Cross-Cultural Care: The Love for Peru, Lima Wheelchair Mission

Rebecca I. Estes*
Nancy Van Slyke &**
Marjorie E. Scaffa

Abstract

This article describes a cross-cultural response to impoverished people with disabilities in Peru. Social and economic conditions within that country call for interventions at multiple levels, individual through national. The Lima Wheelchair Mission is an example of a response on a local level, yet one that is replicable throughout the country, as well as in other countries around the world. Occupational therapy, as well as other professions, can play an important role in developing such interventions. As with all international work, cultural competence is a critical component the Lima Wheelchair Mission.

Resumen

Este artículo describe una intervención intercultural para discapacitados pobres en Perú. Las condiciones socio-económicas dentro de ese país hacen necesario la intervención a múltiples niveles, desde individuales hasta nacionales. La Misión Silla de Ruedas de Lima es un ejemplo de respuesta a nivel local, pero que puede ser replicable a lo largo del país, así como en otros países alrededor del mundo. La terapia ocupacional, así como otras profesionales pueden jugar un rol importante en desarrollar tales intervenciones. Como todo trabajo internacional, la competencia cultural es un componente crítico en la Misión Silla de Ruedas de Lima.

*Rebecca I. Estes is professor at University of South Alabama. Her mailing address is 1504 Spring Hill Avenue, #5108, Mobile AL, 36604, 251-434-3939, e-mail: riestes@usouthal.edu

** Nancy Van Slyke and Marjorie E. Scaffa are professors at the University of South Alabama

Key words/Palabras clave
Cultural competence, occupational therapy, Peru Foundation, community and economic development.
Competencia cultural, terapia ocupacional, Fundación Perú, desarrollo de comunidad y económico.

The Republic of Peru (Peru) is a developing country on the pacific coast of South America with a population of about 27,562,000, as of 2004 (World Health Organization, 2006). Geographically the country is divided into three large regions: the coast, mountain and jungle. From 1987 to 1992 the country experienced a period of political and economic turmoil resulting in a shift from a primarily rural population distribution to an urban distribution that had profound effects on Peru and in particular, metropolitan Lima (U.S. Library of Congress, 2006; Pan American Health Organization, 2007). The combination of this shift and a population explosion, at first, did not seem to be a problem and Peru's policy appeared to be to let it "solve itself". The shanty settlements on the outskirts of Lima, however, have become of increasing concern2. With an unemployment rate of 50% in Lima, those who are unemployed and underemployed migrate to the extremely poor shanty towns on the outskirts of Lima (http://www.loveforperu.org/). The poverty and poor living conditions in the shanty towns increase the health risks already present in a developing country.

Peru's health indicators are poor, with a public health expenditure of only 4.4% of the gross domestic product in 2003 (by comparison, Sweden's expenditure in the same report was 9.4%), a per capita total expenditure on health of 94 US dollars (by comparison, US expenditure in the same report was $5,711), limited access to safe water, only 1.17 doctors per 1000 people, fewer than 1 nurse per doctor and no accounting of numbers of other healthcare professions (World Health Organization, 2006). The World Health Report 2006, states that there are sufficient resources to address global health challenges and calls for international cooperation "…. to align resources, harness knowledge and build robust health systems …" (p. xv) (World Health Organization, 2006). International cooperation can occur on a large scale as well as on smaller scales; the Wheelchair Project in Lima, described here and conducted through the Love for Peru Foundation (Foundation), is just one example.

Cultural Competence

The World Health Organization's call for international cooperation to share resources and address global health challenges requires cultural and linguistic competence in order to meet the needs and respect the diverse beliefs and cultural traditions of populations around the world. Are healthcare providers trained in the United States ready to meet this challenge?

Interest in the cultural competence of healthcare providers in the United States, particularly physicians, has increased over the past ten years and includes a move to include 'cross-cultural care' in educational programs (Weissman, Betancourt, Campbell, Park, Kim, Clarridge, Blumenthal, Lee, & Maina, 2005). The United States as a 'melting pot,' has a culturally diverse population, often with beliefs that conflict with the philosophy of traditional Western medicine. Providing effective, quality, healthcare requires cross-cultural awareness and competence.

A study on the variable knowledge and skill level of 132 first-year medical residents included two measures of cultural competence, one on the level of skill performance and one on the patient satisfaction rating by a standardized patient (Lypson, Frohna, Gruppen, Woolliscroft, 2004). Overall, residents scored 72.3% correct in the skill area and 85.8% in the standardized patient satisfaction area, signifying a passable level of cultural competence. However, the range of scores was 44-98% for the skill measure and 63-100% for the patient satisfaction measure, indicating a broad range of cultural competency skills among the residents.

Weissmann and colleagues (2005) surveyed the attitudes toward cross-cultural care and perceptions relating to preparedness, educational experiences and educational climate relating to cross-cultural instruction of 3,435 medical residents in their final year of training. The researchers found that the residents' self-reported preparedness in cross-cultural care lagged considerably behind their preparedness in clinical and technical areas, indicating the need for significant improvement in addressing cultural awareness and competence in educational programs.

A survey of 248 pediatric residency programs in the United States, Canada and Puerto Rico showed that, of the responding programs, only 25% had international child health electives in their residency programs, and those in existence had little or no formal educational structure (Torjeson, Mandalakas, Kahn, Duncan, 1999). The authors propose guidelines for these electives to enhance the meaningfulness of the international residency experiences. Cultural competence training for physicians, while in existence, has a long way to go to meet the needs of consumers both in the United States and in around the world. Similar studies have yet to be done with occupational therapists.

Cultural and linguistic competence, defined by the Health Resources and Services Administration (HRSA, 2001), is:

> "… a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."(p 1)

HRSA has a vested interest in cultural competence as many of the grants it awards are for programs for culturally and linguistically diverse underserved populations. Recognition of outstanding HRSA programs led to identification of eight characteristics of successful culturally competent services.

Culturally competent programs define culture very broadly, recognizing that an individual's identity results from multiple memberships in both group and individual level cultural categories and subcategories (Health Resources and Services Administration, 2001). Linguistic competence of the healthcare provider or interpreter service is an important characteristic of cultural competence and healthcare providers must be aware of and sensitive to the variations of language, culture and literacy within a target population. Providing culturally competent services requires that the healthcare provider explore life experiences at the individual level as well as be willing to learn about the culture's attitudes and beliefs about healthcare. Reciprocally, the cultural group must learn about the health care delivery system.

Going beyond the awareness level to incorporate the clients and community in the identification of needs and program response and to collaborate with local agencies enhances the cultural competence at the program level. At the institutional level, cultural competence must be incorporated into the strategic plan, included in staffing plans and all activities (Health Resources and Services Administration, 2001).

Cultural Competence in Occupational Therapy

Occupational therapy education is founded, in part, on the belief in a dynamic interchange between the person and their environment and includes training in cultural awareness and an individual's unique involvement in occupation (Dickerson, & Royeen, 2003). Yet, a desirable level of cultural competence among practicing and entry level therapists has yet to be attained, to some extent because there is a lack of specific learning activities in educational programs to foster cultural competence. As well as an inadequate focus on the topic in educational programs; there may also be insufficient cognitive development among students for the necessary critical thinking skills (Wittman & Velde, 2002). Recent literature on cultural competence in occupational therapy centers on actual practice experience (Kondo, 2004; Odwara, 2005; Krenek, & Vasquez, 2006).

Cultural competency is a developmental process that can be conceptualized as a continuum or progression that occurs in six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency13. The process however, is not linear. Individuals and organizations may be at different stages at different times and this will vary by cultural group. Cultural destructiveness refers to an individual or organization's attitudes, policies and practices that are destructive to a particular cultural group, and cultural incapacity is the lack of ability to respond effectively to the needs and preferences of culturally diverse populations. Cultural blindness is the claim by a person or organization that they see and treat all persons the same regardless of their cultural heritage. Cultural pre-competence is the stage where a person or organization begins to become aware of their need to become more culturally responsive.

Cultural competence implies that individuals, organizations and systems demonstrate acceptance and respect for cultural differences and use evidence-based practices that are culture-sensitive. Cultural proficiency requires that individuals, organizations and systems value culture highly, and use culture to guide all their goals and activities. In addition, it encourages the development, publication and dissemination of promising evidence-based practices, interventions and professional education strategies (Cross, Bazron, Dennis, & Isaacs, 1989). There are many dimensions of culture that need to be understood by health care professionals including: health and illness beliefs, decision-making style, healing traditions, privacy issues, communication styles and locus of control. The goal is to move health care professionals, students and organizations from whatever stage they are in currently to cultural competence minimally, and ultimately to cultural proficiency (Mutha, Allen, & Welch, 2002).

When organizations, such as the Love for Peru Foundation, take health care professionals from one country to another to provide services, cultural competence training takes on new dimensions. Some of the board members for the Foundation are from Peru. They provide cultural sensitivity training prior to the mission trips and monitor the volunteers during their activities while in the country to assure that the cultural beliefs, preferences and needs of the service recipients are accommodated. Mission trips such as the ones coordinated by the Foundation are an excellent way to become immersed in a culture and learn the traditions of the people. Occupational therapy education might benefit from experience gained in the medical field where residents can opt for an international residency in pediatrics (Torjeson, Mandalakas, Kahn, Duncan, 1999) and consider offering international fieldwork electives. Partnering with programs such as the one described here may be a first step.

Love for Peru Foundation

The Love for Peru Foundation (Foundation) began in 1999 as a partnership between members of the Gulf Breeze United Methodist Church (Church) and a Rotary Club in northwest Florida.

Piero and Magali Solimano were instrumental in the development of the Foundation and promoting the mission program to their native country, Peru. A small group of volunteers traveled to Lima and were overwhelmed by the extreme needs of families for shelter, food, and health care. Out of this experience the Peru Mission emerged, later to be renamed the Love for Peru Foundation, a nonprofit organization. The primary objective of the Foundation is "To help break the poverty cycle by promoting education and micro-enterprises, while supporting health and nutrition, and alleviating specific hindering hardships on needy families" (www.loveforperu.org/empower_prog.html, paragraph 1).

The church-sponsored mission initially focused on construction of a preschool to meet the needs of 7 small communities. The communities were located in the barren foothills outside Lima, clustered in such a way that they surrounded a solid waste dump site. The initial pre-school construction focus of the mission program, "Project Hope" as it was later called, was expanded to include moving the dump to build soccer fields and play grounds for the children of these 7 communities, expanding the preschool to include the area's first library, and initiating the development of a water and sewage project in the area. As the mission programs expanded and new programs evolved, it became evident that funding and manpower outside of the Church was essential to meet the multitude of needs of the target communities. Local Rotary Clubs in the Florida Panhandle, Rotary International, and other local community churches became involved. With the inclusion of other agencies and the continuing expansion of programs, it became evident that developing a foundation would be essential in order to pursue grant opportunities and explore other sources of financial support. In 2004, the Love for Peru Foundation, Inc. was established with a Board of Directors (Board) that included the Solimanos and individuals who had experience with the various mission projects. The Board included members with backgrounds in finance, administration, medicine and rehabilitation; four individuals represented various Rotary Clubs, Rotary International and the Church.

As of 2007, over 20 teams of volunteers have traveled to Peru. Volunteers are recruited through local churches, Rotary Clubs, and word-of-mouth. Also, people from different parts of the country and other countries have volunteered through the Love for Peru web page. The volunteers have built two preschools, two libraries, a community kitchen, more than 50 houses and 300 latrines. In addition, the Foundation has shipped containers with equipment and supplies for hospitals and the disabled, and has provided medical care to hundreds of Peruvians.

Prior to taking a trip to Peru, the volunteers receive cultural sensitivity training from two Peru natives, Magali and Piero Solimano, who initiated the mission trips to Peru. They provide cultural and mission-related workshops for all team members before every trip. They also work closely with each volunteer while in Peru, to make sure they understand and are sensitive to the culture and local customs. Peruvians are described as "affectionate, courteous, polite and very respectful" and they expect the same from visitors. Even though the people that the mission serves "are very poor, they strive daily to overcome their difficulties and aspire to the same things for their families as we all do" (M. Solimano, personal communication, January 14, 2008). At this point in time, due to logistical concerns, they do not take students on mission trips, only professionals (M. Solimano, personal communication, January 14, 2008). However, this may be an option in the future.

Currently, the Foundation has two large ongoing projects, Project Hope and the Complex for the Disabled, as well as several other smaller projects. Project Hope is designed to promote health, education, social participation and economic development in seven communities with nearly 100,000 residents. The people are extremely poor and many live in cardboard and straw dwellings with no running water or sewage. The area includes a large trash dump for the city of Lima. The goals are to transform the dump site into a recreational area, build a composting center that will provide a source of income for the communities, implement a housing program to provide houses made of wood, bring running water, educate families on health issues and promote education as a means for individuals to break out of the cycle of poverty.

The Complex for the Disabled (the Complex) is a joint project of the Foundation and the Association for the Disabled (the Association). The Association is an organization that attempts to address the needs of disabled persons in Peru, yet it receives no government funding and must rely on donations. The Complex is designed to provide health care services, job training and will generate income for the disabled community. Plans for the complex include a bakery, carpentry shop, shoe repair, library, community kitchen and a medical equipment repair shop. Annually, the Foundation solicits donations of wheelchairs, walkers, portable commodes, shower-chairs, crutches, hospital beds and other medical supplies. These are shipped to Peru in a large cargo container and two local Rotary Clubs cover the costs of shipping. Each year a group of volunteers travel to Peru to fit the chairs and other equipment to 200-300 persons with disabilities during a weeklong stay.

Medical and dental mission trips have also been organized by the Foundation. The medical problems most frequently seen have been parasites, gastrointestinal problems, tuberculosis, asthma, anemia, cerebral palsy, spina bifida and malnutrition. Some Peruvians have become permanently disabled as a result of strokes, accidents and other causes due to inadequate treatment at the time of the incident. Hospital supplies and equipment are extremely limited, so teams must bring the needed supplies with them.

Many who participate in the missions to Peru describe it as "life changing" Although each person's experience is different, each can recount the special moments and memories of their trip as the people of Peru make an indelible impression. One participated stated

> "When you come to Peru you see the sad, poor homes and landscape. Then out of the blue you see cheery faces and a happy attitude. When you arrive the whole town celebrates your arrival with dances and skits. Sometimes they pull you in and make you dance with them!" (www.loveforperu.prg/testimonials.html)

Another volunteer says, "My experience was so many things, it was enlightening, it was humbling, it was touching, it was educational, and it was fun and because of it, I know I am a better person" (www.loveforperu.prg/testimonials.html).

The experience of being a member of a humanitarian team in a developing country seems to have profound positive effects in the lives of the volunteers, as much as it does on the Peruvian people (M. Solimano, personal communication, January 14, 2008).

The Love for Peru Foundation Wheelchair Project

While speaking at a Lima Rotary Club meeting to solicit involvement with Project Hope, a Lima Rotarian approached Piero Solimano about the needs of another community, Huaycan. This community of approximately 17,000, included a fairly large disabled population, living in severe poverty, with very limited access to medical and rehabilitation programs. After further discussion the mission program organized several mission teams to help facilitate the development of an Association for the Disabled and to construct a rehabilitation center. The rehabilitation center included space for therapy services, a soup kitchen, bakery and bio-mechanical shop for wheelchair and assistive equipment repair. The focus of the mission program to Huaycan was to provide support and services to facilitate independence through rehabilitation and development of work skills. The lack of availability of wheelchairs, assistive equipment (e.g., walkers, canes, crutches, commode chairs), appropriate tools and parts for use in repairs of wheelchairs and assistive equipment was a significantly limiting factor in the Huaycan mission program resulting in the creation of the Wheelchair Mission Team (Wheelchair Team).

Since 2003, the Wheelchair Team, led by a Durable Medical Equipment owner, has collected and shipped three large forty foot cargo containers of used rehabilitation equipment to Huaycan. The Wheelchair Team made trips with each container shipment to evaluate, construct or adapt equipment and fit adults and children with appropriate wheelchairs, seating systems and adaptive equipment. The primary responsibility for client evaluation to determine equipment needs and for instruction of client and family members in appropriate care and use of the equipment fell to two Wheelchair Team members, an occupational therapist and a physical therapist. Other Wheelchair Team members have included Church members and Rotarians with a wide variety of skills and often limited experience with rehabilitation equipment.

Under the direction of the Durable Medical Equipment owner, team members performed the manual labor necessary to modify existing equipment or construct seating systems from used parts. In 2007 alone, over 250 wheelchairs were distributed and over 500 disabled individuals received assistance (http://www.loveforperu.org/).

Cultural Competence: A Lived Experience

Thus far we have explored the factual aspects of a cross-cultural experience, information about the country, the culture, the Foundation, and the motivation. In this section we seek to explore and share one occupational therapist's (OT) experience of a cross-cultural trip and how it relates to cultural competence. The excerpts are all taken from an email communication in which the therapist shared her thoughts about and experiences from her trips to Peru, with the Love for Peru Foundation, from a cultural awareness and cultural competence view point. By including a personal perspective it is hoped that the cultural competence concepts presented will be more meaningful and 'real' to the reader.

> "For 6 weeks our team of 15 met weekly to prepare for our first trip. Meetings included orientation to the purpose of the trip, a brief overview of the community and its needs, a discussion of what to take (and not take), and a basic introduction to Spanish and the culture."

Gaining awareness of the culture of a people and their country is the broadest level of understanding and a necessary first step in developing cultural competence. Didactic information provides the basis for this level of awareness but personal experience and actual cultural exposure, provides a deeper, truer understanding as the OT discovered on arrival.

> "Our trip included a short flight to Atlanta and then a 6 hr flight to Lima. I've never flown on such a packed plane—it was a big plane but every seat was taken, there were families obviously flying home to Peru with lots of kids, bags, and suitcases.

> We arrived at 1 am—going thru immigration and customs was a lengthy process …. we entered the main area of the airport where there were thousands of people waiting—it really was scary as there was so much noise, jostling, police everywhere and of course we were trying to keep our group together. I really was quite apprehensive—we did have our own bodyguard and a hired bus to pick us up … I found Lima to be a very modern city with the usual fast food places we have, lots of museums, restaurants, etc. but with armed security outside the banks and lots of people (primarily those with disabilities and children) selling candy on the street corners, outside entrances to churches and restaurants. Unemployment is very high, particularly for the disabled. People seemed very friendly and extremely helpful—in the stores they often would immediately try to help those of us who struggled with the language."

The Wheelchair Team focused on a group of small towns on the outskirts of Lima, actually another, more specific subculture of the country of Peru and city of Lima the team had to learn about and adjust to.

> "The trip to the work site takes about 1 hour …the vegetation becomes very sparse, there's lots of dirt and dust. The traffic is unbelievable—the roads are striped for lanes but NO ONE pays any attention. Most people don't own cars but ride public and private buses or walk. (A small minivan would often pack 20+ people in). There seemed to be a code that the drivers used to indicate passing, right of way, turns, etc. It was apparent why there are so many amputees! Along the road we could see women washing clothes in the river, lots of little open air markets with fruits, vegetables and hanging chickens, and flies everywhere. When we arrived at the «compound» where we were to work the level of poverty overwhelmed us all. I was impressed by how happy everyone was and how giving—they readily helped each other."

In addition to having a broad level of cultural awareness, health care workers in a cross-cultural setting must seek a deeper level of understanding and cultural competence in order to provide effective care at the individual level7. Occupational therapists believe that people adapt through interaction with environments. Environments, from the OT perspective, include not only the physical environment but the individual's social, temporal, cultural, psychological and spiritual environments as well. Providing OT in a cross-cultural environment then, presents a daunting challenge in more than one area! Simply preparing for the unknown may turn out to be the first step.

> "The primary purpose of my first team trip was to build a rehab facility for this community. Except for one other team member, I was the only team member with a rehab background. Our team leaders expected the two of us to do patient assessments while the other team members worked on preparing the site for construction. I have to say that I was quite apprehensive—I had no idea what to expect in terms of types of disabilities, patient needs, equipment or supplies to take, etc. Knowing that a small rehab program was to be developed and that there were plans for future trips to follow up I decided to create a 1-page assessment sheet so that we could maintain some basic records—good thing as we saw 90+ patients that week!"

Gaining cultural competence and understanding at the individual level is best accomplished through first-hand experience. Culture at the individual level means understanding that personal identity is created not only from the broader cultural identity but also includes a person's life experiences and shared attributes with multiple cultural subgroups. OTs provide very individualized care, as do other health care professions, and cultural immersion is one of the most effective ways for health care professionals to recognize the importance of cultural differences and gain a humanistic understanding6. Acquiring an awareness of the individual, their needs and goals is the first step in OT client assessment and treatment. Obtaining this knowledge in a cross-cultural environment may mean realigning ingrained cultural beliefs and being adaptable.

> "The number and severity of the disabilities overwhelmed me. Each one had a story. I felt that I had to hear each one's story (through an interpreter of course) so that I could best make some recommendation … Evaluations were usually conducted outside, in a dusty gated yard. Clients often stood in line for hours to be evaluated. Most were transported to the site crowded into minivans or motorcycle taxis. On one occasion it was necessary to complete the evaluation of three clients while on a school bus…
> I did make 5 home visits – climbed the rocky hillside to see individuals that couldn't make it down the hill. Most of the homes had dirt floors, tin roofs and walls of woven grass. No running water. Blue community outhouses were built every so often on the hillside. The homes that I visited were very clean—amazing how they kept them that way! Trying to determine potential adaptations for a severely involved mother of 4 with rheumatoid arthritis who lived at the top of a steep rocky hill was a challenge. Or better positioning for a 15 year old girl who was totally dependent and cared for by her father … I often felt guilty that I had contributed so little."

The OT refers to the need for an interpreter to interact with the clients who came for treatment. Communication in a cross-cultural setting is more than simply interpreting from one language to another. Health care workers need to recognize linguistic variations within cultural groups and language groups as well as recognizing the variation in literacy levels (Health Resources and Services Administration, 2001).

> "Of obvious concern was the language barrier. The majority of the population spoke Spanish, or, in several cases, the Quechua language, more common to the northern provinces of Peru. The availability of translators varied from day to day as did their abilities and experience."

The highest level of cultural competence, as discussed earlier, is cultural proficiency, when culture is highly valued and used to guide goals and activities. In the health care system, at the individual level, in addition to what has been discussed above, that requires an "… understanding of and respect for … health related beliefs and cultural values…" (Health Resources and Services Administration, 2001). In the continuing account of the OT's experience with the Wheelchair Project this is seen, in part, through recognition of the strengths of clients and a desire to build on these strength. Additionally, she shares the joy of gains made and appreciates the expressions of gratitude not just for care provided, but her humanistic approach.

> "They seemed like very proud people who were thankful for any assistance and made the most of what they had. I saw some very creative adaptations to wheelchairs and other modifications using bits of wire and metal parts from whatever… On my 3rd and 4th trips we did have some equipment (commodes, walkers, etc.) that we could modify and distribute… I truly felt blessed—I couldn't get over how appreciative these people were. For example, one group of 4 sisters, whose disabled brother I taught to do an independent transfer, gifted me with a song, another gave me a small crocheted purse that she had made. On my 1st trip, I treated one young man who was totally dependent secondary to severe burns. On my second trip he was waiting when the bus arrived at the work site to show me how much he had progressed and wanted a new home program; on the 3rd trip he took me for a ride on his friend's motorcycle and worked with the wheelchair crew to repair wheelchairs. I really value the friendships that I made."

The journey to cultural competency is not always easy and requires self analysis, a willingness to interact with people of different backgrounds and cultures in addition to the didactic information. With the need to address cultural competency not only within our own cultural diversity but as members of world-wide teams meeting the health care needs of communities around the globe it would behoove us to increase the focus of cultural competency in the training of new health care workers and therapists.

The plans for the future of the Foundation are to continue working to improve education, health, housing and income generation for the poor in Peru (M. Solimano, personal communication, January 14, 2008). In 2008, the Foundation plans to expand its medical and dental missions by sending at least two health care teams to Peru annually. One team each year will concentrate on surgical cases, primarily plastic surgery and orthopedic surgery, and the second team will be more primary care oriented providing medical, pediatric and dental services.

Clearly the Foundation is achieving its mission. The spirit of the work is expressed in a quote from Ralph Waldo Emerson that serves as the theme for the Foundation's website. Emerson said "It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself."

References

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume 1.* Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

Dickerson, A., and Royeen, C.B. (2003). "Philosophy of professional education", AJOT, 57(6), 640.

Health Resources and Services Administration. (2001). *Cultural Competence Works.* Merrifield, VA: Author.

Kondo, T. (2004). "Cultural tensions in occupational therapy practice: Considerations from a Japanese vantage point", *AJOT, 5*8(2), 174-184.

Krenek, S.M., and Vasquez, M. (2006). "A case report on the collaboration of health care professionals in fitting and training seven Iraqi clients with right wrist disarticulations 9 years post amputation", *AJOT, 60*(3), 340-347.

Library of Congress. Country Studies: Republic of Peru. Retrieved November 1, 2007 from: http://lcweb2.loc.gov/frd/cs/petoc.html.

Lypson, M.L., Frohna, J.G., Gruppen, L.D., and Woolliscroft, J.O. (2004). "Assessing residents' competencies at baseline: Identifying the gaps", *Academic Medicine,* 79(6), 564-570.

Mutha, S., Allen, C. & Welch, M. (2002). "Toward culturally competent care: A toolbox for teaching communication strategies", San Francisco: Center for the Health Professions, University of California.

Odwara, E. (2005). "Cultural competency in occupational therapy: Beyond a cross-cultural view of practice", AJOT, 59(3), 325-334.

Pan American Health Organization. *Health in the Americas, 1998 edition.* Retrieved November 1, 2007 from: http://www.paho.org/english/hia_1998ed.htm.

Torjeson, K., Mandalakas, A., Kahn, R., Duncan, B. (1999). «International child health electives for pediatric residents», Arch Pediatric Adolesc Med, 153, 1297-1302.

Weissman, J.S., Betancourt, J., Campbell, E.G., Park, E.R., Kim, M., Clarridge, B., Blumenthal, D., Lee, K.C., and Maina, A.W. (2005). "Resident physicians' preparedness to provide cross-cultural care", JAMA, 294(9), 1058-1067.

Wittman, P. and Velde, B.P. (2002). "Attaining cultural competence critical thinking, an intellectual development: A challenge for occupational therapists", AJOT, 56(4), 454-456.

World Health Organization. (2006). *Working Together for Health: The World Health Report 2006.* Retrieved November 1, 2007 from: http://www.who.int/whr/2006/en/.