest speakers** who are clients, family members, or community members provide substantive information from first-hand sources and are an invaluable resource for understanding the point of view of the “other.” Topics can include living with HIV/AIDS or addiction, healing resources available in the community, and so forth.

- **Cross-cultural simulation games** in which participants are assigned to membership in fictitious cultures are more time-consuming, but can be extremely productive, especially in diverse participant groups. They work best as half-day development workshops or in staff or department retreats.

- **Theater group performances** that are interactive or improvisational, put on by groups that deal specifically with complex issues such as HIV/AIDS or intercultural conflict, are invaluable for stimulating identification of feelings, values and conflicts.

- **Formal, professionally facilitated retreats** or workshops with experiential or participatory components can be helpful for further exploring issues surrounding human diversity, cultural competence and providing services for clients with or at risk for HIV/AIDS.

*From O’Connor, BB, Promoting Cultural Competence in HIV/AIDS Care* 20

### BOX 4

Training in cultural competence will be a continuing process. The most effective training and development programs go forward in steps, with many opportunities for reinforcement over an extended time frame. Box 5 lists strategies for integrating and sustaining cultural competence development and training in your organization. More information about many of the staff development techniques described here is available in *Promoting Cultural Competence in HIV/AIDS Care*, an excellent resource on this topic by Bonnie B. O’Connor. 21
Strategies for Ongoing Cultural Competence Education and Training

- Include regular cultural discussion sessions, cultural assessment exercises, case conferences or critical incident discussions in the staff development schedule. These will make lasting impressions and promote skill-building when drawn directly from actual situations, rather than created as fictitious “typical” scenarios.

- Consider inviting the client and/or partner/family member involved in a particular assessment, case, or critical incident to attend a discussion and offer their insights, viewpoints, and suggestions. These sessions are best moderated by an experienced facilitator to ensure that exchange of views and proposals for mutually acceptable solutions take place, rather than debates or arguments.

- Build in mechanisms for feedback on what worked and what didn’t. Provide both structured and unstructured opportunities for two-way discussion with staff about how development and training is working or not working. Use relevant feedback to revise the length, sequence, frequency, format, and/or content of training as needed.

- Reinforce changes in behavior and attitudes regularly with memos, signs, and internal e-mail messages with cultural information such as customs relating to holidays and facts about values and beliefs.

- Expect “advances and retreats, moments of epiphany, and lingering blind spots.” Individuals will be at different stages of comfort and accomplishment at any given time. Even the most culturally accommodating individuals will have off days or “hot button” issues.

- Encourage peer support through acknowledging each other’s capabilities and limitations, identifying obstructive or dysfunctional attitudes and changes in procedure and helping to review individual and collective progress and setbacks.

From O’Connor, BB, Promoting Cultural Competence in HIV/AIDS Care

BOX 5

Tools for Implementing This Strategy

Appendix 5 guides individuals in recognizing and reducing the influence of cultural misinformation, identifying common myths about cultural competence and asking themselves questions about their own cultural awareness. Appendix 6 identifies factors that can prevent true communication and presents a framework for overcoming communication barriers from the perspectives of the speaker and the listener. Appendix 7 lists important terms used in this section. Other training tools are listed under Resources later in this section. Links to many of these tools are provided on the CD-ROM.
Integrate Cultural Competence into the Organization’s Mission, Policies and Practices

Cultural competence, inclusively defined, should be integrated into the organization’s mission and philosophy as an integral component.

Policies and practices promoting cultural competence provide critical organizational support for staff. They can be viewed on three levels: organizational, systemic and clinical.  

1. **Organizational policies and practices that maximize diversity throughout the organization, including:**
   - Leadership development for minorities
   - Hiring and recruiting from the community as a priority
   - Workplace diversity training for all staff
   - Involving community representatives in planning and quality improvement through board representation and/or focus group participation

2. **Policies and practices that eliminate systemic or institutional barriers to care, including:**
   - Attention to level of health literacy, language proficiency and cultural norms in all spoken and written health information materials
   - Compliance with Civil Rights Act Title VI legislation mandating provision of interpreter services for clients with limited English proficiency
   - Selection and ongoing quality review of on-site interpreters or interpreter services
   - Collection of race/ethnicity and language preference data for all clinical encounters to monitor racial and ethnic disparities and to initiate quality improvement measures

3. **Clinical policies and programs that integrate sociocultural awareness, cross-cultural communication and client empowerment at all levels, including:**
   - Cross-cultural education as a required, integrated component of staff development and training
   - Culturally and linguistically appropriate client survey methods and process and outcome measures that reflect needs of multicultural populations
   - Programs to help clients navigate the care system and become more active partners in the clinical encounter

It is more challenging to develop true organizational cultural competence than to be competent in providing services to specific groups or populations. Cultural competence and responsiveness to diversity go beyond developing and implementing policies and procedures for specific ethnic groups or special populations.
Tools for Implementing This Strategy

The CLAS Standards: A powerful and practical model for building cultural and linguistic competence is available to clinic managers in the form of the CLAS Standards issued by the Office of Minority Health (OMH). The standards are intended to inform, guide and facilitate required and recommended practices for providing culturally and linguistically appropriate health services. Each of the 14 standards is issued as a mandate, a guideline, or a recommendation by OMH, and they are organized under three themes. Box 6 describes the themes and key elements of the standards.

### The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)

#### Culturally Competent Care

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

#### Language Access Services (Mandates for recipients of federal funds)

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

7. Health care organizations must make available easily understood patient materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**BOX 6**

(Box 6 continued on the next page)
The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)

**Organizational Supports for Cultural Competence**

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

The full set of CLAS standards with descriptive text and broad guidelines for implementation are available from the OMH website. (See the link on the CD-ROM.) A step-by-step guide to assist managers and staff in implementing the standards is also available through the OMH website. The guide is a work in progress that provides practical steps and downloadable and reproducible "checklists" and syllabi that can be used as is or adapted to suit a clinic's needs.

**Improve Language Access for Clients with Limited English Proficiency**

For family planning clinics, the significance of the four CLAS standards for providing language access is borne out by providers in Region I who report that language issues pose challenges in HIV-related situations and in meeting staff training needs. Language barriers create significant deterrents to the use of primary and preventive care services and negatively influence perceptions of health care encounters. With changing demographics, the numbers of people in the U.S. and in Region I who speak languages other than English and have limited English proficiency will continue to grow.

Provisions for the language needs of patients were mandated by Civil Rights Act Title VI in 1964. All health care organizations that receive federal funds are required to demonstrate their ability to provide both culturally and linguistically appropriate care and services for persons of limited English proficiency, at their own expense. This also applies to Title X-funded family planning clinics. The requirement is interpreted to mean that translation services are to be provided for all clients who do not speak English. The four CLAS standards for language access provide helpful information and guidelines for addressing the requirements of the law.

Some Title X-funded family planning clinics have been able to provide unique and innovative language assistance services to their clients with limited English proficiency to comply with Title VI Civil Rights Act requirements. Their experience is summarized in Box 7 on the next page.
Providing Language Assistance Services:
Lessons from Seven Title X Family Planning Clinics

- Staff members reported two types of barriers in providing language assistance services:
  - Client characteristics including linguistic differences, cultural differences and low levels of health literacy
  - Resource barriers including costs associated with interpreter and translation services, cost and limited availability of bilingual staff and volunteers and time constraints associated with treating clients with limited English proficiency.
- Clients reported encountering linguistic, cultural, legal, economic and educational barriers in accessing family planning services during different phases of the clinic visit.
- Clients reported that multilingual signs and education material were very useful in facilitating the clinic visit.
- Clients perceived bilingual staff to be the most effective way of providing language assistance.
- The clinics employ a combination of language assistance services and strategies.
- The clinics expend large amounts of resources to provide language assistance services.
- Bilingual staff members employed by the clinics are highly capable and represent the language needs of the community served.
- There were shortages in bilingual technical staff such as nurses and physicians.

*From COSMOS Corporation, Limited English Proficiency as a Barrier to Family Planning Services*}
Tools For Implementing This Strategy

Appendices 8 and 9 provide more information on Title VI of the Civil Rights Act and other federal laws related to language assistance. It is also important to determine whether any state laws contain provisions related to cultural and linguistic competence that may affect delivery of family planning services in a particular area.

The four CLAS standards for language access provide helpful information and guidelines for addressing the requirements of the law. The online guide to implementation of the CLAS Standards, available through the OMH website, provides tools for managers on: 1) informing clients of their right to language assistance, 2) establishing adequate signage in other languages, 3) developing appropriately translated patient information and education, and 4) creating an efficient, cost-effective system for medical interpretation. (See the link in Resources and on the CD-ROM).

Appendices 10, 11, and 12 provide more detail on strategies used to increase language access in Title X family planning clinics. Appendix 10 describes innovative language assistance services and strategies employed by some of the seven clinics. Appendix 11 provides two tables; the first lists the estimated cost for each of nine methods of providing language assistance and the second compares the average time for each phase of a clinic visit for clients with and without limited English proficiency in each of the clinics studied. Appendix 12 lists the strengths and weaknesses of various methods of delivering language assistance, as perceived by staff and clients in the seven clinics.

Anticipate and Address Barriers Across the Organization

Family planning clinics, like all organizations, are complex systems with interdependent elements, creating and responding to change and stimulus. Acknowledging that barriers will emerge along the journey to cultural competence and planning effectual approaches to address them, wherever in the organization they occur, can help ease the stress of implementing change. Barriers that clinic managers may encounter include:

- **Lack of organizational commitment or support**, for example, in mission, policies, leadership and/or resources; dominance of the Western health care model at the organizational level
- **Lack of support for diversity in leadership and work force**, for example, recruitment, hiring and promotion practices that don’t foster diversity; lack of incentives or rewards for effectual language skills
- **Limited financial resources** for staff, training and other essential activities; lack of sustained funding to support ongoing development of cultural competence
- **Scarcity of time to learn new practices and alter behaviors**, and feelings of pressure due to time constraints
- **Lack of space** for accommodating additional programs to address the community’s needs; insufficient space for improving clinic accessibility, safety, appearance or privacy
Section 4  What Does it Take? Cultural Competence in Your Organization

- **Limited training resources**, including scarcity of evidence-based resources; materials and approaches that define cultural competence too narrowly or that may contribute to stereotyping, such as improper use of ethnic profiles.

- **Fear and resistance to change**, for example, staff members’ fear of the unknown or the new; fear of being viewed as biased or incompetent; entrenchment of the Western health care model; anxiety about making mistakes.

Creativity and innovation will be needed to sustain progress in developing cultural competence and to find sufficient funds and other resources to support such progress. Here are some strategies for approaching barriers to growth in cultural competence:

- **Articulate a clear mission for cultural competence** in written documents and spoken presentations inside and outside the organization, for example, in strategic and program plans, recruitment and retention policies, training programs, community collaborations and public presentations.

- **Communicate evidence** supporting the positive effects of organizational, systemic and clinical cultural competence on quality of care, client and staff satisfaction, positive health outcomes and the overall business of health services.39

- **Seek opportunities to collaborate** with other agencies or institutions in the service area to increase your program’s capacity, skills and/or physical space.

- **Explore participation in managed care arrangements** (which may be an option for some clinics) to increase resources, especially if they have already demonstrated some success with culturally competent programs.40

- **Use care in selecting teaching materials and approaches**, especially in using clinical aids such as ethnic health profiles, to avoid a narrow approach to cultural competence or inadvertently teaching staff to stereotype. There are as yet no standardized, evidence-based curricula for cultural competence training, and not all resources are appropriate in content or method. The number and variety of training resources is growing and should eventually make staff training easier and more accessible.

- **Recognize and respect staff members’ natural resistance and apprehension** about change and highlight the benefits and rewards of building more culturally competent services, for both staff and clients. Managers, caregivers and support staff naturally depend on trusted, familiar models of behavior to guide their actions and decision making. Although cultural competence development may initially place time pressures on already overburdened staff, the development of staff members’ ability to skillfully identify and address clients’ specific needs will ultimately enable them to use scarce time more effectively.
Sustaining the Journey

The journey to cultural competence is not always a comfortable one. Humans and organizations are imperfect and as they continue to grow and learn, mistakes will be made along the way, despite the best intentions. Acknowledge mistakes, apologize for unintentional affronts, and when an approach backfires, try a new one. But don’t give up. As managers and staff continue the journey it helps to remember that the ultimate goal is the delivery of enhanced family planning and HIV prevention services for all.

"Agencies all over this country are faced daily with the realities of diverse clients and how to meet their changing needs and lives. Our ability to adapt, while recognizing our commonalities and celebrating our differences, will determine the effectiveness of our work into the 21st century and how many lives we can impact. It is no longer a question of whether we must change but rather how soon we can change."

Gloria Nieto, People of Color AIDS Foundation, Santa Fe, New Mexico
Southwestern Conference on Rural HIV/AIDS, September 1998
More information on key points discussed in this section and references to training resources, assessment tools and checklists are provided below. Links to most of these resources can also be found on the CD-ROM under Special Section on Cultural Competence. The list of resources grows and changes regularly, so it is helpful to revisit the sites listed on the CD-ROM for new materials and links to other resources.

- **National Center for Cultural Competence**
  Georgetown University
  http://www.georgetown.edu/research/gucdc/nccc
  
  A comprehensive web site offering information, tools and resources for the design, implementation and evaluation of culturally and linguistically competent health service delivery systems. Includes an on-line 20-minute practitioner self-assessment tool that provides a list of suggested resources and learning experiences based on responses.

  **Resource Database:** http://data.georgetown.edu/research/gucdc/nccc/resources/index.cfm
  
  **Products and Tools:** http://www.georgetown.edu/research/gucdc/nccc/products.html
  
  **Cultural Competence Health Practitioner Assessment:**
  http://www.georgetown.edu/research/gucdc/nccc/pa.html
Office Of Minority Health
Department of Health and Human Services
www.omhrc.gov

The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. The following is a list of additional resource links within OMH’s website.

Resource Center: http://www.omhrc.gov/omhrc/index.htm
Center for Linguistic and Cultural Competence in Health Care:
http://www.omhrc.gov/inetpub/wwwroot/cultural/
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care: http://www.omhrc.gov/clas/finalcultural1a.htm
Culture and Health (gateway to OMH resources to help providers deliver culturally competent care. Separate sections for nurses and for physicians.)
http://www.cultureandhealth.org

Advocates for Youth
http://www.advocatesforyouth.org/culturalcompetency.htm

The cultural competency section contains a wealth of information for understanding and communicating cultural competency in sexual and reproductive health issues for youth, including excellent fact sheets on HIV for specific youth sectors, including young women of color, and gay, lesbian, bisexual and transgender youth.

Compendium Of Cultural Competence Initiatives In Health Care
Kaiser Family Foundation
http://www.kff.org/uninsured/6067-index.cfm

In response to the Institute of Medicine’s report that suggested the need to reduce racial and ethnic disparities, the KFF created this compendium to define cultural competency and identify efforts underway in this emerging field.

Cross-Cultural Communications
http://www.culturecrossroads.net/resources.htm

Resources section of this web site offers links to useful tools for improving cross-cultural communications in health care, including finding interpreters, recruiting bilingual staff and developing policies and procedures for serving immigrants.
Cultural Competence Works
Health Resources and Services Administration, DHHS

This publication highlights methods and practices that HRSA-funded programs recognized for providing culturally competent services have implemented to enhance their ability to serve linguistically and culturally diverse populations.

Diversity Rx – Resources For Cross Cultural Health Care
http://www.diversityrx.org

Offers a wealth of resources and information promoting language and cultural competence to improve health care for minority, immigrant and ethnically diverse communities. Access to basic facts and information, models and practices, laws, regulations and standards, resources, bibliographies, news and a free e-mail news list.

National Minority AIDS Education and Training Center - Cultural Competency Resource Center
http://www.nmaetc.org/cultural/cultural.asp

The cultural competency section of this web site offers useful information, data, tools and resources addressing cultural barriers in HIV management.

The Provider’s Guide to Quality and Culture
Management Sciences for Health, DHHS, HRSA, Bureau of Primary Healthcare
http://erc.msh.org/quality&culture

Offers an in-depth, highly readable overview of cultural competence and cross-cultural health care. Includes sensitive information on cultural beliefs and health problems affecting certain cultures.

Training Materials

Caring for People of Many Cultures – Online Course
Nurses Learning Network (NLN)

This online course provides nurses with information about caring for patients from different cultural backgrounds. By completing both parts, participants are eligible for two contact hours after completing the online exam.

Part 2: http://www.nurseslearning.com/syllabus.cfm?CourseKey=1488
Health Care Provider Adherence Training Curriculum
National AIDS Education and Training Centers Program, HRSA, Bureau of HIV/AIDS, Division of Training and Assistance. Available electronically from the Pennsylvania/MidAtlantic AIDS Education and Training Center
http://www.pamaaetc.org/resources.htm

This standardized curriculum was developed by the National AIDS Education & Training Centers to disseminate and conduct education on the new treatment guidelines and adherence issues. Includes a module on cultural competency and experiential exercises on cultural issues.

Promoting Cultural Competence in HIV/AIDS Care. By Bonnie B. O'Connor:

Organizational Assessment Tools

The Cultural Competence Self-Assessment Protocol for Health Care Organizations and Systems
http://erc.msh.org/provider/landrulis.pdf

This protocol builds upon the Georgetown University Child Development Center’s Continuum of Cultural Competency. This tool can be used by clinics for organizational assessments of cultural competence. It is particularly useful for services involving racially and ethnically diverse populations.

Guide to Providing the Language Access Services That Have Been Mandated By Title VI of the Civil Rights Act Of 1964 (CLAS Standards 4,5,6 &7)
Office of Minority Health
http://www.omhrc.gov/clas/sec6intro.htm

This section of the Guide for Implementing the CLAS Standards (DRAFT) offers practical information and guidelines for developing and implementing language access services that comply with the CLAS mandates on language access and Title VI of the Civil Rights Act of 1964.

Checklist #1: Informing patients of their right to language assistance
http://www.omhrc.gov/clas/sec6ck1.htm

Checklist #2 – Establishing adequate signage in other languages
http://www.omhrc.gov/clas/sec6ck2.htm
Checklist #3 – Developing appropriately translated patient information and patient education materials
http://www.omhrc.gov/clas/sec6ck3.htm

Checklist #4 – Steps to creating an efficient, cost effective system for medical interpretation
http://www.omhrc.gov/clas/sec6ck4.htm

Promoting Cultural and Linguistic Competency: Self-Assessment Checklist for Personnel Providing Primary Health Care Services
National Center for Cultural Competence, Tawara Goode, 2000
http://www.georgetown.edu/research/gucdc/nccc/nccc11.html

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices that foster cultural and linguistic competence at the individual or practitioner level.

Cultural Competency Models and Tools for Provider-Client Interaction

BESAFE
National Minority AIDS Education and Training Center Cultural Competency Model.
http://www.nmaetc.org/images/BeSafe.pdf

For health care professionals who treat minority patients with HIV/AIDS. The mnemonic “BESAFE” is a framework that uses culturally pluralistic content and perspectives based on six core elements that give health care providers a culturally relevant framework for providing primary health care services to minority clients with HIV/AIDS.

ETHNIC
http://www.state.nj.us/health/bibs/education/ethnic.html

Ethnic Health Profiles

These are valuable tools for increasing knowledge and sensitivity to various cultures, when used with consciousness to avoid stereotyping and generalizations according to ethnicity. Profiles from the sources listed are free.

- **New Hampshire Governor’s Office of Energy and Community Resources**
  Ethnic Community Profiles
  Comprehensive profiles of 16 underserved ethnic populations in a single printable electronic publication, including information on health beliefs, practices and health risks.

- **Patient and Family Education Services, University of Washington Medical Center**
  A series of brief Culture Clues© tip sheets for clinicians to increase awareness about concepts and preferences of patients from the diverse cultures served by the University of Washington Medical Center. Eight cultures are represented, with additional materials in preparation.

- **EthnoMed**
  Ethnic medicine information from Harborview Medical Center, Seattle, WA
  [http://www.ethnomed.org](http://www.ethnomed.org)
  Extensive, detailed information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle and other parts of the U.S., many of whom are refugees fleeing war-torn parts of the world. Included are profiles of selected ethnic cultures and a link to additional ethnic profiles from the Cross Cultural Health Care Program.
References


References


20. Ibid.

21. Ibid.

22. Ibid.


24. Ibid.


26. Ibid.


28. COSMOS Corporation. Limited English proficiency as a barrier to family planning services.


30. U.S. DHHS, HRSA. Cultural Competence Works
Appendices
Appendix 1

Cultural Competence Organizational Assessment for Reproductive Health **

AGENCY LEVEL

Does my agency:

YES  NO

☐ ☐ Involve staff and ethnic and other communities representing the clinic population in advisory boards, quality monitoring, and materials review?

☐ ☐ Report to the community on cultural competency issues, goals, and progress?

☐ ☐ Provide ongoing cultural competency education for board members?

☐ ☐ Incorporate cultural competency behaviors in job descriptions for all staff?

☐ ☐ Have a system and assigned responsibilities for regular measurement of consumer (and staff) satisfaction and for action based on findings?

☐ ☐ Have a system for handling cultural competency related grievances and complaints?

☐ ☐ Collect data on the community, the client population, staff, board members, volunteers, hired interpreters, and translators and make it accessible to staff?

(*See end of assessment for types of data)

☐ ☐ Conduct regular community needs assessments based on two-way communication with the community and link the information to quality improvement efforts and goals?
### CLINIC LEVEL

**Does my agency:**

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Does the reception staff:

YES  NO

☐  ☐ Welcome clients from all cultures in a warm and friendly manner?
☐  ☐ Receive training in handling calls and visits from clients with limited English proficiency?
☐  ☐ Routinely schedule interpreters and translators for LEP clients?
☐  ☐ Schedule longer appointments for LEP clients?

Do supervisors:

YES  NO

☐  ☐ Have a plan in place about how to work with clients from all cultures around HIV/AIDS issues that was developed with input from clients and staff?
☐  ☐ Regularly monitor progress toward cultural competence at all levels, recognizing ever-changing demographics?
☐  ☐ Adapt policies, procedures, and standards based on information from staff and the community served?
☐  ☐ Actively recruit staff members at all levels that reflect clients’ diversity?
☐  ☐ Provide ongoing cultural competence and cross-cultural communication training for all staff, including themselves?
☐  ☐ Provide training for providers on how to work with diverse clients around HIV/AIDS as well as reproductive health issues?
☐  ☐ Involve members of the community served to provide training on their culture for volunteers board members, and staff?
☐  ☐ Incorporate cultural competency into all staff development activities?
☐  ☐ Provide cultural competency consultation with staff on request?
☐  ☐ Establish close relationships with local cultural and ethnic groups?
☐  ☐ Conduct regular quality review of interpreters and translators?

Provide staff with materials about sexual and reproductive health for specific cultural groups on issues such as:

☐  ☐ • Attitudes about HIV/AIDS
☐  ☐ • Attitudes toward contraceptives
☐  ☐ • Approaches to physical examinations
☐  ☐ • Cultural strengths and assets
☐  ☐ • Gender relations
Appendix 1  Cultural Competence Organizational Assessment for Reproductive Health

☐ ☐ • Family hierarchies (including who makes decisions)
☐ ☐ • Fears and taboos
☐ ☐ • Safe vs. harmful home remedies
☐ ☐ • Problem-solving strategies
☐ ☐ • Specific issues relevant to the community served

☐ ☐ Treat every client with respect, warmth, and sensitivity?
☐ ☐ Value other cultures?
☐ ☐ Make efforts to understand and connect to those from other cultures?
☐ ☐ Show sensitivity to different cultural beliefs about reproductive health and HIV/AIDS?
☐ ☐ Avoid imposing values that may conflict with those of clients?
☐ ☐ Intervene appropriately when a staff member displays cultural insensitivity?

Do service providers and other staff:

YES  NO

☐ ☐ Identify and record clients’ language preferences, proficiency, literacy, and other cultural and demographic specifics that are relevant to providing culturally competent care?
☐ ☐ Take time to make friendly conversation with clients from all cultures and backgrounds?
☐ ☐ Ask about typical health practices in the client’s culture?
☐ ☐ Attempt to learn and use key words in the languages of the populations served?
☐ ☐ Support the use of safe and effective cultural remedies?
☐ ☐ Use community resources as treatment partners?
☐ ☐ Ensure that patient instructions, both written and oral are clear and appropriate for each client’s language preference, proficiency, literacy, and cultural specifics?
☐ ☐ Recognize that limitations in English proficiency do not reflect level of intellectual functioning or ability to communicate in the client’s language of origin?
☐ ☐ Recognize signs of potential stress and trauma or other previous negative experiences in clients, especially refugees and immigrants?
Do interpreters and bilingual staff:
YES    NO
☐ ☐ Speak both languages fluently?
☐ ☐ Have medical interpreter training and testing?
☐ ☐ Use the first person?
☐ ☐ Ensure that service providers and clients communicate directly to each other?
☐ ☐ Offer ethnic and cultural information on reproductive health and HIV/AIDS?

* Types of data to collect: Gender, age, ethnic composition, national origin, sexual orientation, physical ability, developmental level, religion, housing status, and income range of clients served by the clinic. Demographic composition of the entire community – not just current clinic clients. Gender, age, and ethnic composition of staff, board members, volunteers, hired interpreters and translators.

** This checklist is a compilation of tools and information from research of materials available on cultural competency. It uses as a basis the Cultural Competence Checklist for Reproductive Health from “Cultural Competence and Reproductive Health: A Guide to Services for Immigrants and Refugees,” developed by TRAINING 3, the DHHS Region III Family Planning Training Center.
## Appendix 2

### Measuring Achievement of Cultural Competence Components at Organizational, Community, and Individual/Staff Levels

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>RESULTS</th>
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<tbody>
<tr>
<td></td>
<td>Organizational</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td></td>
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<tr>
<td>• What should be included?</td>
<td>Mission and philosophy reflect cultural competence</td>
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<tr>
<td>• What knowledge, skills, and abilities should be present?</td>
<td>Organizational structure reflects community outreach, accessibility, and participation</td>
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<td></td>
<td>Language and culturally-congruent brochures, forms, instructions about services accessible to community</td>
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<td></td>
<td>Staff development programs reflect cultural competence development</td>
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<tr>
<td></td>
<td>Adequate and appropriate resources are available for cultural competence</td>
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<tr>
<td></td>
<td>Adequate language-congruent resources are available</td>
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<tr>
<td></td>
<td>Research initiatives address social and cultural factors influencing health and illness</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>Knowledge of community health services and resources</td>
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<tr>
<td></td>
<td>Knowledge of process for appropriate access of resources</td>
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<td></td>
<td>Knowledge of community leaders, gatekeepers</td>
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<tr>
<td><strong>Skills</strong></td>
<td>Social, cultural, environmental, religious, and biological characteristics of client population</td>
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<tr>
<td></td>
<td>Communication norms, social organization (hierarchy, kinship, gender norms, developmental norms, linguistic characteristics)</td>
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<tr>
<td></td>
<td>Culture specific beliefs, values and practices relevant to health/illness, caring, life transitions</td>
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<tr>
<td></td>
<td>Community resources, gatekeepers, culturally competent staff</td>
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<tr>
<td></td>
<td>Differences between folk ways of healing and caring and organizational culture</td>
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<tr>
<td><strong>Affective</strong></td>
<td>Open-mindedness</td>
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<td></td>
<td>Ethnosensitivity</td>
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<td>Respect for differences</td>
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<tr>
<td>COMPONENT</td>
<td>RESULTS</td>
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<tr>
<td></td>
<td><strong>Organizational</strong></td>
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<tr>
<td>Process</td>
<td>• Coordination of services and programs with community, stakeholders, payers, etc.</td>
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<td></td>
<td>• Defining issues more broadly, differentiating social from cultural factors</td>
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<tr>
<td></td>
<td>• Hiring, promotion and recruitment policies promoting cultural competence</td>
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<td>• Scheduling and delivery of accessible services</td>
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<td></td>
<td>• Population and need-based distribution of services</td>
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<td></td>
<td>• Coordination of service delivery with other community resources to increase access (transportation, social service, payers)</td>
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<td></td>
<td>• Direct accountability for population groups’ access and utilization of services through personalized and culturally competent care</td>
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<td></td>
<td>• Staff development programs address cultural competence development</td>
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<td>• Outreach programs increase cultural competence of targeted communities</td>
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<td></td>
<td>• Use of qualitative and quantitative research methods to determine culture-specific health problems and outcomes</td>
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<td></td>
<td>• Organizational structure defining role responsibilities between community partners and clinic</td>
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<td>• Mechanism established for timely feedback from both partners</td>
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<td></td>
<td>• Monitoring systems for early diagnosis of problem and interventions</td>
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<td>• Monitoring system for outcomes assessment in place</td>
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*Integrating HIV Prevention and Family Planning Services*
<table>
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<tr>
<th>COMPONENT</th>
<th>RESULTS</th>
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<tbody>
<tr>
<td><strong>Outcome</strong></td>
<td><strong>Organizational</strong></td>
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<tr>
<td></td>
<td>• Increased partnerships and communication</td>
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<td>• Early interventions for risk factors</td>
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<td>• Positive qualitative outcomes of care</td>
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<td>• Increased utilization of services by targeted groups</td>
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<td>• Quantitative indices of positive outcomes</td>
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<td><strong>Community</strong></td>
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<td>• Coordinated community action in seeking resources and services</td>
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<td>• Coordinated partnership with clinics in health promotion and early</td>
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<td></td>
<td>risk reduction</td>
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<td>• Improved access and health outcomes</td>
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<td><strong>Individual/Staff</strong></td>
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<td></td>
<td>• Increased self-awareness</td>
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<td></td>
<td>• Increased teamwork</td>
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<td>• Increased client satisfaction</td>
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Adapted with permission from a handout by Dr. Dula Pacquiao, Professor and Director, Transcultural Nursing Institute, Kean University, Union, NJ. Presented at “Cultural Competency Within Your Organization: A Training for Grantees of the Division of AIDS Prevention and Control,” May 24-25, 2001, Princeton, NJ.
Appendix 3

Types and Sources of Information for a Community Profile

Quantitative information - census and aggregate data on community sociodemographic characteristics and relevant health status

Sociodemographic characteristics
- Population density
- Population stability
- Population distribution by factors such as age, gender, language, race/ethnicity, educational level, housing status, household income, number and proportion of groups such as migrants, homeless, non-English speaking
- Unemployment rate

Health status
- Reported HIV/AIDS incidence
- Infant mortality rate by race/ethnicity
- Numbers and causes of deaths by age, gender, and race, as appropriate
- STD Rates
- Pregnancy rates

SOURCES
- State or county Departments of Public Health or Health and Human Services
- Census figures and/or adjustments
- Voter registration data
- School enrollment profiles
- County and state population and health status reports
- Data from local and state planning agencies
- Data from community agencies and organizations, including those serving new immigrants
**Qualitative information** - information about the current and potential client population and the community as it relates to these population groups, obtained through focus groups, key information interviews, etc.

- Client needs, attitudes, health behaviors, and health risks
- Concerns about using health care services
- Health issues of most concern to the client population
- Community needs related to the client population
- Community resources and assets relative to community health, including other community service agencies serving the client population

**SOURCES**

- Clinic board members
- Clinic staff
- Clients
- Local health care providers in hospital and community health centers
- Staff in social service agencies
- Local government
- State health department staff
- Ryan White HIV Planning Council(s) and consortia
- HIV Prevention Community Planning Group(s)
- School officials, teachers, PTA leaders, youth leaders
- Faith-based organizations
Appendix 4

Where to Find Population-Based Data on the Internet

Statistics and Demographic Data

Statistics about immigration patterns:

National, state, and county statistical and demographic data by age, racial, ethnic, and linguistic subgroups:

- General information:
  http://www.census.gov

- Population estimates:
  http://www.census.gov/population/www/estimates/popest.html

- Population projections:
  http://www.census.gov/population/www/projections/popproj.html

HIV/AIDS Surveillance Data

Surveillance data by community from state Departments of Public Health or Health and Human Services:

- Connecticut - http://www.dph.state.ct.us/
- Maine - http://www.state.me.us/dhs/bohl/
- Massachusetts - http://www.state.ma.us/dph/
- New Hampshire - http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/default.htm
- Rhode Island - http://www.health.state.ri.us/
- Vermont - http://www.healthyvermonters.info/

Surveillance and other data at national and state levels:

- Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention - Surveillance:
  http://www.cdc.gov/hiv/surveillance.htm
- Kaiser Family Foundation State Health Care Facts On Line:
  http://www.statehealthfacts.kff.org/
Appendix 5
Improving Cultural Awareness

I. Reducing the Influence of Cultural Misinformation

Use the following steps to identify and reduce reliance on cultural misinformation:

- Recognize that it is impossible to escape the receipt of misinformation (or stereotypes) about different cultures.
- Examine generalizations you hear about different groups, to practice identifying cultural misinformation.
- Examine your beliefs and information about various cultures, to enhance your ability to recognize cultural misinformation.
- Read books, see movies, attend concerts and lectures, and pursue other activities involving different cultures that can broaden your understanding and enhance your sensitivity.
- Listen for expressions of cultural misinformation (stereotypes) in the clinic.
- Gather cultural information from individuals who come to the clinic and evaluate the information as it relates to that individual’s cultural experience.
- Increase your attention to the cultural information that might be available through interactions with individuals and/or their communities.
- Reach beyond your comfort level to converse with a person who identifies with a different culture (e.g., race, economic class, sexual orientation).
- Avoid the temptation to generalize about an entire culture based on your observations or information received from individuals who have attributes of that culture (i.e., apply information only to the situation in which you received it).
- Be careful not to simply label a client as Asian, Hispanic, African, etc. For example, Koreans do not want to be called Chinese, Dominicans do not want to be called Puerto Ricans; Ukrainians do not want to be called Russians.
- Be aware that a person who is a political or religious refugee, undocumented, or in the United States on a visa may have traumatic histories or other experiences and perspectives that require great sensitivity, patience, and assurances of confidentiality.
Appendix 5  Improving Cultural Awareness

- Avoid assumptions that a client’s work or financial status in this country were the same in their country of origin, and consider the effect of any differences on the client’s potential for meaningful economic existence or major loss of status in this country.

- Be aware of the influence of past, current, or anticipated experiences of racism on a client’s health, access to care, treatment regimens, and patient-clinician interactions.

2. Common Myths about Cultural Competence

- Myth # 1: There are too many cultures. I cannot possibly learn what I need to know about all of them.

  Cultural competence does not mean learning as many “characteristics” as possible about every culture. The process of cultural competence means that a person:
  1) learns to recognize and reject his or her preexisting beliefs about a culture,
  2) focuses on understanding information provided by individuals within the context at hand, and
  3) foregoes the temptation to classify or label persons with cultural names.

  This process makes cultural competence a more manageable task that avoids fixed, generalized cultural misinformation.

- Myth # 2: I have examined my preconceptions about the various cultures in my clinic community, changed some of my thoughts, and now feel culturally competent to deal with people who might appear in my clinic.

  Cultural competence is not a one-time, finite achievement. It is a process applied in every encounter with a client. It would be dangerous for a person to conclude that he or she has learned what he or she needs to know about certain cultures, has reached the point of cultural competence, or has even identified (i.e., labeled) the different cultures in his or her clinic population. Regardless of the amount learned about a different culture, each individual’s experience within that culture is unique.

- Myth # 3: As a person of color, I know what it means to be culturally sensitive. I don’t need any special training on how to practice cultural competence.

  Each person has different levels of awareness and sensitivity about his or her own and other cultures. Every human being, however, holds preconceptions about “different” cultures. Every person, including a person outside the dominant culture, must use some kind of deliberate, analytical process to examine cultural misinformation and strive for cultural competence in each individual case.
Myth # 4: I need a more concrete way to achieve cultural competence. This process is too "touchy feely" in asking me to become more aware. How do I become aware? How will that make a difference in my cultural competence?

Awareness means knowledge of the existence of a thing, place, idea, etc. The first step toward cultural competence in treating a client is to become aware that you might have stereotypes or preconceptions about the person. Awareness is a complex skill gained over time. Only with greater cultural awareness can anyone reject or avoid acting on preconceived thoughts, obtain new individualized information, and treat the client with cultural competence.

Myth # 5: There are only a couple of cultures that are different from the dominant (American) culture in my clinic.

Culture is not defined exclusively by race and ethnicity. It includes a broad spectrum of identities. Regardless of the perceived diversity or lack of diversity in the community the clinic serves, every provider encounters clients on a daily basis with cultural experiences that differ from this or her own. Using a process to practice cultural competence routinely in every situation can help a provider ensure fair and equal treatment of every client who comes into the clinic.

3. Developing Awareness

The most critical and difficult aspect of cultural competence is developing awareness. A provider needs to consciously, repeatedly ask himself or herself such questions as:

- What are my preconceived ideas about _________ culture? (i.e., what have I heard, observed, discussed, or otherwise perceived?)
- How have I obtained these beliefs?
- How might these beliefs affect my evaluation of:
  - information from a person who appears to belong to the culture or
  - information from a person who claims expertise about the culture?
- How might my preconceived beliefs influence my treatment of this client?
- Will my preconceived ideas or knowledge preclude me from discussing HIV prevention, testing, or treatment with this client?
- Am I open to listening and learning from others who challenge my thoughts, attitudes and actions?

Appendix 6

Becoming Culturally Competent

According to J. Gallegos, becoming culturally competent involves developing an awareness and acceptance of cultural differences, an awareness of one's own cultural values, an understanding of the dynamics of differences in any helping process, and some basic knowledge about the client's culture. Gallegos goes on to discuss these elements further:

**Awareness and Acceptance of Difference**

The first task in developing cross-cultural skills is to acknowledge cultural differences and to become aware of how they affect relationships with others. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. These differences are as important as the similarities. Acceptance of the fact that each culture finds some behaviors, interactions, or values more important or desirable than others can help the individual interact more successfully with members of different cultures. Awareness and acceptance of differences in communication, life view, and definitions of health and family are critical to successful outcomes. The individual develops a dual perspective which in part is dependent on understanding the role of culture in one's own life.

**Self-Awareness**

To fully appreciate cultural differences, individuals must recognize the influence of their own culture on how they think and act. Many people never acknowledge how their day-to-day behaviors have been shaped by cultural norms and values, and reinforced by families, peers, and social institutions. How one defines "family," identifies desirable life goals, views problems, and even says "hello" are all influenced by the culture in which one functions. A purposeful self-examination of cultural influences can lead to a better understanding of the impact of culture on one's own life. Only then can the complexities of cross-cultural interactions be fully appreciated.

**Dynamics of Difference**

What occurs in cross-cultural interactions is termed by Gallegos as the “dynamics of difference.” When an individual of one culture interacts with a client from another, both may misjudge the other’s actions based on learned expectations. Both will bring to the interaction their own unique history with the other group and the influence of current political relationships between the two groups. Both persons will bring culturally prescribed patterns of communication, etiquette and problem solving. Both may bring stereotypes with them or underlying feelings about working with someone who is "different." The minority client may exhibit behaviors that are adjustment reactions to dealing

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with a culturally foreign environment. Without an understanding of their cultural differences, the dynamics most likely to occur between the two are misinterpretation or misjudgment. These dynamics give the cross-cultural interaction a unique character that strongly influences the helping relationship. By understanding these dynamics and their origins, individuals enhance their chances for productive cross-cultural exchanges.

**Knowledge of the Client’s Culture**

Productive cross-cultural interventions are even more likely when those in a helping position make a conscious effort to understand the meaning of a client’s behavior within his or her cultural context. For example, asking the question, “What does the client’s behavior signify in his or her group?”, helps the person assess a client on the norms of the client’s society, not on those of the dominant culture. Specific knowledge about the client’s culture adds a critical dimension to the helping process. Workers must know what symbols are meaningful, how health is defined and how primary support networks are configured. Information that will add to the helper’s knowledge is vital but because of the diversity within groups it is difficult to achieve comprehensive knowledge. Gaining enough knowledge to identify what information is needed as well as knowing who to ask for information is a desirable goal.

**Barriers to Effective Communication**

Much knowledge and understanding of others comes from genuine efforts to communicate face-to-face. Most of us like to believe that we are effective at communicating. Yet, consider that in any encounter with another person, some or all of the factors listed below may be present and true communication, therefore, may never occur:

- Different values and beliefs
- Misunderstandings about the meaning of nonverbal behavior
- Differences in how people look — assumptions made on the basis of appearance
- Vocabulary issues — language, meaning of words, emotion-laden words
- Inability to hear or understand the words being said
- Differences in the way people relate to others based on their culture
- Expectations based on past experience
- Preoccupation
- Fear, perception of threat
- Emotional blocks
- Stereotypes
- Anger, hostility, or defensiveness
- Status differences

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**Appendix 6**

**Becoming Culturally Competent**

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**Integrating HIV Prevention and Family Planning Services**

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- Factors in the physical environment
- The self-concept of either person
- The "climate" of the communication — time constraints, distractions, mood
- The needs of either person

Fortunately, with knowledge and practice, these barriers can disappear.

Consider the following:

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>COMMUNICATION BARRIER</th>
<th>LISTENER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop ideas according to listener’s values and interests; be open to learning about people who are different from you; avoid being judgmental about the listener’s cultural practices.</td>
<td>BELIEFS AND VALUE SYSTEMS</td>
<td>Be open to learning about people who are different; accept differences; avoid making premature judgements about the speaker’s attitude about your culture.</td>
</tr>
<tr>
<td>Be sensitive to the emotional as well as the basic needs of the listener.</td>
<td>NEEDS</td>
<td>Be aware of the goals and purpose of the speaker.</td>
</tr>
<tr>
<td>Be conscious of past experiences in similar situations; think of listener’s past experiences with social workers or public institutions.</td>
<td>PAST EXPERIENCES</td>
<td>Think in terms of similar past experiences and speaker’s past experiences with persons like yourself.</td>
</tr>
<tr>
<td>Confront rather than deny your own stereotypes; be willing to learn something about the other person; help the listener learn something about you.</td>
<td>STEREOTYPING</td>
<td>Ask questions before drawing conclusions about speaker’s lifestyle, beliefs, characteristics and behaviors; be open to learning something about the speaker; share information about yourself with the speaker.</td>
</tr>
<tr>
<td>Be aware of the listener’s mood, attentiveness, and concerns of the household.</td>
<td>PREOCCUPATION</td>
<td>Acknowledge own problems and consciously focus on the speaker. Ask for clarification or meaning of words with emotional messages.</td>
</tr>
</tbody>
</table>
**How to Overcome Communication Barriers (continued)**

<table>
<thead>
<tr>
<th>SPEAKER</th>
<th>COMMUNICATION BARRIER</th>
<th>LISTENER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be aware of the emotional messages a word may convey.</td>
<td>EMOTIONALLY CHARGED WORDS</td>
<td>Ask for clarification or meaning of words with emotional messages.</td>
</tr>
<tr>
<td>Be cautious about how you approach a subject that may offend the listener; remove yourself from a situation if you are angry.</td>
<td>ANGER/HOSTILITY</td>
<td>Avoid escalating the anger; it is more important to listen than to respond angrily; don’t jump to conclusions.</td>
</tr>
<tr>
<td>Recognizing that if a person has a poor self-concept it will interfere with communication; make such a person feel comfortable and relaxed; respect the listener’s self-concept.</td>
<td>SELF-CONCEPT</td>
<td>Respect the speaker’s perception of his or her role in the situation.</td>
</tr>
<tr>
<td>Choose words with the listener in mind; use an interpreter whom worked with before and who is familiar with your speech habits and style.</td>
<td>LANGUAGE</td>
<td>Repeat what the speaker has said in order to check your own understanding; ask questions if speaker uses unfamiliar words.</td>
</tr>
<tr>
<td>Use descriptive and nonjudgmental language; use non-threatening approach; make the listener feel secure and at ease.</td>
<td>DEFENSIVENESS</td>
<td>Feel comfortable and secure about your own capabilities and accept the capabilities of others.</td>
</tr>
<tr>
<td>Keep in mind the listener’s status and role in the family and community.</td>
<td>STATUS</td>
<td>Think of the speaker in terms of his or her qualifications and abilities.</td>
</tr>
</tbody>
</table>

Becoming culturally competent is a developmental process for each person. It is not something that happens because one reads a book, attends a workshop or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to take risks.

Once we ourselves begin to identify what we value, how our culture influences what we value, and how our values drive our decisions, then we can begin to understand others, and we can provide the same opportunities for our volunteers through training.

*Reproduced with permission from National CASA (Champions for Abused Children). Prepared by NCASAA Staff.*

**Cross-cultural:** Processes, communication, etc., involving two or more cultural groups; often implies the bridg-
Appendix 7

Important Terms

ing of a gap between the groups

**Culture (broad meaning):** all that people have learned and shared, including skills, knowledge, language, values, perceptions, motives, symbols, etc.

**Culture (narrow meaning):** the dynamic patterns of learning behaviors, values, or beliefs exhibited by a group of people who share historical and geographic proximity

**Cultural awareness:** Being cognizant, observant, and conscious of similarities and differences among cultural groups

**Cultural sensitivity:** Understanding the needs and emotions of your own culture and the culture of others

**Ethnic:** Of, or relating to, large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background

**Ethnicity:** Ethnic quality or affiliation

**Interpretation:** refers to the spoken word; receiving a message in one language and delivering exactly the same message in another language through a verbal exchange (includes sign language and body language messages)

**Medical interpretation:** refers to the spoken word; the conversation between provider and client is interpreted within the medical context, with a specific emphasis on the ability to use and explain medical terms in both languages

**Multicultural:** Designed for or pertaining to two or more distinctive cultures

**Race:** A social construct used to separate the world’s people. There is only one race, the human race, comprised of individuals with characteristics that are more or less similar to others
**Racism:** A complex system of beliefs, social norms, and laws based on the premise that some human population groups are inherently superior or inferior to others because of genetically transmitted characteristics.

**Stereotypes:** Rigid preconceptions about all members of a particular group, whether defined along racial, religious, sexual, or other lines. The belief in a perceived characteristic of the group is applied to all members without regard for individual variations.

**Translation:** refers to the written word; materials written in one language are translated into another. Casual or improper translation can result in misuse of terms or misunderstanding of contextual information in the new language.

Sources: Tawara D. Goode, Georgetown University Child Development Center, Center for Health and Mental Health Policy; National CASA Association; Durham et al, Interpreting Services Manual, University of Massachusetts Medical Center; Julio Dicent Taillepierre, City of Minneapolis Interdepartmental New Arrivals Work Group, Welcoming New Arrivals to Minneapolis: Issues and Recommendations.
Appendix 8
Office for Civil Rights Policy Guidance for Limited English Proficiency (LEP) Persons

Title VI of the Civil Rights Act of 1964 and its supporting regulations seek to ensure that no person is subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal funding. The August 30, 2000 Office for Civil Rights (OCR) Policy Guidance clarifies the responsibilities of providers of health and social services who receive Federal financial assistance from the U.S. Department of Health and Human Services (HHS) (“recipients,” “providers,” or “covered entities”), and provides guidance in fulfilling responsibilities to Limited English Proficient (LEP) persons, pursuant to Title VI of the Civil Rights Act of 1964. The policy guidance reiterates HHS’ longstanding position that in order to avoid discrimination against LEP persons on grounds of national origin, health and social service providers must take adequate steps to ensure that such persons receive free of charge the oral and written language assistance necessary to afford them meaningful access to services. The policy guidance specifically states that the use of family members and friends as interpreters is not considered an adequate means of guaranteeing such access.

The policy guide states that there is no “one size fits all” solution for Title VI compliance with respect to LEP persons. The OCR will make its assessment of the language assistance needed to ensure meaningful access on a case by case basis, and a recipient/covered entity will have considerable flexibility in determining precisely how to fulfill this obligation. The OCR will focus on the end result—whether the recipient/covered entity has taken the necessary steps to ensure that LEP persons have meaningful access to its programs and services. The key to providing meaningful access for LEP persons is to ensure that the recipient/covered entity and LEP person can communicate effectively. The steps taken by a covered entity must ensure that the LEP person is given adequate information, is able to understand the services and benefits available, and is able to receive those for which he or she is eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of his or her situation to the service provider.
The OCR has found that effective programs usually have the following four elements:

- **Assessment**
  The recipient/covered entity conducts a thorough assessment of the language needs of the population to be served.

- **Development of Comprehensive Written Policy on Language Access**
  The recipient/covered entity develops and implements a comprehensive written policy that will ensure meaningful communication.

- **Training of Staff**
  The recipient/covered entity takes steps to ensure that staff members understand the policy and are capable of carrying it out.

- **Vigilant Monitoring**
  The recipient/covered entity conducts regular oversight of the language assistance program to ensure that LEP persons meaningfully access the program.

*Source: Providers Guide to Quality and Culture: Culturally Competent Organizations.* 
(http://erc.msh.org/mainpage.cfm?file=9.3.htm&module=provider&language=English)
Appendix 9

Federal Laws Related to Language Assistance

**Title VI of the Civil Rights Act of 1964:** “No person in the United States shall, on 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.” Any agency or organization that receives federal funding must provide services and information in appropriate language access for persons of limited English proficiency in all programs and services, at their own expense. These laws apply to Title X family planning clinics, whether their federal funding is received directly or through a state or local agency. This requirement is interpreted to mean that translation services are to be provided for all clients who do not speak English. The Department of Health and Human Services, Office of Minority Health has put forth a set of mandates that relate to this federal law.

**The Hill-Burton Act:** Enacted by Congress in 1946, the Hill-Burton Act encouraged the construction and modernization of public and nonprofit community hospitals and health centers. Facilities that have received federal funds under this act are obliged to make services available to all persons without discrimination on the basis of race, color, or national origin. This includes the obligation to provide language assistance to those who need and to notify patients that interpretive services are available.

**Medicaid:** This Federal-State cooperative program of medical assistance provides health insurance to adolescents, children and families who are poor; people with disabilities, and those who are indigent and elderly. Medicaid regulations require Medicaid providers and participating agencies to render culturally and linguistically appropriate services.

**Other federal laws that may apply to some family planning services:** Medicare; Federal Categorical Grant Programs; Emergency Medical Treatment and Active Labor Act. Most of these laws govern treatment in hospitals and emergency rooms.

*Adapted from “It’s the Law!” by Tawara Goode et al. Policy Brief 2. National Center for Cultural Competence, Bureau of Primary Health Care Component, January 2001*
Appendix 10

Title X Clinics’ Experience Providing Language Assistance Services: Strategies

Innovative Language Assistance Services and Strategies Adopted by Title X clinics

- **Development of a strategic partnership with an area hospital**
  One of the clinics studied has established a strategic partnership with an area hospital to provide the clinic with bilingual physicians fluent in various languages. The agreement stipulates that all clients requiring follow-up care be referred to the hospital and assigned to a provider who speaks the client’s language.

- **Design of clinic services based on findings from client and community focus groups**
  One clinic designed all of its clinical services based on the results of multiple focus groups conducted with community members and clients. Some design considerations included the clinic’s location, its architecture, theme of art work displayed, size of in-take and examination rooms, and the use of an appointment line that is not menu-driven.

- **Interpretation using teleconference technology**
  One clinic has adapted teleconference technology to provide language assistance to LEP clients. The clinic uses its language bank to identify individuals fluent in the language required for interpretation and links the client and interpreter via a high-speed Internet connection that transmits simultaneous video and audio signals.

- **Remote telephone interpretation**
  LEP clients who require language assistance at one clinic are provided with in-house interpreters trained in medical interpretation who are in a centralized location. High-quality interpretation is provided via a speakerphone and dual headsets, which are used to minimize concerns over confidentiality.

- **Mobile health van**
  A family planning clinic that serves a rural population provides language assistance to difficult-to-reach LEP clients using a health van staffed by bilingual providers, medical assistants, and intake personnel.
Provider training in communicating through an interpreter.
To increase the quality and effectiveness of interpreting encounters, a family planning clinic’s delegate provides in-house training for physicians and nurse practitioners on how to correctly use an interpreter during an examination.

Off-site interpreter program.
Staff from one clinic provide language assistance to LEP clients throughout all phases of the clinical visit, and even accompany the client off-site for follow-up care.

Adapted from “Limited English Proficiency as a Barrier to Family Planning Services” Final Report. Executive Summary. COSMOS Corp. for the U.S. Department of Health and Human Services Office of Population Affairs. March 2003. From a review and assessment of the language assistance services and activities being provided to limited English proficient (LEP) individuals in seven Title X-funded family planning clinics.
## Appendix 11

**Title X Clinics’ Experience Providing Language Assistance Services: Costs**

<table>
<thead>
<tr>
<th>Method of Providing Language Assistance</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpretation</strong></td>
<td></td>
</tr>
<tr>
<td>Bilingual Staff</td>
<td>$18-$87k/year*</td>
</tr>
<tr>
<td>Staff Interpreters</td>
<td>$27-$57k/year + stipend ($50-$500/month)</td>
</tr>
<tr>
<td>Contract Interpreters</td>
<td>$35-$40/hour</td>
</tr>
<tr>
<td>Language Line</td>
<td>$2.50-$4.50/minute ($50-$60/call)</td>
</tr>
<tr>
<td>Remote Telephone Interpretation</td>
<td>$20-$30/call**</td>
</tr>
<tr>
<td>Volunteer Interpreters</td>
<td>$250-$650/volunteer***</td>
</tr>
<tr>
<td>Interpretation via Teleconference</td>
<td>$5-$15k/connection + interpreter fees</td>
</tr>
<tr>
<td><strong>Translation</strong></td>
<td></td>
</tr>
<tr>
<td>On-site Translation</td>
<td>$30-$50k/year + stipend ($50-$150)</td>
</tr>
<tr>
<td>Outsourced Translation</td>
<td>$0.12-$0.25/word</td>
</tr>
</tbody>
</table>

* Salary range based on clinic administrators’ estimates.
** Average call estimate based on anecdotal information presented by clinic staff at Santa Clara Valley Health and Hospital System.
*** Estimate includes cost of providing training in medical interpretation.
### Estimated Average Time Difference For The Treatment Of LEP and Non-LEP Clients, By Clinic*

<table>
<thead>
<tr>
<th>Phase of Clinic Visit</th>
<th>Intake</th>
<th>Exam &amp; Treatment</th>
<th>Follow-up Care/Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-LEP</td>
<td>LEP</td>
<td>Diff.</td>
</tr>
<tr>
<td>Clinic 1</td>
<td>20</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>15</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>15</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Clinic 4</td>
<td>20</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>Clinic 5</td>
<td>20</td>
<td>45</td>
<td>25</td>
</tr>
<tr>
<td>Clinic 6</td>
<td>20</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Clinic 7</td>
<td>15</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>18</td>
<td>34</td>
<td>16</td>
</tr>
</tbody>
</table>

*Time estimates are expressed in minutes and are based on estimates reported by staff involved in different phases of a family planning visit. Estimates for intake were provided by front-line personnel (e.g., receptionists, medical assistants, etc.) and are based on a first visit. Exam and treatment estimates were presented by providers (e.g., nurses, nurse practitioners, and physicians) based on a clinical visit where a procedure had been scheduled. Follow-up estimates were provided by both providers and intake staff.

Reprinted from “Limited English Proficiency as a Barrier to Family Planning Services.” Final Report, Executive Summary, COSMOS Corp. for the U.S. Department of Health and Human Services Office of Population Affairs. March 2003. From a review and assessment of language assistance services and activities being provided to limited English proficient (LEP) individuals in seven Title X-funded family planning clinics.
## Appendix 12

Title X Clinics’ Experience Providing Language Assistance Services: Lessons

<table>
<thead>
<tr>
<th>Method of Delivering Language Assistance</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual Staff</td>
<td>• Expedited appointments</td>
<td>• Confidentiality can be compromised</td>
</tr>
<tr>
<td></td>
<td>• Able to ask questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feel less dysfunctional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td></td>
</tr>
<tr>
<td>Telephone Interpreters</td>
<td>• More privacy during exams</td>
<td>• Limited privacy</td>
</tr>
<tr>
<td></td>
<td>• Expedited appointments</td>
<td>• Feel rushed</td>
</tr>
<tr>
<td>Face-to-Face Interpretation</td>
<td>• Able to ask questions</td>
<td>• Impersonal</td>
</tr>
<tr>
<td></td>
<td>• Body language exchanged</td>
<td></td>
</tr>
<tr>
<td>Translated Client Education Materials</td>
<td>• Provide good visuals</td>
<td>• Lack new contraceptive methods</td>
</tr>
<tr>
<td></td>
<td>• Used for reference</td>
<td></td>
</tr>
<tr>
<td>Multilingual Signs</td>
<td>• Orient clients to clinic services</td>
<td>• Do not help clients with low literacy</td>
</tr>
<tr>
<td></td>
<td>• Inform clients of their right to</td>
<td>• Restricted to 3 languages</td>
</tr>
<tr>
<td></td>
<td>language assistance</td>
<td></td>
</tr>
<tr>
<td>Multilingual Videos</td>
<td>• Provide good visuals</td>
<td>• Language too technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cannot be referenced</td>
</tr>
</tbody>
</table>

*Applies only to contract interpreters.


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