

# EXECUTIVE REPORT and RECOMMENDATIONS

## *2007 Women's Health Policy Summit*

### **Building Multicultural Women's Health:**

### **Setting an Agenda for Los Angeles**

Convened by the Los Angeles County Department of Public Health, Office of Women's Health  
and Collaborating Organizations



COUNTY OF LOS ANGELES  
**Public Health**

Office of Women's Health

# foreword

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## *Dear Friends and Colleagues,*

The 2007 Women's Health Policy Summit, *Building Multicultural Women's Health: Setting an Agenda for Los Angeles*, was held on May 24, 2007 with the specific goal of identifying gaps in current health care trends and proposing future steps that will improve the health status of women in Los Angeles County.

The summit successfully brought together over 400 women's health care leaders, experts, providers, researchers, and advocates to serve as the impetus to improve the health status of women, especially low-income women and women of color.

The short-term policy recommendations developed by the ten workgroups present a variety of priorities including the formation of public and private collaboratives, comprehensive data collection, public and provider education, and targeted programs and initiatives. We envision these recommendations will serve as a blueprint to improve women's health and decrease the disparities that currently exist.

This executive report was compiled to provide a contextual overview of each workgroup and to showcase the recommendations. It is hoped that this report, created for funders, legislators, advocates and key stakeholders, will be used to help prioritize where new policies and funding is most needed. A comprehensive implementation plan to move the recommendations forward over the next few years is in motion and should culminate in effective programs and policies, and work towards the elimination of health disparities.

Your ongoing participation in improving the health care of women in Los Angeles County is greatly appreciated.

Sincerely,



Jonathan E. Fielding, MD, MPH  
Director of Public Health and Health Officer



Ellen Eidem, MS  
Director, Office of Women's Health



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This executive report was written and edited by the  
2007 Women's Health Policy Summit workgroup leaders and the Office of Women's Health.  
Workgroup photos may not be representative of a specific workgroup.

Graphic Design by Luci Kwak

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# 2007 Women's Health Policy Summit

## Building Multicultural Women's Health: Setting an Agenda for Los Angeles

### INTRODUCTION

#### A Brief Summit History

In 1997, the Los Angeles County Commission for Women with the support of the Board of Supervisors convened the first L.A. County Women's Health Policy Summit which resulted in recommendations to improve the health status of women. Included was a recommendation to create an Office of Women's Health (OWH) which became a reality in 1998. In 1999, the OWH convened a second Summit to discuss best practices in women's health.

The 2007 Women's Health Policy Summit was charged with identifying current gaps, trends, and future steps to improve the health status of women, especially low-income women of color.

*Building Multicultural Women's Health: Setting an Agenda for Los Angeles*, an all day interactive conference, brought together over 400 women's health leaders for a dialogue around some of today's most pressing women's health issues to determine the most realistic and effective ways to improve women's health in Los Angeles County in the next two years.

The charge was to develop short term priority policy recommendations that will reduce health disparities and improve health outcomes for women in Los Angeles County, especially low-income women of color. The morning panel, *Achieving Equitable Health*, featured a diverse panel of experts who provided a context for building multicultural women's health. Keynote speaker Dr. Vivian Pinn, Director of the Office on Women's Health Research at the National Institutes of Health, outlined the successes we have achieved in women's health and the challenges and opportunities we continue to face.

Ten different breakout workgroups, each facilitated by leaders in the field, focused on the intersections of women's health issues and the social and environmental determinants of health. The result of the workgroups' efforts was priority recommendations aimed at improving the health of women in Los Angeles County. An afternoon Listening Panel of funders, policymakers, and other key decision-makers commented on key recommendations from each workgroup.

In addition to the panels and workgroups, the Summit included a Poster Session highlighting Promising and Innovative Practices in community-based and grassroots organizations that are successfully addressing health disparities.

A video on Building Multicultural Women's Health was shown, featuring seven Los Angeles County women's health leaders who provided information on the causes and effects of health disparities and the importance of providing culturally and linguistically-competent healthcare for all.

The Summit was also the forum for the release of "Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Insurance Status," the first report developed by the Los Angeles County Department of Public Health dedicated solely to examining the key indicators of health for women.

## Overarching Issues Identified in Recommendations

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A total of 48 priority recommendations were developed at the 2007 Summit. Although each workgroup addressed distinctly different issues, several common themes were identified among the recommendations, highlighting some of the overarching issues that are critical to consider in reducing health disparities among women in Los Angeles County.

**Access** – Improve access to health care by addressing barriers such as cost, limited public information on service availability, the lack of culturally and linguistically-appropriate services, and inadequate transportation needs for the elderly and women with disabilities.

**Data Collection** – Increase the availability of data in several health areas including violence, adolescents, immigrant health, lesbian, bisexual and transgender health, and influences of the environment on reproductive health.

**Public and Professional Education** – Provide health education to the public through media campaigns and school-based programs, to health care professionals using CME opportunities, and to lay health workers with trainings on various topics including cultural competency and health disparities.

**Dedicated Staff Time** – Increase the number of public health staff dedicated to working in areas that have traditionally received little attention such as the intersection of environmental health and reproductive health justice, immigrant health rights, women with disabilities and lesbian, bisexual and transgender health.

**Local Community Collaborations** – Establish and support collaborations with communities such as advisory boards and neighborhood councils to encourage local community involvement in health promotion.

**Funding Opportunities** – Update funding agencies about important health issues that require increased funding in order to establish connections and encourage dialogues between funders and appropriate agencies or organizations in need of funding.

**Legislative Action** – Establish and pursue policy recommendations around key health issues such as universal health care and the effects of the environment on violence and reproductive health.

The recommendations in this report are intended to be utilized by health care stakeholders, funders and policymakers to generate funding, programs, and policies that work to eliminate health disparities and better address the needs of multicultural women's health.

An implementation plan is being developed by the Summit Leadership Task Force consisting of Summit Planning Committee members, workgroup leaders, and the Office of Women's Health and their advisory body, the Women's Health Policy Council.

For more information, please contact the Office of Women's Health at 626-569-3850 or visit the website at <http://www.lapublichealth.org/owh> or [preventionmatters.org](http://www.preventionmatters.org).

# photos

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*2007 Women's Health Policy Summit*

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**Building Multicultural Women's Health: Setting an Agenda for Los Angeles**

**R E C O M M E N D A T I O N S**

# Workgroup 1

## Healthy Aging & the Social Determinants of Health

### Workgroup Leaders

Janet Frank, DrPH, MS, Assistant Director for Academic Programs, Geriatric Medicine and Gerontology; Adjunct Assistant Professor, UCLA School of Public Health

Michelle Geller, MD, Assistant Clinical Professor of Medicine, Harbor-UCLA Medical Center

Monika White, PhD, President and CEO, Center for Healthy Aging

Antronette Yancey, MD, MPH, Associate Professor, Department of Health Services and Co-Director, Center to Eliminate Health Disparities, UCLA School of Public Health

### Challenges to Aging Healthfully

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There are a number of factors that impact a woman's ability to age healthfully:

- **Socioeconomic Factors**

Women tend to live longer than men, and the majority of the elderly are women. Women more often live below the poverty level, and more often live alone. Only 42% of older women are married while 72% of older men are married.

- **Caregiving**

Older women provide the majority of caregiving to older adults who are frail and/or disabled. The burden of caregiving is a major determinant of health/mental health problems. Research shows that women who are caregivers have a greater incidence of depression, increased harmful behaviors, increased risk of heart disease, lower levels of self-care such as physical activity, and increased mortality.

- **Access to Care / Transportation Barriers**

Older women, especially those who live alone, require community-based services such as accessible medical care, supportive care and transportation assistance. In Los Angeles in particular, services for the ACCESS program (complementary paratransit program for functionally-disabled individuals) are often restricted to certain geographic areas for pick up and drop off. More flexible boundaries would make it easier for older people to travel across city and other jurisdictional boundaries that are quite meaningless when acquiring needed services.

- **Health Disparities**

Many factors are rooted in the early family environment and based on systematic racial and ethnic group discrimination that is experienced over a lifetime. Health status disparities exist between non-Latino whites and different groups of minority elderly for a number of acute and chronic conditions, disability, and mortality. Research has attempted to explain these disparities by examining the role of factors such as social and economic status, neighborhood effects, racism, culturally and situation-influenced health behaviors, the interaction of genetics with environmental causes, and medical care inequities. While additional research to document elderly health disparities and identify their causes is needed, the largest knowledge gap involves developing effective interventions and strategies that reduce those disparities among the elderly.



## Need for Provider Education and Workforce Diversity

The rapid aging and diversification of our older population brings a demand to address the current deficits in training in gerontology and geriatrics among health and social service professionals, and for a well-prepared faculty to teach future care providers. Due to the increasing racial and ethnic diversity of older adults, the workforce that will be prepared to serve them must be increasingly multilingual, culturally competent, and optimally reflect the racial and ethnic composition of the older people they serve.

### RECOMMENDATIONS

#### #1 - MOBILITY AND INDEPENDENCE

Create a Joint Subcommittee to improve and expand transportation services for the elderly and disabled addressing three areas: assess regulations that restrict the ACCESS program, flex the boundaries that currently exist, explore existing alternative models by May 2008, and pilot a program by May 2009.

#### #2 - RESOURCES FOR CAREGIVERS AND ELDERLY

Form a collaborative of Los Angeles County departments to develop a strategic multi-lingual campaign that utilizes communication, social enterprise, public relations, social marketing, and existing media outlets to increase knowledge of caregiver and elderly resources. Additionally, the collaborative will identify what resources exist and what is under-utilized and develop and launch a website that will connect caregivers with the existing services available to them. The website will be publicized during the media campaign. Collaborative will also identify funding and resources by May 2008, and produce and deploy four PSAs in commercial TV in at least two languages by May 2009.

#### #3 - ADVISORY BOARD

Identify various programs within the county that serve the aging population and develop an advisory board to meet and discuss current issues including access to services, eligibility criteria, service quality and gaps in resources.

#### #4 - REGIONAL TRANSPORTATION

Create a regional transportation service for elderly/disabled using the Independent Transportation Network America as a model. Also identify other alternative models.



## Workgroup 2

# Reproductive Health & the Environment

### Workgroup Leaders

Martha Arguello, Director, Health & Environmental Programs, Physicians for Social Responsibility

Rocio L Córdoba, JD, Executive Director, California Latinas for Reproductive Justice

Tracey Woodruff, PhD, MPH, Director, Program on Reproductive Health & Environment, UCSF

### Worrisome Trends

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In the US, there are worrisome health trends among women and their children. For example, at least 12% of the reproductive age population reports difficulty in conceiving and maintaining pregnancy. This appears to be increasing, most markedly in women under 25 years old. In addition, other fertility-related diseases like endometriosis and polycystic ovarian syndrome are diagnosed more frequently now, which may result from an increase in prevalence, better detection, or both. There are also increasing trends in adverse health effects in infants.

### Cause and Effect in Vulnerable Populations

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Research indicates that environmental contaminants are likely to be playing a role in these disturbing trends. Center for Disease Control data shows exposures to chemicals like phthalates, bisphenol A, and perfluorinated compounds are common and almost every person has detectable contaminants in their bodies - some at levels near or above those shown in scientific studies to cause adverse effects.

Conception, pregnancy or infancy are “windows of vulnerability” and exposures to chemical contaminants around these times can be particularly harmful.

- ✦ **Bisphenol A**, found in polycarbonate plastic and can linings. Exposure early in life can cause permanent changes and increased risk of infertility, miscarriage, and breast cancer.
- ✦ **Phthalates**, found in personal care products and vinyl products. Prenatal exposure has been linked to reproductive effects in male babies like undescended testicles and deformities of the penis.
- ✦ **Cadmium**, a metal found in cigarette smoke and in the air, has been linked to gynecological disorders in women, such as endometriosis.
- ✦ **PFCs (perfluorinated chemicals)**, common in stainproof and stick-free products. Prenatal exposures in animals can result in irreversible damage in offspring.

Health effects do not only manifest in the exposed. They are starting to show up in the children of exposed mothers, fathers and grandparents, passing from one generation to the next.

### Building Alliances with Reproductive Justice Organizations

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Building alliances between reproductive justice and environmental justice advocates is a clear example of the cross-issue/cross-movement work made possible by adopting a reproductive justice framework. Systemic policy and social change addressing women’s intersecting social, economic, environmental and health concerns is vital to promoting reproductive justice while furthering disenfranchised communities’ health, progress and opportunities.

## Necessary Steps

To address increasing concern about the potential impact of environmental contaminants on reproductive health, additional chemical testing, research, public information and awareness, professional education, alliance-building, advocacy and policy changes are critically needed to reduce exposure to hazardous chemicals.

### RECOMMENDATIONS

#### #1 - CHEMICAL POLICY REFORM

Assign a dedicated Los Angeles County Department of Public Health (LAC-DPH) program staff to work on the intersection of environmental health and reproductive justice issues. This person would help convene and facilitate key partners in the environmental health and reproductive justice communities to develop a concrete work plan that promotes the adoption of a comprehensive chemical policy reform in California that is directly related to promoting positive reproductive and environmental health and justice outcomes.

#### #2 - FURTHER RESEARCH

To develop an understanding of how the environment affects women's health, it is recommended that the LAC-DPH collect additional data on environmental health exposures and risks that impact reproductive health and birth outcomes such as proximity to freeways and other sources of environmental toxicants. Ensure that this data is used as indicators of women's health and addresses racial, ethnic and economic disparities facing the most underserved women and families.

#### #4 - TOWN HALL MEETING

Hold an informational public hearing featuring key stakeholders who will link the issues of environmental health and reproductive justice and make policy recommendations.

#### #5 - EDUCATION AND TRAINING

LAC-DPH programs working on women's reproductive health issues should partner with existing environmental health and reproductive health justice groups to increase educational opportunities on environmental health and reproductive health issues, such as grand rounds, CME opportunities, trainings for promotoras and within existing community-based sexual health education programs.

#### #3 - EDUCATE FUNDERS

Educate private and public funders about the need to support cross issue movement building between reproductive and environmental health and campaigns to promote environmental health and reproductive justice.



## Workgroup 3

# Universal Health Care & Women's Health

### Workgroup Leaders

The Honorable Abbe Land, Councilmember, City of West Hollywood  
Co-CEO, The Los Angeles Free Clinic

Barbara Masters, Public Policy Director, The California Endowment

Alina Salganicoff, PhD, Vice President and Director, Women's Health Policy, Kaiser Family Foundation

### The Importance of Health Coverage for Women

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Health coverage plays a critical role in improving women's access to care and health outcomes.

To make health care reform meaningful, we need to make sure women's health issues are appropriately addressed.

- Women's economic disadvantage relative to men and disproportionate reliance on publicly-funded health programs makes coverage critical.
  - 2.5 million women are uninsured in California. Women of color, low-income and foreign-born women are at high risk for being uninsured.
  - In California, uninsured women are distributed across the age span, nearly two thirds are low-income, and two thirds are in a family where there is at least one full time worker.
- Health care costs are increasingly a problem for all women. Problems with affordability can limit access to care for uninsured women as well as women on Medicaid and those with private insurance.
- Women with health coverage are more likely to obtain needed preventive, primary and specialty care services, have better access to many of the new advances in women's health, and better health outcomes, such as survival rates after cancer diagnosis. In contrast, uninsured women are more likely to postpone care, forgo filling prescriptions, and often delay or go without important preventive care such as mammograms and Pap tests, leading to poorer health outcomes and excess mortality.

### Key Policy Considerations for Women

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- Affordability – health care costs are a major challenge for many women.
- Availability of premium subsidies for low-income women who may lack the means to purchase their own coverage.
- Cap out-of-pocket expenses for women with unmanageable health expenses.
- Scope of Benefits – continuous comprehensive services are important for all women, regardless of age or health status. Comprehensive services may include preventive care, health education, inpatient hospitalization, outpatient services, reproductive health, dental, vision, mental health, prescription drugs, and care coordination.
- Access – economic, social and logistical barriers can make it difficult for many women to access and utilize a full range of health care services.

- Health Care Systems and Quality – Research has demonstrated that uninsured women often get a lower standard of health care. It is necessary to maintain oversight of systems and processes to include quality improvement, performance measurement, and program monitoring.
- Safety Net - even with health care reform, there is still a potential for many women to fall through the cracks in the system, so protection of the health care safety net is critical.

## RECOMMENDATIONS

Fundamental principles that must be included in any comprehensive health plan.

### #1 - MANDATORY COVERAGE

All women living in California must be covered regardless of immigration status.

### #2 - COST SHOULD NOT BE A BARRIER

Affordability is an issue and should not be a barrier to care, especially for low-income women. Share of cost, monthly premiums, and other approaches should be explored.

### #3 - QUALITY AND WELLNESS-FOCUSED

Quality health coverage must be wellness-focused and include, at a minimum, medical, dental, mental health, full reproductive services, and prevention and educational programs. Care should be evidence-based when appropriate.

### #4 - SIMPLE SYSTEM

System must be simple, streamlined, accessible and easy to understand. Consideration should be given to Ombudsman and patient advocate approaches and other similar programs.

### #5 - AVAILABLE SAFETY NET SERVICES

Safety net services must be available, and any plan provider must offer and be compensated for those services.



## Workgroup 4

# Adolescence & Healthy Relationships

### Workgroup Leaders

Cynthia Davis, MPH, Program Director, University HIV/AIDS Education and Outreach Projects, Charles R. Drew University of Medicine and Science

Sarah Guerry, MD, Medical Director, STD Program, LA County Department of Public Health

Susan Rabinovitz, RN, MPH, Associate Director, Division of Adolescent Medicine, Childrens Hospital, Los Angeles

During the transition from childhood to adulthood, adolescents develop patterns of health behavior and make lifestyle choices that affect both their current and long-term health and well-being. Adolescent girls are often adversely affected by serious health issues such as violence, substance use, and risky sexual behavior, and factors such as family support, peer group behavior, school environment, and community characteristics significantly contribute to girls' health outcomes. More age- and gender-specific data are needed to better assess and monitor adolescent health.

### Facts about Adolescents

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- ✦ Sexually active adolescent and young adults bear some of the greatest burden of STDs in Los Angeles County and nationally.
  - ✦ More than 60% of all Chlamydia cases, half of all gonorrhea cases, and 75% of new HPV infections occur in 15 – 24 year olds.
- ✦ Seventy-four to 95% of teen pregnancies are unintended.
- ✦ More than 60% of high school seniors in the U.S. report ever having sexual intercourse. Among sexually active U.S. high school students, 55% of girls and 70% of boys reported using a condom the last time they had sex.
- ✦ While both females and males may suffer dating violence, girls in heterosexual relationships are more likely to be injured, more likely to be sexually assaulted, and more likely to suffer emotionally than their heterosexual male peers.
- ✦ Adolescent girls are the fastest growing population in the juvenile justice system – they are mainly girls of color from low-income neighborhoods, and have often experienced interpersonal, familial, and/or sexual violence.
- ✦ Suicide is the 3rd leading cause of death for youth 15 – 24; four times as many boys die by suicide, but girls make attempts more often and report more depression.

### Factors that Promote Risky Behavior and Negative Outcomes in Adolescent Girls

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- ✦ **Poverty** - lack of insurance and transportation, high unemployment and crime rates, and minimal social and community services available.
- ✦ **Loss or absence of a protective family** is often associated with a history of sexual abuse, victimization, and/or witnessing domestic violence.
- ✦ **Inadequate and unsafe school environments** - lack of comprehensive health education, limited opportunities for educational or career success, lack of meaningful, engaging extracurricular activities, and violence.
- ✦ **Limited access to teen-friendly services** - lack of confidentiality, inconvenient locations, limited availability after-school or on weekends, and limited female-responsive services.

In order to have the most positive impact on adolescent health, youth, their parents, government, community organizations, schools, and other community members must work together to ensure that adolescent girls have access to female-responsive services, and opportunities for educational and career success, positive relationships with caring adults, and meaningful involvement in their communities.

## RECOMMENDATIONS

### #1 - GIRLS COUNCIL

Within two years, establish a Girls Council with dedicated staff support from the appropriate LAC-DPH program that will advise and assist with implementing adolescent-focused programs and campaigns. The Girls Council should be representative and geographically and ethnically-diverse while also including girls from the juvenile justice, foster care, and mental health systems.

### #2 - COMPREHENSIVE HEALTH EDUCATION

Mandate comprehensive health education that will utilize evidence-based programs and scientific knowledge for grades K-12; With the acknowledgement that the antecedents of risky behavior are often similar for many adolescent health issues, the curriculum will build core competencies including lessons on healthy living, nutrition, dating violence and communication. Education to be offered during school hours and in after-school programs.

### #3 - YOUTH DEVELOPMENT ACTIVITIES

Mandate that all schools provide meaningful, extracurricular activities to be offered during school hours and after-school. Expand youth development activities in community settings. All activities should engage youth in positive, meaningful ways; include opportunities for youth leadership development; offer youth relationships with caring adults; incorporate youth feedback into the design of programs; expose youth to new opportunities; and build competencies for employment and education. Activities should also engage parents and offer opportunities for parent involvement, skill-building, and leadership development.

### #4 - YOUTH LEADERSHIP IN SCHOOLS

All public schools should support youth leadership, build youth competencies, and promote positive youth development on campus and in the community. Schools should offer meaningful ways for youth to be involved in reviewing curricula and school calendars; designing extracurricular activities; educating their peers and developing campus-wide campaigns to promote adolescent health; and contributing to local communities. Students participating in leadership activities should be inclusive of all youth on campus, including marginalized youth such as gay, lesbian, bi-sexual and transgender youth, youth in the foster care system, and youth on probation.

### #5 - TEEN HEALTH "SCORE CARD"

Within one year, form a collaborative consisting of public agencies and private hospitals to review and identify data elements to track, research, evaluate, and publish. Within two years, the collaborative will develop a teen health "score card" using data from government and community agencies to track assets and risks.



## Workgroup 5

# Immigrant Women & Health

### Workgroup Leaders

Miya Iwataki, Director, Office of Diversity Programs, LAC Department of Health Services  
Gerrie Rosen, PhD, Director of Refugee Safehaven, African Community Resource Center  
Beatriz Solis, MPH, PhD, Senior Regional Program Officer, The California Endowment

### Key Health Issues Faced by Immigrant Women

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- ✦ In addition to the health issues experienced by most women, immigrant women also experience health issues rooted in conditions related to domestic violence, rape, experiencing war and living in refugee camps, sweatshop labor, domestic servitude and agricultural labor. Immigrant women and their health are frequently overlooked and undervalued.
- ✦ Culture and language are key health issues for immigrant women, and often make the difference in access and quality of care. Language barriers have made the availability of trained health care interpreters a necessity.
- ✦ Immigrant women bring with them traditional beliefs, attitudes and practices related to health.
- ✦ Immigrant women who are refugees or asylees face even more complex health and cultural issues including culturally inappropriate INS health assessments, poor hygiene and spread of disease from living in overcrowded camps, rape and Post-Traumatic Stress Disorder.

### Immigrant Women and Trafficking

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- ✦ There is an over-representation of women among “survival” migrants. The U.S. State Department estimates that females make up 80% of trafficked individuals.
- ✦ Trafficking is not limited to commercial sex work and includes domestic servitude, sweatshop labor, agricultural labor, military conscription, and begging.
- ✦ Post-trafficking health issues include fatigue and weight loss, neurological and gastrointestinal problems, sexual and reproductive issues and many others.

### What Recent Research Tells Us

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- ✦ The foreign-born population in Los Angeles continues to grow: Asian – 66%, Latino – 49%, Pacific Islanders – 27%, White – 15%, Black - 6%.
- ✦ Needed resources remain insufficient, with over 49% of LA women living below 200% of the Federal Poverty Level.
- ✦ In 2006, LA County Department of Health Services (DHS) provided health services for 3,954,922 patient visits. Almost three-fourths of DHS patients were uninsured.
- ✦ Over two million DHS visits were immigrant patients representing over 98 different languages and speaking little or no English.



- Disaggregation of health data for ethnically-diverse populations such as Asians and Pacific Islanders is needed for accurate understanding and program planning.
- Immigrants are less likely to access preventive care services. Emergency care use among immigrant households is low, despite poorer health status, especially among children.

The health needs of immigrant women are often complicated by traumatic life experiences and fear of authority as well as cultural and linguistic barriers. Culturally and linguistically-appropriate outreach is essential for services to be utilized.

## RECOMMENDATIONS

### #1 - VALUE STATEMENT AND RELATED MEDIA CAMPAIGN

Los Angeles County Department of Health Services (LAC-DHS) should issue a statement ensuring that all individuals who reside in Los Angeles County are valued, their health is valued and that they should have equal access to health care. Additionally, this statement and overall message should be developed into a funded multilingual media and outreach campaign utilizing ethnic media channels.

### #2 - IMPLEMENT CULTURAL AND LINGUISTIC STANDARDS

Implementation of DHS Cultural and Linguistic Standards across all Los Angeles County health care services by utilizing the newly created LAC-DHS Health Care Interpreter positions, budgeting these items, and securing funding to hire and train a significant number of interpreters.

### #3 - CULTURAL COMPETENCY TRAINING

Ensure cultural competency training in County hospitals and medical centers by working with promotoras and collaborating with community-based organizations to utilize the expertise of the community in the training of all staff levels. Contract with community-based organizations for providing and enhancing services whenever possible.

### #4 - CREATION OF IMMIGRANT HEALTH OFFICE

Create an office of immigrant health/ rights that will coordinate across County programs to ensure improved services.

### #5 - IMPROVE DATA COLLECTION

Improved and disaggregated data collection to ensure all immigrant populations are identified, specifically targeting underserved groups.



## Workgroup 6 Violence & Health

### Workgroup Leaders

Kay Buck, Executive Director, Coalition to Abolish Slavery & Trafficking

Crystal Crawford, Esq., Executive Director, California Black Women's Health Project

Olivia G. Rodriguez, Executive Director, Los Angeles County Domestic Violence Council

### Violence Against Women is Pervasive and Affects Health and Quality of Life

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Many women in Los Angeles County experience violence in different forms. Domestic violence, which includes physical, sexual, or psychological harm to another by a current or former partner or spouse, affects more than 32 million Americans each year, with more than 2 million injuries or claims and approximately 1300 deaths. The consequences of turning our backs on domestic violence in the community reach far beyond the prolonged suffering of the immediate victim.

Approximately 50,000 people are trafficked into the U.S. each year, most of whom are women and girls. Los Angeles is a top "destination city" where people are enslaved for forced labor or sex trafficking. Most victims are exploited by traffickers because of low socio-economic status, gender discrimination, lack of education and economic opportunity, and reliance on third parties for information about migration. Women's physical, mental, and sexual health is negatively impacted by trafficking which is difficult to research due to its illicit nature.

### The Complexity of Violence

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According to the World Health Organization, the complexity of violence-related health issues increases when victimization is undetected or unreported, resulting in high and costly rates of utilization of the health and mental health care system. Stigma is a barrier which discourages women from getting help due to the fear of shame, discrimination and disrespect. Adding to the complexity is the fear women experience due to the threats of violence towards them and their families by the perpetrators, thus forcing the victims to suffer in silence.

### What is Needed

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Prevention at every level is necessary to stop the occurrence of violence against women. Primary prevention - targeting violence before it begins - requires population-based strategies, policies and actions at the environmental and system level.

- The intersection of violence and health needs to be highlighted in the media to increase awareness and educate the public and media professionals.
- There is a need for increased research on the ways personal and community violence, including trafficking and domestic violence, impact women's health.
- Women report that they believe their neighborhoods to be unsafe. Collaborations with community groups and existing convenience and liquor stores may be part of the solution, partnering to improve the quality of life.

- Some schools are failing to live up to their safety obligations. The Attorney General's Office and the Department of Education are working with schools and their communities to address teen dating violence. Expanding effective services will result in improved educational, emotional and behavioral development for students of all ages.
- With a growing number of survivors of trafficking being identified in Los Angeles, now is the time to establish a comprehensive infrastructure to accommodate the unique health needs of this population. Prevention initiatives need to take on more importance, forcing systems, multinational corporations and consumers alike to take action for accountability.

## RECOMMENDATIONS

### #1 - MALE SPORTS SPOKESPERSON

A program within LAC-DPH that works on the intersections of public health and violence to work with professional and collegiate sports organizations to develop a media campaign where men take an active role in opposing violence against women.

### #2 - PHYSICAL ENVIRONMENT AND VIOLENCE

Develop policy recommendations designed to address the association between the physical community environment and violence, including liquor store density and other negative influences such as gang and domestic violence.

### #3 - PARTNER WITH SCHOOLS

Partner with LAUSD to develop a violence-related curriculum that is an integral part of K-12 education.

### #4 - MEDIA SUMMIT

Convene a media summit to educate media professionals on the issues related to violence against women such as trafficking, mental health, and the impact of the physical environment by involving experts, survivors, and male advocates.

### #5 - DATA

Elevate the quantity and quality of data related to violence against women on issues such as the trafficking of women and girls.



## Workgroup 7

# Racism, Multiculturalism, & Health

### Workgroup Leaders

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### Diversity and Health in Los Angeles

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- Ethnic minorities make up about 33% of the U.S. population while in Los Angeles County (LAC) they are the majority, representing 64% of the population. As one of the most ethnically diverse places in the world, LAC is home to over 10 million people: 45% are Latinos from countries including Mexico, Central and South America, and the Caribbean; 12% are Asian or Pacific Islanders; 10% are African Americans with a growing representation from Africa and the Caribbean; and smaller groups from other countries including Russia and the Middle East.
- Women make up 46% of LAC with ethnic minority women making up 28% of the workforce. Despite advances in medicine, health disparities in ethnic populations persist. Recent data from LAC indicates that ethnic minority women experience not only higher incidences of chronic diseases, but also disproportionately suffer from chronic morbidity (pain and physical complications) and mortality due to these diseases and illnesses.

### Factors Contributing to Health Disparities

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Health disparities exist primarily because health discrimination exists. While many factors have been identified as playing a role in health disparities, those in particular related to racial/ethnic inequality that continue to maintain disparate health are:

- **Social and Structural Inequities** - Access and quality of care is often a function of gender, citizenship status, race/ethnicity, residential neighborhood conditions and employment status.
- **Financial Standing** - dictates quality and accessibility to health care, residence, healthy foods, education and recreation. Many underserved neighborhoods embody the “broken windows syndrome” where crime, vandalism, high stress, and other negative conditions result in poorer quality of life and less tangible emotional support and health promotion opportunities.
- **Culture** - Cultural practices due to shared historical experiences of poverty and oppression reinforce health behaviors and practices that may be in conflict with Western medicine traditions and health promotion messages.
- **Personal Factors** - Life experiences and exposures foster particular health behaviors that compromise the ability to choose or to act on healthful practices.

- ✦ **Institutional Factors** - The Institute of Medicine (2002) reports that quality of care differs by ethnicity, such that people of color receive inferior care based upon biases held by practitioners or the health care system itself.
- ✦ **Health Education** - Professional education and provider training on health disparities and quality of care based on racial and ethnic inequalities and human diversity are lacking.

The root causes of health disparities are multiple, thus the solutions must be multi-pronged and systemic. Health care providers must understand how our diverse populations live and work - their lifestyles, culture, history and current environmental conditions - to know how best to deliver effective health programs. It is imperative that health care providers, health organizations, advocates, policymakers, funding agencies, industry and communities work together towards the eradication of disparities, and provision of comprehensive care for all.

## RECOMMENDATIONS

### #1 - COLLABORATIVES

Establish and maintain proactive collaboration between health providers, health care systems including the insurance industry, community-based organizations, governmental agencies, business, and philanthropy. The goals of these coalitions are to develop and implement targeted programs to increase awareness of and eliminate health disparities.

### #2 - SOCIAL MARKETING CAMPAIGNS

Develop and implement public health “truth” campaigns that utilize social marketing in creative and artistic ways to broaden the appeal to diverse age groups, i.e. use of popular culture and music including hip-hop.

### #3 - CME TRAINING

Ensure that all health providers complete quality, accessible CME training on health disparities based on racial and ethnic inequalities. Advocate to CMS and JCAHO to mandate training in licensing requirements. Conduct rigorous monitoring to ensure program accountability and sustainability.

### #4 - NEIGHBORHOOD DEVELOPMENT

Examine environmental health issues impacting the health of communities; eliminate substandard housing in low-income communities; decrease food insecurity by promoting farmer’s markets and alternatives for low-cost fresh fruits and vegetables.

### #5 - NEIGHBORHOOD COUNCILS

To combat “broken windows syndrome,” integrate a public health agenda with neighborhood councils and neighborhood watch programs.



## Workgroup 8

# Heathy Lifestyles & Chronic Disease Prevention

### Workgroup Leaders

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Margaret Lynn Yonekura, MD, Director of Community Benefit, California Hospital Medical Center  
Associate Professor, Clinical Obstetrics & Gynecology, UCLA

### Chronic Diseases and Health Promotion

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Chronic diseases are the leading causes of death and disability in the United States. They account for 7 out of every 10 deaths and affect the quality of life of 90 million Americans. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Sedentary lifestyle, risky drinking, unhealthy diet, and smoking are the leading behavioral causes of disease, death, and loss of functioning. So, what prevents people from adopting a healthy lifestyle, thereby reducing their risk of chronic disease?

Healthy lifestyle has been viewed as patterns of behavior based on individual choices about diet, exercise and substance use; interventions have been focused on persuading individuals to change these behaviors to reduce their risk for disease. But this approach fails to analyze the determinants of lifestyle and ends up blaming individuals at highest risk for poor health.

### Need for a New Approach

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To reduce the burden of chronic disease, eliminate health disparities, and engage more constituencies in promoting health, we need to reconsider our approaches to health promotion. People make choices in a physical and social context. We need a socioecological approach to health promotion that acknowledges the multiple and complex influences on everyday lives through their personal characteristics, social interactions, and cultural, environmental, behavioral and biological factors that influence their health. The impact of the role of women as health care promoters for themselves and their families cannot be underestimated.

We can learn from successful tobacco control efforts that education, exhortation and "individual responsibility" are not enough. Strategies must be multi-pronged, comprehensive and sustained.

Five action areas provide a framework for addressing the determinants of health:

- ✦ **Building healthy public policy** - smoke-free public areas, banning use of trans fats, requiring health care coverage for primary and secondary preventive services.
- ✦ **Creating supportive environments** - providing time for and access to physical activities at the worksite and schools, offering healthy food options in cafeterias and vending machines at worksites and schools.
- ✦ **Strengthening community action** - building parks and safe exercise paths, establishing community kitchens, food banks, and affordable grocery stores.
- ✦ **Reorienting health services** to optimizing wellness as the focus rather than treating diseases, and implementing primary and secondary prevention guidelines for common chronic conditions such as cardiovascular disease, diabetes, lung disease and preventable cancers.

- **Developing personal knowledge and skills** - social marketing of a healthy lifestyle, awareness of risk factors for common chronic diseases and promoting healthy behaviors.

Every person wants optimal health and function. We must make a healthy choice not only the right choice but the easy choice for all women.

## RECOMMENDATIONS

### #1 - USE SCHOOL FACILITIES

Local communities will encourage and support the joint use of school district facilities for:

- After-hours use for safe exercise and recreation opportunities for adults and students
- Adult education to include healthy lifestyle education (nutrition, meal preparation)
- Partnering with community-based organizations or other public-private partnerships to provide health education resources and potential revenue streams to support efforts.

### #2 - APPLY THE TOBACCO CONTROL MODEL

Apply the tobacco control model and focus on community engagement to get communities ready for change, i.e., embracing a healthy lifestyle and disease prevention approach.

- Funding from collaboration of foundations, Los Angeles County Department of Public Health.
- Partner with American Heart Association, American Cancer Society, etc.
- Partner with media and celebrities to disseminate messaging about healthy lifestyles and disease prevention.
- Disseminate what works to communities.
- Create systems with sustainable funding and incentives to educate and empower residents to adopt healthy lifestyles.
- Mandate the labeling of all foods including fast food and restaurant food.
- Ban trans fats and high fructose syrups.

### #3 - EXPANSION OF COMMUNITY CLINICS

Expand community clinics to increase accessibility of health care preventive services, health education, and medical treatment that is culturally-sensitive and appropriate for the community. Chronic disease rates can be monitored for impact.

- Sites should provide safe exercise facilities for the local community.
- Sites should engage and involve community leaders in all aspects of program planning before beginning a healthy behaviors educational program.

### #4 - WORKSITE WELLNESS

Encourage the establishment of Worksite Wellness Programs.

- Annual employee health exams should include comprehensive screening.
- Provide incentives for small businesses to participate.
- Make stairways desirable and accessible for exercise and frequent use: well-lit, ventilated, attractive, with music, pictures, and other appealing features.



## Workgroup 9

### DISABILITY & ACCESS

#### Workgroup Leaders

Janet Neal, Advocate and Chair, Los Angeles County Commission on Disabilities

Mary Ann Cummins Prager, EdD, Director, Center on Disabilities, Cal State University, Northridge

Yaga Szlachcic, MD, Chief of Cardiology, Rancho Los Amigos National Rehabilitation Center

#### Access to Care

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Access to health care for women with disabilities is complicated by a number of factors not faced by women without disabilities.

- The physical layout of hospitals, clinics and community health agencies may prevent women from accessing care. Modified equipment may not be available, beginning at the most basic level with items that should be standard such as accessible examination tables.
- Attitudinal barriers abound in issues related to disability and reproductive health, consistent with a general fear and discomfort in communicating with women with disabilities. Sometimes patients are viewed as immature and not in control and many women with mental health disabilities report that they are marginalized.
- There tends to be a lack of social networks and support systems for women with disabilities.
- Research on people with disabilities is limited but even more so for women with disabilities.
- Complicated health care materials (brochures, medical instructions, pharmacological inserts) can be a barrier to compliance with health care instructions, particularly if it is not available in alternate formats and appropriate languages.
- Transportation for those who cannot drive themselves or use public transportation options is a significant barrier to obtaining access to health care for many women with disabilities.

#### Key Considerations

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- Policies and funding that support women with disabilities is critical.
- Many medical professionals need more training, which could be delivered through the Continuing Medical Education process, to ensure the elimination of attitudinal barriers and lack of knowledge that prevent them from adequately serving women with disabilities.
- Research should be conducted that considers the impact of a variety of disabilities on outcomes related to medical interventions and medications. It is essential that women are able to access health care and therefore increased funding is needed for options such as ACCESS (the Los Angeles County complementary paratransit program for functionally-disabled individuals).



- Women with disabilities need to be brought out of the shadows and featured in marketing and advertising campaigns so that their needs and views are seen and accepted as mainstream issues.

## RECOMMENDATIONS

### #1 - SATELLITE OF OWH POLICY COUNCIL

Create a satellite of the Office of Women's Health Policy Council with an emphasis on women with disabilities and focused on policy, funding, and information dissemination including development of a virtual community on the web.

### #2 - CME REQUIREMENTS

Change the CME requirements so that all licensed medical professionals are required to learn about and be sensitive to the special health needs of persons with disabilities including the reproductive health issues faced by women with disabilities. Medical professionals should be knowledgeable about the physical, attitudinal and knowledge barriers that prevent or limit access to health care.

### #3 - RESEARCH FUNDING

Increase funding for specialized research on health-related matters for women with disabilities.

### #4 - TRANSPORTATION FUNDING

Because access to transportation can limit access to health care, support funding increases for specialized transportation services such as ACCESS and other public transportation options.

### #5 - VISIBILITY OF DISABLED WOMEN IN MEDIA

Increase the visibility of women with disabilities in marketing and advertising campaigns so that their needs and views are seen as mainstream issues.



## Workgroup 10

# Sexual Orientation & Gender Identity

### Workgroup Leaders

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Susan Berke Fogel, JD, Healthcare Attorney, Advocate & Consultant

Surina Khan, Program Director, The Women's Foundation of California

### Health Risks

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- Lesbian, bisexual and transgender women are at risk for the same health conditions and diseases as all women, yet their health needs are often neglected in practice, health education, and research. They may experience greater rates of some conditions, but the limited research into their health needs reveals a paucity of knowledge and is a significant barrier to improving their health status. There is very little data available describing the health of transgender women with respect to primary, preventive and chronic disease care.
- Lesbians and bisexual women appear to have higher rates of obesity, smoking and alcohol consumption. They may be at different risks for cancers if they do not bear children and if they do not have access to regular gynecological exams.
- The stress of long-term discrimination or feeling the need to keep their sexual orientation hidden has physical and mental health consequences. The goals of Healthy People 2010 include increasing the cultural competency of providers in health promotion and disease prevention. This is particularly needed for lesbian, bisexual, and transgender women.

### Interaction with the Health Care System

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- There is a need for improved communication on the part of health care providers.
  - A majority of lesbians and bisexual women sampled reported a negative interaction with a health care provider. Studies indicate that health care providers may continue to exhibit a sense of homophobia to their patients as well as when they are training future providers.
  - A majority of health care providers do not address sexual orientation or issues of gender identity. Often providers, especially in gynecology, assume patients are heterosexual, placing the patient in the uncomfortable position of deciding how or whether to disclose her sexual orientation or gender identity.
  - Lack of disclosure may lead to insufficient and/or inappropriate care.
  - Poor communication and/or a negative experience may lead women to defer seeking future health care.

- Lesbians and bisexual women have lower rates of accessing the health care system.
  - Some studies have demonstrated lower rates of health insurance, with no comprehensive policy of extending health insurance to a partner/spouse. Lesbians and bisexual women report lower rates of having a usual source of health care and lower rates for receipt of preventive health care including cancer screening. There are concerns regarding lack of insurance coverage for fertility and conception.
  - Most public programs focus eligibility on child-bearing - either based on pregnancy and parenting, or based on preventing pregnancy, which leaves many lesbians without access to services.

Research needs to include sexual orientation and gender identity as part of the socio-demographic items collected.

## RECOMMENDATIONS

### #1 - IMPLEMENTATION OF CULTURAL COMPETENCY TRAINING

Los Angeles County should take the leadership in integrating and coordinating cultural competency trainings on Lesbian, Bisexual, and Transgender (LBT) health care in medical education, residency training, union health care worker training, and in County programs including violence prevention, tobacco education, reproductive health, adolescent health, and mental health. Within one year, the County should conduct a review of the existing curricula and create a plan for integrating LBT issues in the training.

### #2 - LBT WOMEN AND RESEARCH

Identification of and questions about LBT persons should be included in all funded research and activities. In addition, the County should conduct a needs assessment of women who identify as LBT in order to better understand LBT health issues.

### #3 - REDEFINING CULTURAL COMPETENCY

For all purposes, the definition of “cultural competency” should be revised to include LBT competency, including having the State require inclusive cultural competency training as part of required CME for medical professionals.

### #4 - INCREASING INCLUSION OF LBT ISSUES AT OWH

The Office of Women’s Health should ensure that LBT health issues are included in its agenda, and should take a leadership role in fostering collaborations between women’s health advocates and LBT advocates by convening a series of meetings/seminars among community-based stakeholders.

### #5 - ORGANIZE OUTREACH CAMPAIGN

A collaborative of community partners including City and County government programs and CBOs should explore a public education campaign to reach out to LBT women and teens and to educate the public about LBT health issues.



## PROMISING & INNOVATIVE PRACTICES POSTER SESSION

A *Promising & Innovative Practices Poster Session* was highlighted at the Summit to bring attention and recognition to extraordinary community-based and grassroots programs successfully addressing health disparities and improving the well-being of women and girls.

Although some of the programs may not have quantitative data, financial resources, or a formal evaluation, they are strongly supported by and successful for the communities served. All participating programs have made a significant contribution in their target populations and have high potential for replication and/or adaptation to other settings.

Please visit the Office of Women's Health Website to read the Promising & Innovative Practices abstracts:  
<http://www.lapublichealth.org/owh> or [preventionmatters.org](http://preventionmatters.org)



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