The Israel National Institute for Health Policy and Health Services Research

Culturally Appropriate Health Care by Culturally Competent Health Professionals

International Workshop Report

Editor: Leon Epstein

October 2007, Caesarea, Israel

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CONTENTS

Introduction

The last decade has seen a major development in the appreciation of the degree to which health care services should be delivered in a manner that is appropriate for the cultural and social heterogeneity of the population. This "change" is evident in many parts of the industrialized world (including North America, Western Europe, Australia, New Zealand as well as areas in Latin America and Asia).

The background to this is the growing evidence that health care, at all its levels of promotion, prevention, early diagnosis, treatment and rehabilitation, has frequently failed in those sections of society that are different from the major social and cultural groups. Further, these differences also relate to the interface between the patients and the likewise multi-cultural providers of the care. With notable exceptions, change in these areas has largely by-passed Israel.

The Israel National Institute for Health Policy and Health Services Research (NIHP) decided to accept the challenges presented by these issues and held an International Workshop on **"Culturally Appropriate Health Care by Culturally Competent Health Professionals"** in Caesarea, Israel in October 2007.

The Defined Objectives of the Workshop were:

1. To provide an understanding of the relationship between CULTURE and HEALTH.
2. To provide an understanding of the relevance of cultural and social disparity to the development, increase and possible reduction of health inequality.
3. To develop an understanding in the Health Care System (HCS) Leadership[1] of:
   a. The relevance of the cultural background of the different groups in an heterogeneous society, socio-culturally, to the planning and provision of health care[2].

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[1] Health Care System Leadership: Ministry of Health, Kupot Holim (HMOs), Health Academia, Israe Medical Association, Professional Organisations, Hospital Management

[2] Including Primary, Secondary and Tertiary prevention

   b. The relevance of the cultural background to the utilization of and compliance with health care services.
   c. The role of the Cultural Competence (CC) of health professionals in providing appropriate and quality health care to culturally heterogeneous population groups.
   d. The importance of linguistic appropriateness in the functioning of health care services.
4. To provide an understanding of the need to adapt the planning and provision of Health Information[3], at the population level, to the social/cultural background of the target population/s.
5. To expose the participants to the experience in North America and Western Europe in developing Culturally Appropriate Health Care and the CC of health professionals.
6. To initiate a dialogue in the HCS Leadership on the development of a program for Israel in Culturally Appropriate Health Care including the development of measures of Culturally Appropriate Health Care and CC and minimal levels of CC.
7. To provide educators in the HCS[4] with an experience in CC training for health care professionals

The Program

Six internationally renowned experts were invited to take part in the Workshop together with invited speakers from Israel:

Prof. Robert Like, Robert Wood Johnson Medical School, New Jersey, who is a leader in the US in the field of Cultural Competence of health professionals in general and physicians in particular.

Prof. Joseph Betancourt of Harvard Medical School and the Massachusetts General Hospital who was one of the authors of the IOM book on "Unequal Treatment" and heads the Mass General program on reducing health diversity.

Prof. Juergen Pelikan from Vienna who was central in the European Migrant Friendly Hospitals project and the European Health Promoting Hospitals.

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[3] Information related to rights under the Health Insurance Law; Availability and Access to Health Care; Health Risks; Health-related Behaviour; etc.

[4] Including physicians, nurses, public health specialists, social workers, pharmacists, health system managers, and others

Prof Gary Kreps an expert in health communication at all levels of the population from the George Mason University in Fairfax, Virginia.
Marjory Bancroft from Baltimore. Director of Cross Cultural Communications and considered a leader in the US in CC training.
Nataly Kelly a Consultant in Professional Interpreting.

We want to acknowledge our appreciation for the support given by **The Hadassah Medical Organization, The Israel Medical Association and The Myers-JDC-Brookdale Institute** that facilitated the attendance of our invited international experts.

The Workshop Program consisted of four parts:

1. **The Background to Cultural Appropriateness of Health Care:**
   The first day was devoted to reviewing the rationale for raising the issues.
   - the relationship between socio-cultural disparities and health was reviewed concerning North America (J. Betancourt), Western Europe (J. Pelikan) and Israel (L. Epstein)
   - the implications of Cultural Competence for Clinical Practice, Health Care organizations and Public Policy (R. Like)
   - Health Communication at the population level (G. Kreps) and the challenges posed by Social Marketing of health issues (N. Guttman)
   - The critical role of language in a multi-cultural society as seen in Israel (M. Schlesinger), the role of interpreting services (M. Bancroft and N. Kelly) and the relevance of Health Literacy (D. Levine)

2. **What has and can be done?**
   The morning of the second day was devoted to reviewing what has been done and the possibilities for change.
   - The European Migrant Friendly Hospitals Project (J. Pelikan)
   - The Boston Health Disparities Project and the Massachusetts General Hospital Program (J. Betancourt)
   - An Israel example — Diabetes in immigrants from Ethiopia (A. Jaffe)
   - The US CLAS Standards and the training of health professionals in CC (M. Bancroft and N. Kelly)
   - Graduate and undergraduate medical training in CC (R. Like)

3. A National Program for Israel

In the planning of the workshop it was decided that there should be a tangible outcome to the deliberations. This was a new feature in the Institute Workshops.

A Position Paper on **"Cultural Appropriateness of Health Services: Definition of Standards for Health Services, and for the Training of Health Professionals in Cultural Competence (CC), with the Objective of Reducing Health Inequality"** was prepared and presented for discussion on the second afternoon. In addition to the issues raised at the workshop the Position Paper was recirculated to all participants and updated for publication in this book.

4. The Third Day

Another innovation was the planning of a "hands-on" practical experience with a special workshop (dedicated training day) on **"Cultural Competence in Health Care: Culture and Language in Patient-Centered Care"** held on the third day (11/10/2007) and conducted by Marjory Bancroft and Nataly Kelly.

The enthusiasm that accompanied the participation and the response to the opportunity of experiencing a planned training day indicates the need for such activities.

The attendance at the Workshop and the active participation of those present, and especially the continued interest in the subjects raised, leaves little doubt that the decision to hold the event was more than justified. The challenge now is to translate the experience into practical action in the Health Care System.

Thanks

The Workshop would not have taken place without the tremendous efforts of the NIHP staff and especially that of Ziva Litvak. Special thanks to Amy Lipman for the organization and logistics of the event. The preparation of this book would not have happened without her.

Special appreciation to Prof Gur Ofer and Prof Haim Doron for their support and encouragement.

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Health and Health Care Implications of Cultural and Social Diversity: The Israel Reality

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ABSTRACT

During the 60 years since the creation of the State of Israel it has seen repeated waves of immigration from throughout the world. This is in addition to the highly varied cultural background of the local population. In the health care context this cultural diversity is a feature both of those in need of health care and of those providing it. The meeting between them delineates an important feature of the complexity of health care delivery to the Israeli population. In addition, the degree of socio-economic diversity has been growing and is at present amongst the greatest in the industrialized world.

The first line of the National Health Insurance Law states that it is based on principles of JUSTICE, EQUALITY AND SOLIDARITY. However the combination of social and cultural risk is associated with extensive inequality in health status (both physical and mental) and in health care delivery*. The individual is therefore not receiving equitable health care.*

There is at present no defined policy in Israel in relation to health inequality in general and the need to combat the health effects of cultural and social diversity in particular. Two recent research projects have defined the constituents of such policy as a basis for planned action in the health care system. These include:

- The need for a defined policy at a national level determined by the Ministry of Health and the Health Funds whose responsibility it is to plan, provide and assess the content of health care in order to
  - prevent the development of negative health effects of socio-cultural diversity
  - reduce health inequality where it already exists
- The reduction of physical and financial obstacles to equitable access to quality health care

- The planned development of Cultural Appropriateness as an essential constituent of health care delivery that includes:
    - provision of culturally appropriate health-related information for the heterogeneous Israeli population
    - recognition of the central role of language to the appropriate access and use of health care (written material and signs translated into the relevant languages, provision of interpreter services)
    - responsibility of the academic institutions for the training of the future health professionals in Cultural Competence
    - responsibility of the service agencies for the training of their health professionals in Cultural Competence

While there have been many planned interventions in Israel related to different facets of the above constituents of Culturally Appropriate Health Care they have been sporadic or in relation to a specific problem in a defined population group. There is a need to move from them to a national awareness of the issues, a defined policy and planned action.

DEFINING THE PROBLEM

One of the major objectives of the National Health Insurance Law 1994 is stated in its first sentence: "National Health Insurance according to this Law is based on the principles of justice, equality and solidarity ……..".(1) The reality in Israel is very different.

There is substantial data available that reveal differences in life expectancy, general mortality, infant mortality, accidents and their sequelae, health-related behaviour, and in access to and the quality of health care services.(2,3) Further these disparities are manifest in many of the demographic characteristics of the population – by gender, ethnicity, religion and degree of religiosity, socio-economic status (income), educational level, employment, age, and geography (e.g. center vs. periphery).

Moreover, the scope of health inequality is not static; in many important measures, it is growing at an alarming rate. In 1996 the difference in life expectancy at birth between Jewish and Arab males was 1.5 years. By 2006 it had widened to 4.6 years – a threefold increase.(4) Manor et al. found that the difference, by educational level, of age-adjusted odds ratio of death in both men and women, has widened over the last two decades.(5, 6)

Infant mortality is considered to be an important indicator of both the health status of a population and the equity of its health care. In addition to substantial difference by, area of living and population group (among other parameters), there is a very important difference by level of maternal education at the time of birth. In 1993-1996 there was a 3.5 times difference in the mortality of babies born to women of less than 5 years of formal education (13.4/1,000) as compared to babies born to academically qualified women (3.8/1,000).(7) In 2000-2002 the difference grew to 4.6 times (12.8/1,000 and 2.8/1,000).(8) A number of points need to be stressed in this connection. When a women is seen in the health services during pregnancy or on bringing the child for examination in the first year of life it is **too late to change (improve) her level of formal education**, and the challenge before the health service provider is to combat this risk. However in most health care frameworks educational level is not even recorded.
Jaffe(9) in another paper in this book has summarized the increasing prevalence of diabetes in Ethiopian immigrants to Israel since their arriving in the country. This certainly recalls a similar finding in the Yemenite Jewish migration to Israel prior to and soon after the creation of the State.(10)

Why is there Health Inequality?

It is internationally accepted that the major causes of health disparities lie in the general socio-cultural diversity of the population, — income, education, area of living and cultural background. While this is certainly relevant for Israel as well, it is important to define the different constituents of the socio-cultural diversity in the Israel population. These include:

a. The socio-economic differential that manifests itself in the widening income disparity in the population and substantial differences in educational level. The expression of these differences can be referred to as the "Culture of Poverty". Israel has the highest differential in income distribution of all the countries in Europe.(11)

b. The two major population groups in Israel — the Jewish and the Arab – are not single homogeneous entities. Jewish society has, in addition to its ethnic diversity, a very significant divide in relation to the degree of religiosity that extends from the ultra-religious Haredi groups to those who are secular in their beliefs and practices. Arab society is likewise not a single entity. The Moslem, Christian, Druze and Bedouin groups have substantial differences in many health-related characteristics. This diversity finds its expression in many health related outcomes.

c. For more than 60 years Israel has been the focus of migration of multitudes of people from many countries who all brought with them their own understanding of health and disease and experience of health care.

At the source of the disparities expressed in these different groups is their cultural background and for the purposes of this paper the following definition of culture is very relevant:
"Culture is a set of distinctive values, beliefs and perceptions that manifest themselves as human behaviour".
In relation to health the critical element is in the behaviour of individuals that is related to their cultural background. However it is of importance to ask an additional question in the field of health and health care — **whose culture** and **whose behaviour** is relevant?
The initial answer is clear and relates to the cultural background and all the above characteristics of the patient and their families and especially concerning their behaviour, whether promotive/preventive, compliant with recommended treatment or responsive to follow-up.

However there is a tendency not to consider two other groups:

1. **The Health Professionals:** The cultural background of the professional providers in Israel is as varied culturally as the patients they treat and it is at this interface that the issue of culture and health is of paramount importance.
2. **The Decision Makers** in terms of policy and delivery of health care. The principles of equality and solidarity were certainly central features in decision making in general, and in relation to health care, in particular at the founding of the State. However substantial changes have occurred in the economic and social philosophy of decision makers that have manifested themselves both in widening general disparities and in the degree to which society sees itself responsible for the health of all its members.

The totality of the culture and behaviour of the patients, the providers and the decision makers, and the interaction between them, constitutes the culture of the health care system. As awareness of the importance of the cultural background to the health of the population grew, so too did the need to promote the Cultural Appropriateness of the Health Care system while accenting the role of the Health Professionals and their functioning in a Culturally Competent manner. This was the theme of the Workshop.

WHAT HAS AND HAS NOT BEEN DONE? *

This relates to the three groups defined above:

1. **The Decision Makers:** There is no defined policy, in relation to Health Inequality in general and Cultural Appropriateness in particular, of the Ministry of Health, the 4 Health Funds (HMOs), the academic institutions, professional organizations, etc. While the presence of socio-cultural diversity and its relevance for health has been known for many years, the extent of the problems and the fact that the health effects are becoming greater has not been appreciated.(11) A major implication is the lack of planned action on a national level.(3,10) It should be stressed that this situation exists notwithstanding the availability of substantial data on a national and local level, most of which has not been used.
2. **The Health Professionals:** While the importance of poverty and culture to health is a subject raised in almost all academic programs in the health field, health professionals are rarely provided with the understanding of their role in combating the health-related results and especially do not receive the practical tools that they can utilize in their day to day work.
3. **The Population:** It should immediately be stated that there have been many programs directed to specific disease entities and/or specific population groups (HIV/AIDS in the Ethiopian immigrants, infant mortality in the Bedouin in the Negev or in the Arab population of the Western Galilee, mammography in the ultra-religious, diabetes in the Ethiopian immigrants, and others). However this arose because of a specific issue, frequently propagated by highly motivated professionals but not as part of a national policy, and frequently short-lived.

WHAT NEEDS TO BE DONE?

Two research projects in recent years carried out in the Myers-JDC-Brookdale Institute(12) and in the Taub Center for Social Policy Studies in Israel(3) have

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* As was seen at the time of the workshop

defined the need for national and institutional policy as well as the content of required action in relation to both health disparities and the need for cultural appropriateness and cultural competence. It is recommended:

I. National Policy

There is an urgent need for a clear definition of a National Policy by the Ministry of Health and the Health Funds that will provide all the service providers with the necessary directives and frameworks to act. It is after all their responsibility to plan, provide and assess the appropriateness of the health care services in their endeavour to maintain and promote the health of the population. National policy and action will be required to achieve two clear objectives:

1. To prevent the development of the negative health effects of socio-cultural diversity, e.g. increased infant mortality in low education mothers.
2. To identify existing health inequality with a view to intervene and reduce its extent, e.g. differential control of diabetes in low income patients.

It is clear that a prerequisite for such policy is the recognition of the issues and their severity that should lead to a political, professional and individual "will to act".

Further it should be realized that this is not a one-time effort but needs to planned, carried out and evaluated over an extended period of time. It will be the responsibility of the Health Care System and its institutions to provide the necessary resources from within or from external sources. The existence of health inequality and the lack of cultural appropriateness is costly for the system and the economic value of its reduction should be substantial.(13)

II. Physical and Financial Obstacles

A very important element in any planned action in this regard relates to the provision of quality health care services and ensuring equitable access to them for all population groups.

Further there exist substantial financial barriers to obtaining equitable care. This is manifested, amongst other things, in the requirement for co-payments especially for drugs and consultative care, as well as the possibility of purchasing supplementary insurance.

These very relevant and important issues were not considered in any detail in this workshop.

III. The Development of the Cultural Appropriateness of Health Services

Like any development in the field of health care the "revolution" required in order for services to be delivered in a Culturally Appropriate manner by Culturally Competent health professionals must be seen as the planned introduction of an "**essential constituent of health care delivery".**

The Commonwealth Fund in New York has defined Cultural Appropriateness and Competence(14) as:

"The ability of **systems** to provide care to patients with diverse values, beliefs, and behaviors including tailoring delivery of care to meet patients' social, cultural and linguistic needs.

The ultimate goal is a **health care system and workforce** that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or language proficiency".

The achievement of this goal provides a tremendous challenge to all health services and the professionals who work in them. It includes a number of constituent entities that include:

a. The provision of health-related information that is culturally appropriate for the heterogeneous Israeli population. The existence in Israel of very many population groups with tremendously different understanding of (amongst other things) health and disease (and their development), the need for early diagnosis and treatment, compliance with a medical regimen, and indeed all the components of the clinical process, requires that information to the public be provided in a culturally appropriate manner.

b. Recognition of the critical role of language in all societies and especially in a multicultural country such as Israel. It is a basic need of every patient to be understood and to understand what is said in their interaction with the health care system. This relates to at least three subjects:

- the need for signs in hospitals and clinics to appear in the major languages of the target population

- translation into the major languages of material that is distributed to patients and especially forms that they are requested to sign
- the provision of professional interpreting services when these are required in the clinical encounter.

c. Training in Cultural Competence in the Academic Frameworks: It should be the responsibility of the academic institutions to include specific training in Cultural Competence for all health professionals — physicians, nurses and para-medical personnel, including those who will function in administrative roles. It should be stressed that this training should include the relevance of Cultural Appropriateness and Competence to the potential reduction in health inequality.

d. Training in Cultural Competence for Health Professionals working in the field: This is probably one of the major challenges facing the system as it introduces the recommended changes. Health professionals in all fields and levels of functioning need to be aware of the importance of the issues, to be acquainted with the changes required, and to receive training in Cultural Competence on an ongoing basis. It is only when the subject of Cultural Competence becomes an integral part of the training and functioning of all health care professionals that substantial change will occur.

This is indeed the responsibility of the service frameworks — hospitals and community clinics alike.

CONCLUSION

Health professionals and the decision makers in the health care system have a clear responsibility to ensure the provision of health care that is delivered in a manner appropriate to the tremendously varied cultural background of the Israel population. This will require an awareness of the issues, their extent and seriousness, the will to plan, introduce and accept changes in the functioning of the system and its professionals, and thus to meet a basic human right to the highest possible level of health of all in Israeli society. It is their right and the responsibility of the system.

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Racial and Ethnic Disparities in Health Care

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INTRODUCTION

Over the course of its history, the United States has experienced dramatic improvements in overall health and life expectancy largely due to initiatives in public health, health promotion, disease prevention, and chronic care management. Our ability to prevent, detect and treat diseases in their early stages has allowed us to target and reduce premature and costly morbidity and mortality. Despite interventions that have improved the overall health of the majority of Americans, racial and ethnic minorities (Blacks, Hispanic/Latinos, American Indian/Alaska Native, Asian/Pacific Islanders) have benefited less from these advances (1). As a result of this and other causes, certain racial and ethnic minorities tend to suffer poorer health outcomes than whites from many major diseases (such as cardiovascular disease, cancer, diabetes, etc.) in the United States. These differences in health outcomes have been termed *racial and ethnic disparities in health*. Similarly, research has highlighted that minorities also may receive lower quality of care than whites in the health care setting — even when confounders such as stage of presentation and comorbidities are controlled for — and they have the same level of health insurance. These differences in quality are called *racial and ethnic disparities in health care* (1).

Nature and Extent of Racial and Ethnic Disparities in Health and Health Care

Research has shown that minority Americans have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS, among others (1,2). Multiple factors contribute to these racial and ethnic disparities in health. First and foremost, there is little doubt that social determinants — such as lower levels of education, overall lower socioeconomic status, inadequate and unsafe housing, racism, and living in close proximity to environmental hazards — disproportionately impact minority populations, and thus contribute to their poorer health outcomes (3-7). For example, three of the five largest landfills in the country are found in African-American and Latino communities; these environmental hazards have contributed to some of the highest rates of pediatric asthma among these populations (8). Second, lack of access to care also takes a significant toll, as uninsured individuals are less likely to have a regular source of care, are more likely to report delaying seeking care, and are more likely to report that they have not received needed care — all resulting in avoidable hospitalizations, emergency hospital care, and adverse health outcomes (9-11).

In addition to the existence of racial and ethnic disparities in *health*, there has also been research supporting the existence of racial/ethnic disparities in the *quality of care* for those with access to the health care system. For instance, disparities have been found in the treatment of pneumonia and congestive heart failure (African-Americans receiving less optimal care than whites when hospitalized for these conditions) (12,13) and referral to renal transplantation (African-Americans with end-stage renal disease being referred less to the transplant list than whites) (14). Disparities have also been found in the utilization of cardiac diagnostic and therapeutic procedures (African-Americans being referred less than whites for cardiac catheterization and bypass grafting)(15-19), prescription of analgesia for pain control (African-Americans and Latinos receiving less pain medication than whites for long bone fractures and cancer) (20-22), and surgical treatment of lung cancer (African-Americans receiving less curative surgery than whites for non-small cell lung cancer) (23), among others. Again, many of these disparities occurred even when variations in factors such as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account.

ROOT CAUSES FOR RACIAL/ETHNIC DISPARITIES IN HEALTH CARE

The Institute of Medicine (IOM) Report *Unequal Treatment*, released in March 2002, remains the preeminent study of the issue of racial and ethnic disparities in health care in the US (1). The IOM was charged to assess the extent of racial/ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care and to evaluate potential sources of racial and ethnic disparities in healthcare. To provide recommendations regarding interventions to eliminate healthcare disparities, the IOM studied health system, provider, and patient factors. The report found that:

- Racial and ethnic disparities in healthcare exist and, because they are associated with worse health outcomes, are unacceptable.
- Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.
- Many sources — including health systems, healthcare providers, patients, and utilization managers — may contribute to racial and ethnic disparities in health care.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.
- A small number of studies suggest that certain patients may be more likely to refuse treatments, yet these refusal rates are generally small and do not fully explain healthcare disparities.

Unequal Treatment went on to identify a set of root causes that included, among others:

1. Health System Factors: These include issues related to the complexity of the health care system, the difficulty that minority patients may have in navigating this complex health system, and the lack of availability of interpreter services to assist patients with limited-English proficiency.
2. Provider-Level Factors: These include issues related to the health care provider, including stereotyping, the impact of race/ethnicity on clinical decisionmaking, and clinical uncertainty due to poor communication.
3. Patient-Level Factors: These include patient's refusal of services, poor adherence to treatment, and delay in seeking care.

A more detailed analysis of these root causes is presented here.

Health System Factors

Health System Complexity

Even among those who are insured, educated, and have a high degree of health literacy, navigating the health care system can be extremely complicated and confusing (24). Some, individuals, however, may be at higher risk for receiving substandard care because of their difficulty navigating the complexities of the U.S. health care system. These individuals may include those from cultures unfamiliar with the Western model of health care delivery, those with limited-English proficiency, those with low health literacy, and those who are mistrustful of the health care system. People from these backgrounds may have difficulty knowing how and where to go for a referral to a specialist; how to prepare for a procedure, such as a colonoscopy; or how to follow-up on an abnormal test, such as a mammogram, for example. Since people of color in the US tend to be over-represented among the groups listed above, the inherent complexity of navigating our health care system has been seen as a root cause for racial/ethnic disparities in health care (1).

Provider-Level Factors

Provider-Patient Communication

There is significant evidence that highlights the impact of sociocultural factors, race, ethnicity, and limited-English proficiency on health and clinical care (25). Health care professionals frequently care for diverse patient populations who present varied perspectives, values, beliefs, and behaviors regarding health and well-being. These include variations in recognition of symptoms, thresholds for seeking care, comprehension of management strategies, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications. In addition, sociocultural differences between patient and provider influence communication and clinical decision making, and are especially pertinent given the evidence that clearly links provider-patient communication to improved patient satisfaction, adherence, and subsequently, better health outcomes (26, 27).

Thus, when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated effectively in the medical encounter, patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care may result (28).

A survey of 6,722 Americans 18 and over (29) shed additional light on this issue, and is particularly relevant given the important link between provider-patient communication and health outcomes. White, African-American, Hispanic, and Asian-Americans who had had a medical visit in the last two years were asked whether they had trouble understanding their doctor; whether they felt the doctor did not listen; and whether they had medical questions they were afraid to ask. The survey found that 19% of all patients experienced one or more of these problems, yet whites experienced them 16% of the time, compared to 23% of the time for African-Americans, 33% of Hispanics, and 27% of Asian-Americans.

In addition, provider-patient communication without an interpreter, in the setting of even a minimal language barrier, is recognized as a major challenge to effective health care delivery (30-32). Communication issues related to discordant language disproportionately affect minorities and others with limited-English proficiency and likely contribute to racial/ethnic disparities in health care.

Clinical Decisionmaking

Theory and research on clinical decisionmaking suggest that physicians' understanding and interpretations of information obtained from patients, as well as assumptions about patients themselves, may contribute to racial and ethnic disparities in health care (33,34). Stereotyping is central to this process. Stereotyping can be defined as the process by which people use social categories (e.g. race, gender) in acquiring, processing, and recalling information about others (35). The literature on social cognitive theory highlights the ways in which natural tendencies to stereotype may influence clinical decisionmaking. Faced with enormous information loads and the need to make many decisions, people subconsciously simplify the decisionmaking process and lessen cognitive effort by using "categories" or "stereotypes" that group information and decisions into groups or types that can be more quickly processed and executed. Sometimes, those stereotypes are applied to individuals who are lumped together into groups to which certain beliefs and expectations are attached (36). Interestingly, people may not be aware of their attitudes or consciously endorse stereotyping. Nevertheless, when people assign someone to a particular class or group, they tend to make a "snap judgment" in which they subconsciously and automatically assign the group's characteristics to that individual. Although *functional*, stereotyping can be systematically biased as people are automatically classified into social categories relating to dimensions such as *race, gender*, and *age* (1). These biases may exist in overt forms, as represented by outward racism or bigotry. However, because of their origins in virtually universal social categorization processes, they may also exist, often unconsciously, among people who strongly endorse egalitarian principles and truly believe they are not prejudiced. For example, doctors may suconsciously begin to equate certain races and ethnicities with specific health beliefs and behaviors (i.e. "these patients" engage in risky behaviors, or "those patients" tend to be non-compliant) that are more associated with the social environment (poverty, etc) than patient's racial/ethnic background or cultural traditions. This "conditioning" phenomenon may also occur if doctors are faced with certain racial/ethnic patient groups who don't frequently choose aggressive forms of diagnostic or therapeutic interventions. The result over time may be that doctors begin to believe that "these patients" don't like invasive procedures, and thus they may not offer them as options very ardently, if at all (37). In addition, doctors are commonly taught that their own personal characteristics (race, ethnicity, socioeconomic status), and personal characteristics of the patient and the clinical setting, should be excluded from consideration in the formulation of clinical decisions. Many non-medical factors, however, ranging from the patient's physical appearance to the organizational setting in which medical care is delivered, may have as much influence on clinical decisions as the actual signs and symptoms of disease. These non-medical factors include characteristics of the patient (including patient age, gender, socioeconomic status, race/ethnicity, language proficiency, and insurance status), characteristics of the doctor (including the specialty, level of training, clinical experience, age, gender, and race/ethnicity) and features of the practice setting (including location, organization of practice, form of compensation, performance expectations, and incentives (33). This may furthermore contribute to unconscious stereotyping.

All individuals stereotype subconsciously, despite the best intentions to treat every patient equitably. The challenge is that if left unchecked, stereotyping (especially stereotypes derived abnormally from conscious and subconscious societal cues, such as those related to race) may lead to lower quality of care for certain groups — such as minorities — who may be deemed less worthy of diagnostic or therapeutic procedures or resources (34,38). What is particularly salient is that stereotypes tend to be activated most in environments where the individual is *stressed, multitasking*, and under the *time pressure* — the hallmarks of the clinical encounter (1,36).

Patient-Level Factors

Mistrust

Trust is a crucial element in the therapeutic alliance between patient and health care provider. It facilitates open communication and is directly correlated with adherence to physician recommendations and patient satisfaction (39). Patients who mistrust their healthcare providers are less satisfied with the care they receive (40) and mistrust of the health care system greatly affects patient's use of services. This lack of confidence in physicians also results in inconsistent care, doctor shopping, self-medicating, and an increased demand for referrals and diagnostic tests by patients (41).

Based on historical factors of discrimination, segregation and medical experimentation, African-Americans in particular may be especially mistrustful of providers (42). The exploitation of African Americans by the U.S. Public Health Service during the Tuskegee study left a legacy of mistrust that persists even today among this population (43,44). A national survey, found that there is significant mistrust of the health care system among minority populations. Of the 3,884 individuals surveyed, 36% of Hispanics and 35% of African-Americans (compared to 15% of whites) felt they were treated unfairly in the health care system in the past based on their race and ethnicity. Perhaps even more alarming — 65% of African-Americans and 58% of Hispanics (compared to 22% of whites) were afraid of being treated unfairly in the future based on their race/ethnicity (45).

This mistrust may contribute to wariness in accepting or following recommendations, undergoing invasive procedures, or participating in clinical research. This in turn may lead doctors to misunderstand why African-American populations seem less adherent or less interested in aggressive treatments.

KEY RECOMMENDATIONS TO ADDRESS RACIAL/ETHNIC DISPARITIES IN HEALTH CARE

Unequal Treatment provides a series of recommendations to address racial and ethnic disparities in healthcare, focusing on a broad set of stakeholders. These included *health systems interventions, provider interventions, patient interventions, as well as some general recommendations.* These recommendations are described in more detail below.

Health System Interventions

- **Collect and report health care access and utilization data by patient's race/ethnicity**
  Any effort to identify and address disparities must begin with the collection of race/ethnicity data and the stratification of quality measures by these groupings.
- **Encourage the use of evidence-based guidelines and quality improvement**
  As part of ongoing quality improvement efforts, particular attention should be paid to the implementation of evidence-based guidelines for *all* patients, regardless of their race and ethnicity.
- **Support the use of language interpretation services in the clinical setting**

The use of interpretation services has clear implications for delivery of quality health care by improving doctors' ability to communicate effectively with patients with limited-English proficiency.

- **Increase the proportion of underrepresented minorities in the healthcare workforce**
  Despite composing 30% of the population, minority students accounted for approximately 6% of physicians and 10% of medical school graduates in 2001 (46, 47). It will be difficult to develop a diverse health care workforce that can meet the needs of an increasingly diverse population without dramatic change in the racial and ethnic composition of medical student bodies.

Provider Interventions

- **Integrate cross-cultural education into the training of all health care professionals**
  The goal of cross-cultural education is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds, and focuses on enhancing awareness of sociocultural influences on health beliefs and behaviors, and providing skills to understand, and manage these factors in the medical encounter (1). Cross-cultural education includes curricula on health care disparities, how to use an interpreter, and how to effectively communicate and negotiate across cultures.
- **Incorporate teaching on the impact of race, ethnicity, and culture on clinical decisionmaking**
  Unequal Treatment found that stereotyping by health care providers might lead to disparate treatment based on a patient's race or ethnicity. The LCME — the body that accredits medical schools — now has a directive that states that medical education should teach how a patient's race, ethnicity, and culture might subconsciously impact on communication and clinical decisionmaking (48).

Patient Interventions

- **Educate patients on how to navigate the healthcare system, and how to be more active in the medical encounter**
  Difficulty navigating the health care system and obtaining access to care can be hindrance to all populations, but to minorities in particular (1). Similarly, lack of empowerment or involvement in the medical encounter by minorities can be a barrier to care as well. Interventions should be developed to increase patients'

knowledge of how to best access care and participate in treatment decisions.

General Recommendations

- **Increase awareness of racial/ethnic disparities in health care**
  Recent surveys have shown that both physicians and the public tend to be unaware of the extent, and the severity, of racial and ethnic disparities in health care in the US. For example, a survey of 2,608 physicians whose primary activity is patient care found that the majority of respondents (mainly white) said that the health care system "never" 14% or "rarely" (55%) treats people differently based on race/ethnicity (49).
- **Conduct further research to identify sources of disparities and promising interventions**
  While the literature that formed the basis of the findings and recommendations of *Unequal Treatment* provided significant evidence for racial and ethnic disparities, there is clearly a need for a research agenda that identifies promising practices and disparities solutions (1).

NEW AREAS FOR EXPLORATION

Disparities and Quality Improvement

One major recent advance is that key healthcare stakeholders have begun to understand that disparities are in fact an *inequality* in quality. Health plans and hospitals, for example, have begun to consider the importance of stratifying their quality data by race/ethnicity so as to identify disparities and develop interventions to address them. The emergence of targeting disparities through quality improvement has gained significant traction nationally, especially given the fact that the IOM Report *Crossing the Quality Chasm* highlighted among its six pillars of quality the concept of *equity* — the principle that health outcomes should not vary based on personal characteristics such as race, ethnicity, and gender (50). There is no doubt that the quality approach to address disparities has great promise.

A VIEW FROM THE FIELD

The Boston Public Health Commission

After the IOM Report *Unequal Treatment* was released, Boston Mayor Thomas Menino convened the CEO's of all major hospitals, as well as prominent leaders from the community and business sector, to begin a discussion about how the city could address racial and ethnic disparities in health and health care. After this meeting, the Mayor, in partnership with the Boston Public Health Commission (BPHC) and its Director John Auerbach, appointed a Task Force (composed of hospital CEO's, business leaders, community leaders) and a Hospital Working Group (composed of leaders from the area of quality within Boston hospitals) to develop a city-wide blueprint over the course of a year. The Disparities Project released its findings in the summer of 2005, which included a City Data Report on Disparities, a Task Force Report on Addressing Disparities in Health, and a Hospital Working Group Report on Addressing Disparities in Health Care. In September of 2005, the Mayor Menino announced that $1 million dollars in grant funds would be distributed to more than 30 organizations to carry out the report's recommendations and help eliminate racial and ethnic disparities in health and health care. In March of 2007, Mayor Menino and the BPHC released a report detailing progress over the course of the first year of the Health Disparities Project. Mayor Menino remains the only leader of a major city to tackle this issue in such a comprehensive and dedicated fashion, and the BPHC the only health department that has spearheaded such a broad effort.

Massachusetts General Hospital (MGH)

In February 2003, in response to the release of the Institute of Medicine Report *Unequal Treatment*, MGH President Dr. Peter Slavin formed the MGH Disparities Committee. Dr. Slavin believed that while data specific to disparities at MGH was important, it was not necessary to begin to take action given *Unequal Treatment* had documented the issue nationally. In short, instead of embarking on a several year process of trying to identify disparities at MGH before taking action, Dr. Slavin felt that if the IOM said racial/ethnic disparities in health care existed, we should assume they existed at MGH until proven otherwise — and that if any disparities were found, interventions to address them should be developed immediately. To begin this effort, the MGH Disparities Committee was tasked to: 1) Identify key areas where racial disparities in health care may exist at MGH; 2) Develop solutions to address disparities found at MGH; and 3) Coordinate their efforts with the Mayor's city-wide initiative on disparities. The Committee divided itself into three subcommittees — Quality; Patient Experience and Access to Care; and Education and Awareness. Over the course of the last few years, the Committee has developed a diverse portfolio of activities:

1. MGH Disparities Dashboard

The goal of the Disparities Dashboard is to monitor several key components of quality by race and ethnicity. It was developed in response to The IOM Report *Crossing the Quality Chasm*, among which equity – the principle that quality of care should not vary by race, ethnicity, or gender, among other characteristics – is one of six pillars of quality. The first key step to insuring that a *Disparities Dashboard* could be developed was to pass a medical policy stating that all quality improvement data collection and initiatives need to be stratified by race and ethnicity.

2. Patient Telephone Survey

The Patient Experience and Access to Care Subcommittee became interested in better understanding minority patient's experience of care at MGH. Whereas patient satisfaction data could be stratified by race/ethnicity and provides some general information on patient experience, racial/ethnic minorities are often under-represented in patient satisfaction surveys and it was felt that a more detailed exploration of issues of race and racial disparities was helpful and necessary.

3. Multicultural Community Advisory Committee:

The Patient Experience and Access to Care Subcommittee also felt that MGH should develop a mechanism to routinely bring the community perspective into the disparities agenda. In 2004, it was decided that a Multicultural Advisory Committee (MAC) should be formed to achieve this purpose. The goal of the MAC is to advise MGH on minority patients' experiences of care and the perception of the hospital in various minority communities, as well as provide guidance and feedback on MGH's disparities efforts and initiatives. It is comprised of leaders, patients and their families from various minority communities.

4. Quality and Safety Rounds

Quality and Safety Rounds were started at MGH in 2002 with the goal of identifying from hospital staff what might be key issues that could jeopardize patient safety or lead to medical errors. To achieve this goal, a doctor-nurse team routinely visits an inpatient floor (in rotating fashion) and meets with a group of multi-disciplinary members of the care team who are available over lunch (which is provided as an incentive for attendance). Issues that have been identified in general include prevention of falls, for example. In 2003, a specific question focused on disparities was incorporated into Quality and Safety Rounds.

5. Diabetes Coaching and Colorectal Cancer Screening Navigator Programs

At MGH, an analysis of hospital data revealed significant disparities in diabetes management and colorectal cancer screening between minorities and whites. Program elements of the culturally competent diabetes management program include telephone outreach to diabetics that are in poor control using an electronic diabetes registry, group education sessions offered both in Spanish and in English, and a bilingual, culturally competent diabetes coach who works closely with patients to help them identify and deal with potential barriers to care. The CRC program focuses on helping patients overcome barriers to CRC screening by employing a bilingual, culturally competent lay "coach" or patient navigator. The bilingual patient navigator helps patients navigate through the MGH system and facilitate the process of obtaining a colonoscopy, including by providing assistance with scheduling, preparation, transportation, and follow-up.

6. Hospital Awareness

The MGH Hotline is a full-color, four-page weekly newsletter that is available to MGH employees, patients and visitors at the hospital campus, as well as at off-site clinics and buildings. Over the past several years, *MGH Hotline* has made a special point of providing frequent, regular coverage of issues and initiatives focused on racial/ethnic disparities in health care. This constant presence not only updates faculty, staff, and patients, but also communicates the importance of these efforts nationally, regionally and locally. The team in charge of developing the MGH Hotline articles has also been involved in creating a campus-wide poster campaign on MGH's efforts to identify and address racial/ethnic disparities in health care.

CONCLUSION

The issue of racial and ethnic disparities in health care has gained national prominence, both with the release of the IOM Report *Unequal Treatment,* as well as with the many recent articles that have confirmed their persistence. Furthermore, another influential IOM Report, *Crossing the Quality Chasm,* highlights the importance of equity — that there be no variations in quality of care by personal characteristics including race and ethnicity — as a central principle of quality (50). There are many obvious opportunities for interventions in the critical area of eliminating racial and ethnic disparities in health care. Greater attention to addressing the root causes of disparities will improve health care leaders and practicing clinicians ability to improve the care provided to *all* patients, not just those who are racial and ethnic minorities.

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The European Migrant Friendly Hospitals Program and its link to the Health Promoting Hospitals

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Migrants and ethnic minorities are especially vulnerable groups. They often face difficulties in accessing adequate health services, which are frequently not tailored to their needs (for an overview of research on the impact of migration and ethnic diversity on health care delivery see Bischoff 2006). Being one of migrants' first access points to health care, hospitals are a specifically important healthcare setting for migrants.

Already in 2001, this issue was raised within the WHO network of Health Promoting Hospitals.
(For the network's mission, concept, strategies, standards and development see the following websites and publications:
Gröne & Barbero 2005; Pelikan/Krajic/Dietscher 2001; Pelikan 2008
http://www.euro.who.int/document/E86220.pdf
http://www.hph-hc.cc/
http://www.euro.who.int/healthpromohosp
http://who-cc.dk/)

Health equity and improving the health of vulnerable groups is a major issue in the general health promotion movement; for hospital organisations, problems and conflicts around health care for migrants and minorities are increasingly considered under a quality perspective, as a quality issue asking for strategies measures of quality assurance and improvement.

Migrant and minority health was put on the agenda especially in the Italian HPH Network, which has been confronted in the last 15 years with quickly growing numbers of ethno-culturally very diverse immigrants and in whose health care system clinical and social care as well as public health perspectives are connected in rather integrated organisations.

So, on initiative of the Regional HPH Network of the Emilia Romagna, a project proposal was put together, in co-operation with other national and regional HPH networks in Europe. The European project "Migrant-friendly hospitals" (MFH) got financial supported from the European Commission, DG SANCO, and was able to work with hospitals from 12 EU member states from the end of 2002 to the beginning of 2005. For a project description see Krajic et al. 2005a; http://www.mfh-eu.net/public/files/mfh-summary.pdf

On the European level, the hospitals organised themselves as a benchmarking group, supported by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine at Vienna University as Co-ordinating Centre.

To make use of this potential, local "overall projects" (see below) were implemented to establish a framework for overall organisational development, and to facilitate three specific subprojects. These subprojects were selected on basis of a systematic needs assessment. See for strategy, concepts, tools and results the report on http://www.mfh-eu.net/public/files/experiences_results_tools/op_developing/Results_NeedsAssessment.pdf

The subprojects aimed at implementing and evaluation innovations in three action areas:
- Interpreting in clinical communication
- Training and information in mother and child care
- Cultural competence training for staff.

Interventions were designed according knowledge available from the systematic literature review (Bischoff 2006/ first version 2004) and supported by international experts in the specific intervention areas.

Interpreting in clinical communication

Research shows that non-local language speakers, especially migrant populations and ethnic minority groups often cannot communicate with their clinicians adequately to receive necessary information about their care. On the other hand clinical staff often does not understand the patients' needs and do not receive all relevant information from the patient. Within the sub-project "Improving interpreting in clinical communication" nine European hospitals worked together to improve communication between non-local language speakers and clinical staff by developing, implementing and evaluating professional interpreter services. The article outlines different strategies to improve clinical communication with migrant and ethnic minority patients (telephone interpreting, face-to-face interpreting, intercultural mediation and written material as supportive information) and evaluates their effectiveness from the perspective of the providers and the patients.

Evaluation was carried out in a benchmarking design including a pre — and a post-intervention staff survey and a post — intervention patient survey. In general, evaluation results of the pre — and post-intervention staff survey show that the implemented measures proved to be effective for both groups of stakeholders. Based on project experiences and results, recommendations are made for a concerted hospital quality management response to the problem of language barriers in clinical communication.

For a more detailed scientific analysis, see Novak-Zezula et al. 2005 and the detailed report, including tools for implementation and evaluation, on ttp://www.mfh-eu.net/public/experiences_results_tools/interpreting.htm

Training and information in mother and child care

The World Health Organization initiative 'Making Pregnancy Safer' (2000) names working with individuals, families and communities in a health promotion and empowerment approach as key strategy for maternal and newborn health. As migrant women were found to have a higher risk than the average population of under-using prenatal care and of receiving inadequate care in the pre — and postnatal phase, the group is highlighted as of particular concern for health policies and programmes.

In this subproject, two hospitals (in Austria and Italy) worked on the development and implementation of training courses for pregnant migrant/ethnic minority women. The courses designed on the basis of a needs assessment with migrant women, focused on four quality dimensions: access, information, sensitivity to literacy levels and support of facilitators. Evaluation was based on post-course interviews with clients and staff, including ratings of the four quality dimensions and the effects on maternal literacy of participants.

Main results in both countries showed that (1) women gave positive ratings on all quality dimensions and reported that their knowledge improved a lot (2) staff members' ratings concerning knowledge gain were less positive; (3) despite all efforts to make access to courses easy (no fees, transportation facilities, child care), participation was disappointingly low. Discussion and analysis of these results within the European project group indicate that (1) courses are a successful measure for women who attend; (2) the knowledge needs of clients are different from the perspectives of staff, something that should be investigated more fully (3) closer co-operation with migrant communities and a better understanding of the role of men (husbands and relatives) and their integration into service planning are needed to increase the access rates of migrant/ethnic minority women to maternity care services.

For a more detailed analysis, see Karl-Trummer et al. 2006 as scientific paper and the detailed report, including tools, on http://www.mfh-eu.net/public/experiences_results_tools/mother_and_child_care.htm

Cultural Competence Training

Cultural competence training (CCT) for staff in health care seems one of the most widespread measures to deal with ethno-cultural diversity, especially in North America. Most of the documented studies and experiences on cultural competence training originate from the US, whereas European contributions still are rare — at least from continental Europe. Training for all types of hospital staff was implemented in seven European hospitals, primarily with the goal to support staff. Evaluation criteria were feasibility/acceptability, quality, effectiveness, cost-effectiveness and sustainability. Data were collected by a staff questionnaire in a before — after design, by documentation sheets, telephone interviews with project co-ordinators and group discussions at project meetings. Key findings: 7 of 8 pilot hospitals managed to implement CCT, with (a) wide variations of acceptance among staff as measured by participation (b) considerable variations in quality as measured by concordance with a training "Pathway" agreed upon (c) generally good impact on staffs' self-perceived knowledge, skills and comfort level in trans-cultural situations (d) good cost-effectiveness concerning external costs and (e) good sustainability as far as the general acceptance of the issue as part of CPE for hospitals is concerned.

Main critical points for implementation: (1) Support by management is crucial (2) Time and energy is needed to convince staff of relevance (3) Training oriented at solving the real specific problems of everyday practice is more likely to be accepted (4) A skills-oriented design including experiential learning is useful but difficult to integrate with long working hours and changing shifts (5) Recruiting competent trainers is crucial – but the profile required for an integrated, skills oriented training is difficult to match. (6) Thus, splitting the integrated training model into a short generic introduction combined with inclusion of cultural diversity issues into normal quality improvement routines of departments should be tested.

For a scientific analysis, see Krajic et al. 2005; detailed report, including the tools for implementation and evaluation: http://www.mfh-eu.net/public/experiences_results_tools/cultural_competence_training.htm

Overall Organisational Development Process

Sustainable improvements of complex organisations, like hospitals, can be achieved only within the framework of an overall organisational development process. In line with quality management procedures, this process was initiated by defining three core principles of migrant friendliness: valuing diversity by accepting people with diverse backgrounds as principally equal members of society; identifying the needs of people with diverse backgrounds and monitoring and developing services with regard to these needs; and, finally, compensating for disadvantages arising from diverse backgrounds.

For defining and measuring "Migrant Friendliness" an assessment instrument was developed. The "Migrant Friendly Quality Questionnaire" (MFQQ) covers the status quo of overall "migrant-friendliness" concerning services and (quality) management structures. Having been used for two assessments (2003 and 2004) within the 12 European Partner Hospitals and for 5 observer hospitals in Germany and Ireland, all locally organised within the Health Promoting Hospitals network, the MFQQ instrument proved to be feasible and informative.

The MFQQ was useful in systematically assessing migrant-friendly structures such as interpreting services, information material for migrant patients, culturally sensitive services (religion, food), as well as components of a (quality) management system to enable and assure the migrant-friendliness of services, but experiences also indicate areas for further improvement.

For a more detailed analysis see Karl-Trummer et al. 2007 and the report, including tools, on http://www.mfh-eu.net/public/experiences_results_tools/

developing_mfh_overall_projects.htm. For an edited version of the MFQQ instrument, contact the authors.

European Recommendations: The Amsterdam Declaration

For general agenda setting on the issue, to disseminate project results and to provide an ongoing process, on a EU level the Amsterdam Declaration "Towards Migrant-Friendly Hospitals in an Ethno-Culturally Diverse Europe" was developed and launched at the final Conference of the Project in December 2004, supported by a range of relevant international organisations, including IOM, ILO, WHO, IUHPE, HOPE, IAPO etc. The Amsterdam Declaration is available in 11 European languages, see:
http://www.mfh-eu.net/public/european_recommendations.htm

Follow up: Task force on Migrant Friendly and Culturally Competent Hospitals (MFCCH) in HPH network

To safeguard continuity of work on that issue after the end of the EU project, a Task Force has been set up within the Health Promoting Hospitals Network, co-ordinated by the Regional HPH Network of the Emilia Romagna, Italy, which had had a prominent role already in initiating the European Project. Since 2005, the task force has organised HPH presentations and discussions at each of the annual HPH conferences, at general health promotion and also Public Health conferences. See abstracts and Powerpoints in the Virtual Proceedings of the HPH conferences at http://www.hph-hc.cc/conferences.php.
Semi-annually, the Advisory Board is meeting in different parts of Europe, exchanging perspectives, preparing public presentations and further projects to develop and proliferate knowledge and tools. For information and materials on the meetings, see http://www.who-cc.dk/news-1.
Since 2007, the Task Force has been able to systematically co-operate with a researchers' network in the European Cost program, thus building up its capacities for research and proliferation. (COST Action IS0603 Health and Social Care for Migrants and Ethnic Minorities in Europe, http://www.costhome.eu/management/index.php/Main_Page).

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Cultural Competence: Implications for Clinical Practice, Health Care Organizations, and Public Policy

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Abstract

Developing cultural competence has been proposed as a strategy that can help to reduce disparities and inequalities experienced by patients in a culturally, ethnically, and socially diverse society. The cultural competency movement has reached "the tipping point," and a variety of important systemic, organizational, clinical, and community-based cultural competency initiatives are underway around the world. In this paper, the concept and rationale for culturally competent health care is defined. Important environmental forces discussed include the changing general population and workforce demographics; efforts to eliminate disparities and inequalities in access to care, service utilization, quality, and health outcomes; emerging accreditation, legislative, and regulatory requirements; business and market forces, and malpractice and liability concerns. The American Medical Association's educational DVD, Eliminating Racial and Ethnic Disparities: One Physician at a Time, is used to illustrate selected cultural, language, and health literacy issues that contribute to racial and ethnic disparities in clinical care settings. Strategies and best and promising practices for becoming a culturally competent practitioner, health care organization, and service delivery system are described. It concludes with a review and discussion of current legislative, accreditation, and policy initiatives in the United States that are supporting disparity reduction efforts as well as the provision of culturally and linguistically appropriate care.

Interest in the subject of culturally competent health care has reached the "tipping point,"[1] and a variety of important initiatives are underway around the world.

During this presentation, I would like to share information about several of these efforts, focusing on the United States' experience. In particular, 1) the concept and rationale for culturally competent health care will be defined; 2) selected cultural, language, and health literacy issues that contribute to racial and ethnic disparities in clinical care settings will be discussed; and 3) legislation, accreditation, and policy initiatives that relate to disparity reduction and culturally and linguistically appropriate service delivery will be described.

In their seminal Commonwealth Fund Report, Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches, Betancourt et al.[2] discussed how cultural competence needs to be understood and operationalized at the organizational, systemic, and clinical levels. A useful general definition of cultural competence (and there are many others) is the following: "cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs." (page v).

The Georgetown National Center for Cultural Competence has provided the following rationale for why culturally competent health care is important: 1) responding to demographic changes; 2) eliminating disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds; 3) improving the quality of services and outcomes; 4) meeting legislative, regulatory, and accreditation mandates; 5) gaining a competitive edge in the marketplace; and 6) decreasing the likelihood of liability/malpractice claims.[3]

Research is currently ongoing relating to whether cultural competence can reduce racial and ethnic disparities in health and health care. Strategies and interventions being examined include: interpreter services, recruitment and retention of minority staff, cultural competency training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, involving family and/or community members, immersion into another culture, and administrative and organizational accommodations.[4-6]

A variety of collaboratives have formed that are engaged in disparities reduction and cultural competency-related quality improvement, educational, and advocacy efforts. These include: the Institute for Healthcare Improvement (IHI) Health Disparities Collaboratives — *Changing Practice/Changing Lives* (www.healthdisparites.net), National Initiative for Children's Healthcare Quality (NICHQ) - Improving Cultural Competency in Children's Health Care (http://www.nichq.org/NR/rdonlyres/5B534B7B-0C38-4ACD-8996-EBB0C4CB2245/0/NICHQ_CulturalCompetencyFINAL.pdf), and the National Health Plan Collaborative (http://www.chcs.org/NationalHealthPlanCollaborative/index.html)

The American Medical Association, National Medical Association, National Hispanic Medical Association, and more than 65 other leading health professional associations have also formed a National Commission to End Health Care Disparities whose mission is the following: "The Commission to End Health Care Disparities, inspired by the Institute of Medicine Report, "Unequal Treatment," recognizes that health care disparities exist due to multiple factors, including race and ethnicity. We will collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system." (see www.ama-assn.org/go/healthdisparities and http://www.ama-assn.org/ama/pub/category/12809.html).

A growing number of educational programs are now available to help raise awareness of physicians and other health care professionals about the subject of disparities in health and health care as well as the role of cultural and linguistic competence in helping to close the disparities gap. An example of a particularly relevant and impactful DVD is the American Medical Association's Working Together to End Racial and Ethnic Disparities: One Physician at a Time (http://www.ama-assn.org/ama1/pub/upload/mm/433/health_disp_kit.pdf)

Important issues addressed in the DVD include: quality of care, trust and stereotyping, cultural competence, language barriers, and health literacy in real world clinical care settings. A more in-depth discussion of available graduate and undergraduate curricula, training activities, and educational resources can be found in another chapter in this book (see Graduate and Undergraduate Cultural Competence Education, pages 156-169)

Improving communication skills during clinical encounters is seen as critical along with developing an increased awareness of the "health seeking process,"[7] the roles of the popular, folk, and professional sectors of care,[8] one's own personal and professional values, attitudes, beliefs, behaviors, and biases,[9] and the impact of biomedical culture.[10] A useful framework summarizing key issues that need to be addressed in providing culturally competent, patient-centered clinical care is RESPECT.[11] (see Figure 1)

Figure 1: Respect Model

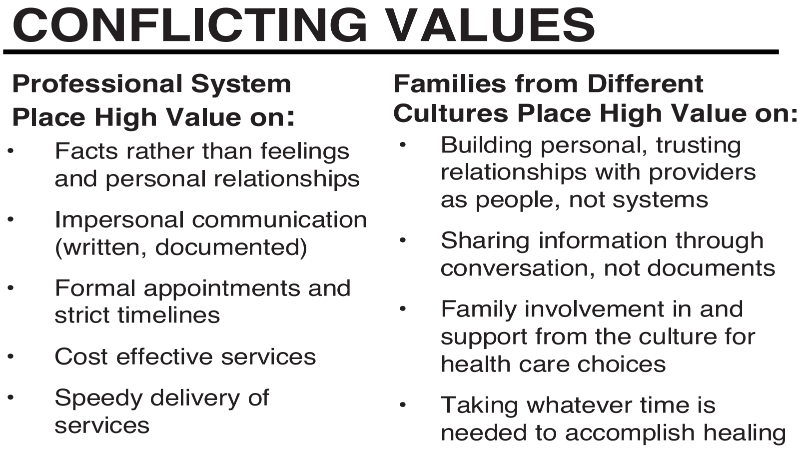
R : Respect
E : Explanatory Model
S : Sociocultural Context
P : Power
E : Empathy
C : Concerns and Fears
T : Therapeutic Alliance/Trust

Developed by the Boston University Residency Training Program in Internal Medicine, Diversity Curriculum Taskforce. Published in Bigby J.A., ed. Cross-Cultural Medicine, Philadelphia, PA, American College of Physicians/ACP Press, 2003, p. 20.

This figure is reprinted with permission from the American College of Physicians /ACP Press.

As health care organizations and systems embark on the "cultural competency journey," they also need to recognize and address the conflicting perspectives that often exist between what professionals and patients/families/ communities value.[12] (see Figure 2).

Figure 2



CONFLICTING VALUES

Professional System Place High Value on:

- Facts rather than feelings and personal relationships
- Impersonal communication (written, documented)
- Formal appointments and strict timelines
- Cost effective services
- Speedy delivery of services

Families from Different Cultures Place High Value on:

- Building personal, trusting relationships with providers as people, not systems
- Sharing information through conversation, not documents
- Family involvement in and support from the culture for health care choices
- Taking whatever time is needed to accomplish healing

Nelkin VS, Malach RS: Achieving Healthy Outcomes for Children and Families of Diverse Cultural Backgrounds: A Monograph for Health and Human Services Providers. Bernalillo, NM: Southwest Communication Resources, 1996, page 20.

This figure is reprinted with permission from Abrazos Family Support Services/Southwest Communications Resources.

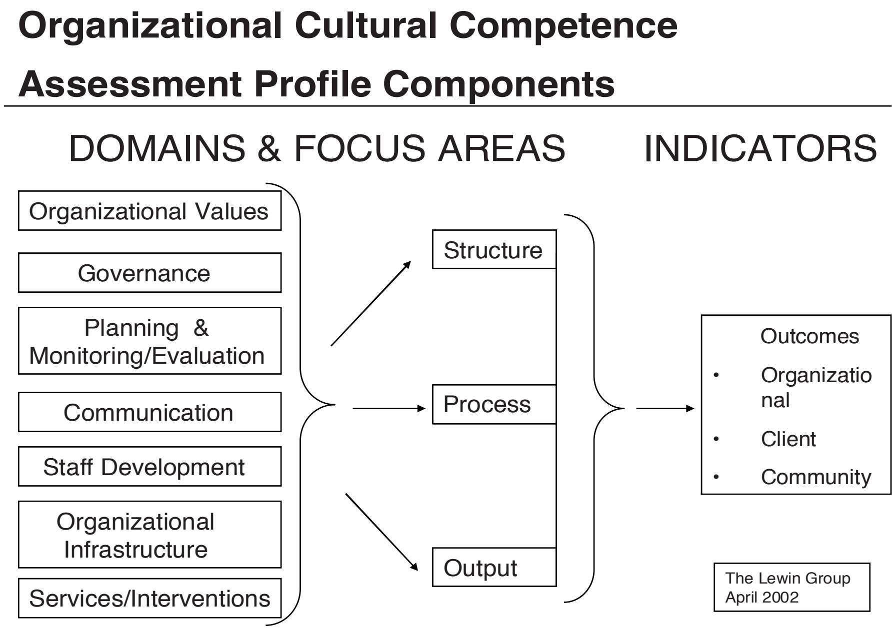
In order to improve "organizational/systemic cultural competence," the United States Department of Health and Human Services' Office of Minority Health has published the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15 (see Table 1 in appendix), as well as related assessment and educational programs. http://www.thinkculturalhealth.org

Organizations such as the Joint Commission have prepared a cross-walk between the CLAS Standards and existing accreditation requirements.[13], and also published findings from national studies examining how hospitals are addressing language access, cultural competency, health literacy, and patient safety challenges in their organizations.[14-15] Similarly, the National Committee on Quality Assurance (NCQA), with funding support from the California Endowment, has developed an award to recognize innovative practices in managed care plans relating to serving culturally and linguistically diverse populations.[16] In Europe, The Amsterdam Declaration Towards Migrant Friendly Hospitals in an Ethno-Culturally Diverse Europe, provides another important framework that has now been connected to the World Health Organization's Health Promoting Hospital's Network. (http://www.mfh-eu.net/

public/european_recommendations.htm). Similar efforts are also underway in Australia, Asia, the Middle East, and other nations.

In terms of assessing "organizational/systemic cultural competence," a variety of tools exist that have been used in different settings (e.g., hospitals, ambulatory care facilities, managed care plans). The Lewin Group, for example, has published, Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profiles http://www.hrsa.gov/culturalcompetence/indicators). The Lewin framework can be used as an organizing framework, a readiness tool, or for staging progress on the continuum of culturally competent service delivery.[17] (see Figure 3).

Figure 3



Linkins KW, McIntosh S, Bell J, Chong U, The Lewin Group. Indicators of Cultural Competence in Health Care Delivery Organizations: An Organization Cultural Competence Assessment Profile, prepared for the Health Resources and Services Administration, U.S. Department of Health and Human Services, April 2002. http://www.hrsa.gov/culturalcompetence/indicators

Additional helpful assessment tools and resources can also be obtained at sites including the Georgetown University National Center for Cultural Competence (http://www11.georgetown.edu/research/gucchd/nccc), the Cross-Cultural Health Care Program (http://www.xculture.org), DiversityRx (http://www.diversityrx.org), and the Medicare Quality Improvement Community (MedQIC) cultural competency website (http://www.medqic.org/dcs/ContentServer?cid=1157485300999&pagename=Medqic%2FContent%2FParentShellTemplate&parentName=Topic&c=MQParents).

The need to address health literacy, cultural competency, and language access challenges in an integrative manner has been stressed.[18] Collecting reliable and valid self-identified race, ethnicity, and primary language data has also been recognized as essential to ongoing quality improvement and patient safety efforts.[19-23]

Legislative interest in cultural competence, improving language access, and eliminating racial and ethnic disparities in health and health care is also increasing. At the Federal level, the Minority Health and Health Disparity Elimination Act of 2007 (S. 1576) http://www.govtrack.us/congress/bill.xpd?bill=s110-1576; Minority Health Improvement and Health Disparity Elimination Act of 2007 (H.R. 3333) http://www.opencongress.org/bill/110-h3333/show; and the Health Equity and Accountability Act of 2007 (H.R. 3014) http://www.opencongress.org/bill/110-h3014/show have all proposed significant funding for cultural competency initiatives as an important strategy for improving the health and health care of racial and ethnic minority groups.

"At the State level, New Jersey, California, Washington, and New Mexico have enacted legislation mandating cultural competence training for health professionals, over the past three years, and at least seven other states have proposed bills or have bills pending.".[24] http://www.thinkculturalhealth.com/cc_legislation.asp. Forty three states have one or more laws addressing language access in healthcare settings, and a growing number of states have provided funding for studies of disparities and identifiable minority health initiatives, cultural competence, and minority health awareness months.[25]

In an important Commonwealth Fund monograph, A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities, McDonough et al.[26] identified the following eight key needs for policymakers:

1. Addressing the need for better and more consistent data collection
2. Effectively evaluating programs to determine which disparities reduction initiatives produce positive results
3. Emphasizing stronger cultural and linguistic competence in all disparities reduction activities
4. Establishing and expanding workforce development programs to increase diversity and to improve the cultural competence of all health care professionals
5. Ensuring access to services as well as screening (lack of health insurance is a major obstacle to reducing disparities)
6. Creating and/or improving state minority health offices and infrastructure;
7. Involving all health system stakeholders in efforts to reduce disparities
8. Create a national coordinating body to promote state-based activities for eliminating racial and ethnic health disparities

As cultural competence, language access, and disparities reduction efforts in health care organizations and service delivery systems proceed, it will be important to apply the insights gained from chaos and complexity science in different practice settings.[27-29] In particular, it will be important to address these issues ecologically in relationship to patients, practitioners, the clinical encounter, interdisciplinary teams, the organizational context, the local community, and the health system. It will also be important to navigate between different preferred metaphors for diversity - melting pot, mosaic, salad, rainbow, kaleidoscope, tapestry, cauldron, and others - that may be guiding (consciously or unconsciously) these transformational initiatives.

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APPENDIX

Table 1. : The U.S. Department of Health and Human Services Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/ oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

    Published in the_*Federal Register*: December 22, 2000 (Volume 65, Number 246, pages 80865-80879). Additional information is available at: www.omhrc.gov/CLAS.

Challenges and Dilemmas in Social Marketing of Health Issues in Culturally and Socially Diverse Populations: The Case of Israel

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Government agencies and public organizations are increasingly enlisting social marketing strategies to influence health-related behaviors.[1] This essay begins with a brief overview of social marketing as it relates to the promotion of health in diverse populations and then raises seven challenges and ethical dilemmas as they relate to the case of Israel, with implications to other contexts as well.

SOCIAL MARKETING AND HEALTH PROMOTION IN DIVERSE POPULATIONS

There are numerous definitions of social marketing and each may represent different ideological and pragmatic approaches on how to influence people's attitudes and behaviors for the purpose of promoting the welfare of individuals and society.[2] A typical definition of social marketing refers to it as "a program-planning process that applies commercial marketing concepts and techniques to programs that aim to promote voluntary behavior change of individuals or communities in order to advance their personal welfare or the good of the public".[3]
Some approaches broaden this definition to include a wide array of cross-disciplinary theory-based behavior-change approaches that draw on a series of strategic elements. The strategic elements "borrowed" from commercial marketing can remind health promotion practitioners that even well-intentioned health promotion goals are not initiated in a vacuum, and may not necessarily be a priority for intended populations with other vital concerns such as housing, education, discrimination or employment. An underlying assumption in social marketing is that it behooves those who aim to promote changes in health practices in diverse communities to attend not only to the kind of issues that commercial marketers take into consideration (e.g., attitudes towards benefits; promotion channels), but also to issues unique to social causes (e.g., social disparities, institutional

changes).

Social marketing key elements: Designing and implementing a program with a social marketing approach calls for systematic and culturally-attuned methodology. Thus, the growing movement in healthcare to address issues of cultural competence corresponds to a central role accorded to social marketing in health promotion. The core assumptions upon which social marketing is based are compatible with some of the underlying assumptions of cultural sensitivity: to consider the needs and wants of the intended populations and to take into consideration their cultural beliefs, norms, customs, and social system. Social marketing, however, also draws upon the notion of the "marketing mix," which is adapted from commercial marketing and originally referred to as "the four Ps": "Product," "Price," "Place" and "Promotion," and an additional central element, which is "segmentation." The marketing 'Ps' are modified for social marketing; for example, "Product" typically refers to the positive attributes and benefits associated with the recommended behavior or practice, in particular as they relate to the wants and needs of the intended population. Several other key elements are elaborated below, and are followed by a discussion of some challenges and ethical concerns associated with these elements when applied to the context of social marketing in diverse populations.

Price or "cost": The consideration of how intended audiences view the potential "costs" and "benefits" of the behavior they are encouraged to adopt or avoid is one of the major elements in social marketing.[4] This corresponds to theoretical conceptions in the health promotion literature such as the Health Belief Model's element of "barriers"[5] and economics or psychological frameworks such as "exchange" and gain- and loss-framed messages.[6] "Price" refers to the various "costs" people may assume in order to adopt the behavior, which may be physical, emotional, making an effort, giving up something pleasurable, changing one's personal identity, and other types of hardships. Marketing professionals emphasize that the "cost" or the barriers to the adoption of the recommended practice must be seen from the viewpoint of the intended population. Consequently, involving members of the intended population in the intervention process would focus on addressing the "costs" or barriers associated with adopting the recommended behavior and potential for increasing perceived benefits or rewards. This has particular relevance when the intended population consists of members of minority groups or is culturally diverse, because their conceptions of what constitutes a "price" may be unique to their circumstances or cultural beliefs. Thus, for Arab women living in a certain village, walking as a form of physical activity may not be a feasible option because it may not be culturally acceptable for women to go for a walk for this purpose.

Place: The "place" in social marketing programs may refer to the location in which the recommended activity can take place or organizations and agencies that promote the recommended behaviors. For members of diverse populations, the "place" where services may be provided or pertinent health-related information may be disseminated is also of particular importance. People may not go to a site viewed as inaccessible, whether because of language, attitudes of service providers, or difficulties related to physical access. All these are issues that social marketing identifies as critical elements that need to be addressed in order to succeed in achieving desired behavior changes.

Promotion: This refers to the communication channels or strategies used to reach to the intended populations. These may include various media or interpersonal contacts, but, perhaps more importantly, what is most appropriate according to those who are intended to be involved in the program. Promotion can be paid for (e.g., paid advertisements or direct mailings), or achieved through public relations strategies (e.g., newspaper articles). Promotion may be carried out through interpersonal networks, community events, websites, or through influential individuals; for example, to reach ultra-orthodox Jewish women, the women who administer public ritual bath houses may carry out promotion. In Israel in ultra-orthodox communities an effective strategy for disseminating information is through posters posted on community billboards in public places; in particular near the synagogue and places of study when men are the intended population of the social marketing program. When promoting health issues to diverse population special is needed not to offend potential audiences, whether through graphic portrayals, language and content. Further, some groups may be offended if they see that materials or messages have been tailored to meet the needs of certain other groups, but none have been developed for them.[7] Thus, promotion of materials for particular groups needs to take into consideration that other groups may be exposed to these materials and may feel they are entitled to the same.

Competition: A marketing perspective also underscores the issue of competition: what in the social and physical environment may compete with the adoption of the recommended practices? Which products, behaviors or services compete in their attractiveness, comfort, ease, acceptability and accessibility, with the ones the program is trying to promote? For example, competition for smoking prevention initiatives may be the marketing of cigarettes, which is culturally tailored to the intended population; for example, there are cigarette brands produced to appeal to members of certain ethnic groups. Competition can also be commercially-produced soft-drinks or "fast foods," which compete with more nutritional food products.

Segmentation: Perhaps one of the marketing principles most relevant to health promotion in diverse populations in the notion of "segmentation": identifying sub-groups within a population according to relevant characteristics, not necessarily according to conventional sociodemographics. For example, subgroups may be identified according to attitudes or practices directly related to the specific issue. The intended population is never viewed as a monolithic entity. Rather, care and scrutiny are used to identify groups within the general population, or within various cultural groups. Thus, a central tenet in social marketing is to identify and characterize the unique perspectives and preferences of each sub-population, rather than assume that certain health recommendations or "tips" would appeal to all. For example, an intervention to promote consumption of vegetables and to reduce intake of sweet beverages among families of single-parent Ethiopian immigrant women in Israel, who tend to be employed outside the home in low-paying jobs, does not follow a social marketing approach if it focuses on research results demonstrating the benefits of vegetables and the harm of sweet beverages. A program following a social marketing approach would aim to learn from the women themselves, Who may think that it would make it difficult to increase the consumption of vegetables and to reduce the consumption of sweet beverages in their families. It would try to learn from the women why they purchase sweet beverages for their children, even if they understand this may be detrimental to their health. Based on these insights, the program would develop activities, information and practical suggestions to reduce the women's purchase and serving of sweet drinks. The suggestions and tips would relate to these women's lifestyle and economic means. Ideally, the program progresses further to promote changes in the social and economic environment that prevent the Ethiopian families from adopting behaviors that can help promote their health.

It is commonly agreed that the "marketing" elements in social marketing that draw on a commercial marketing approach may not being fully compatible with programs that aim to promote social and health issues. Nonetheless, the consideration of the "marketing mix" elements in social marketing, in particular the consideration of the notion of "costs" from the perspective of the intended population as well as the notion of alternative ways to think about sub-populations according to their behaviors and beliefs, can offer important insights for the design of programs that aim to address the needs of diverse populations. Further, the systematic process of marketing, planning and implementation that takes into consideration competition, collaborations and a through formative evaluation process offers important insight on how to improve the design and implementation of social marketing programs aimed to advance the health and welfare of diverse populations.

CHALLENGES AND ETHICAL CONCERNS IN SOCIAL MARKETING TO DIVERSE POPULATIONS

Because social marketing, by definition, aims to influence the beliefs and practices of members of the intended population, it raises issues concerning respect for people's autonomy and privacy.[8] In fact, each of the elements of social marketing present particular challenges that relate to health and culturally and socially diverse populations.[9] In the following sections, seven challenges associated with social marketing and diverse population are explored as they relate to the following issues: (1) Diversity within minority groups themselves; (2) Avoiding stigmatization; (3) Commercial competition; (4) Choosing behavior-change theories beyond individual-change models; (5) Using new and conventional media channels; (6) Moral relativism and harm reduction; (7) Adopting both a culturally-sensitive approach.

1. The challenge of diversity within minority groups themselves

Marketing planning differentiates populations into subgroups of, for example, people who share needs, wants, lifestyles, values, or social relationships that make them likely to respond similarly to public health interventions. In social marketing, similarly, characterization of sub-groups within the intended population is likely to focus on attitudes or behaviors as they relate to the issue or behavior-change goal that is being promoted. Thus, an important task in developing a social marketing health intervention in diverse populations is to identify relevant segments or sub-populations that would be accorded high priority in program development. This differentiation can enable the program to "target" particular sub-groups by using particular communication channels and appealing to particular values and norms. Further, it can "tailor" the intervention: making efforts to literally customize communication tactics to fit the social and cultural beliefs and practices of intended audiences.[10] This may include specific tips or messages to suite the particular preferences or characteristics of individuals or members of very small groups.[11] For example in particular ultra-orthodox communities there is a relatively high number of unvaccinated children because of lack of trust in particular healthcare givers in the community regarding immunizations. Thus, mobile services that provide vaccinations or special "vaccination days" in a setting that these members of the community trust can be arranged. Clearly, within each population there is an additional diversity. For example, In Israel, among ultra-orthodox Hassidic Jews, there are over two hundred communities, each influenced by its religious leader, and each with its own sub-culture, beliefs, and norms.

In commercial and social marketing, people's sense of identity and identification are considered as important factors in their consumption of goods and services. This has also been found to be related to their mass media use. With the large number of media outlets in Russian it is evident that many of the Russian immigrants in Israel, even those with high Hebrew proficiency, tend to prefer Russian language media. A study by Adoni, Caspi and Cohen[12] provides an analysis of the media use of several minority groups in Israel. Drawing on their analysis, the researchers created a grid in which within each immigrant or minority group four groups are identified according to two major parameters: those who make high or low use of their own language media and those who make high or low use of the majority language media. The combination of these two creates four groups, which they labeled as (a) "Dualists" – those who are both high in their use of the majority language; (b) "Adapters" – those who are high in their use of Hebrew and low in their use of their own language; (c) "Separatists" – those who are low in the use of Hebrew media and high in the use of their own; and (d) "Detached" – those who are low in their use of media in either language. Data regarding the Russian immigrant population indicate that close to half can be characterized as "Separatists," whereas less than a third as "Dualists." By implication, there are various ways of "segmenting" or identifying sub-groups within a minority or immigrant population, and one important way is to identify sub-groups according to their identity, as it is reflected in their use of media and sense of assimilation into the larger society. This type of sense of identity clearly has implications to health promotion and social marketing initiatives. For each sub-group it would be important to address particular group norms, aspirations (or lack of them), and sense of individual and collective self-efficacy, which may be a critical factor in the adoption of health-promoting practices.[13]

Regarding the Arab population in Israel, Adoni, Caspi and Cohen's study finds a different pattern of media consumption: among Arabs, half can be considered Dualists, whereas a third are Separatists. It was found that many read papers in both languages, but more tend to read Arab weekly magazines. About a third of those who do not use Hebrew language media say this is because of lack of sufficient linguistic fluency. It was also found that people value newspapers published in Arabic by members of their own community much more highly than those produced by Israeli Jewish media. The researchers conclude that the Arab community suffers from a paucity of media compared with the Israeli majority and Russian minority. Data from other studies also indicate a high popularity of regional Arabic media and that Israeli Arabs tend to watch Arab language media, regardless of their Hebrew language proficiency. Critics maintain that Israeli media does not provide sufficient channels, relevant program and characters for the Arabs citizens to identify with, and thus many tune to local "Pirate" Arab radio stations and regional television stations. Nonetheless, it has been found that many tune to Israeli channels for education and health issues.[14]

The development of social marketing programs for members of the Arab minority population in Israel poses challenges that go beyond mere "segmentation" and identification of which media channels may be most appropriate to reach them. It raises the challenging issue of providing an equitable supply of media outlets for disadvantaged minority populations. If such channels are limited and if there is a gap between media channels available to these and other populations, this has implications for the equitable dissemination of pertinent health-related information. One such challenge is the limited media outlets available for immigrant Ethiopians in Israel, who are a relatively small linguistic and ethnic minority. This population is allocated only a few hours a week of programming in Amharic on public radio and television channels. However, these are the main mass media outlets for most older and new immigrants, because many are not proficient in Hebrew and do not have reading skills in general.[15] Currently available programs in Amharic are considered to be a critical source of information on health, welfare rights, and current events by a majority of the older Ethiopian immigrant population and the new immigrants. It is common for people to change their schedules in order to be able to listen to the radio program in Amharic on the public radio broadcasting. Reaching linguistic minorities through radio and television, and in particular those with low levels of literacy, is highly dependent on the availability of public media outlets that are linguistically and culturally accessible to these populations. Yet the availability of such media outlets may be limited because of the restricted political power of these groups. By implication, health promotion activities may need to include advocacy to advance the overall availability of media channels to minority populations.

2. The challenge of avoiding stigmatization

The challenge of segmentation can be linked to the challenge of avoiding stigmatization of minority populations or populations that hold particular cultural norms and beliefs. Concerns about stigmatization are typically raised when health interventions aim to address a medical condition or a health-related practice that is relatively prevalent in a particular minority group. The concern is that focusing on the minority population or its particular practices may lead to stigma and further marginalization of this group. This may occur, for example, when addressing sensitive issues such as HIV, which is relatively more prevalent in the Ethiopian immigrant population in Israel than in other population groups, or addressing diabetes among Arab women, which may be related to weight gain. Another way social marketing practices related to segmentation may serve to stigmatize people is when producing print materials for people with very low literacy. This requires the development of materials and programs that are both culturally appropriate and appear dignified for the populations for whom they are intended. This can be done by using cultural themes, different types of media and designs, and content is based on the views and suggestions of the members of the population themselves, rather than what an outsider may view as appropriate for "low literacy" populations.

3. The challenges of commercial competition and acculturation

Marketers carefully map and analyze various factors, companies and products that may compete with the product they aim to promote. In social marketing, it is also critical to identify the various types of "competition" and to find ways to address them. One type of competition is the strong allure of commercial factors (e.g., sweet, commercially-produced beverages). This type of competition concerns all population groups, but may pose a special challenge for members of low-income minority or immigrant populations who may find that their acculturation into the larger society often involves adopting the consumption of different food products or a more sedentary lifestyle. Additionally, they may not feel they are able to adopt practices that can help promote a healthier lifestyle, such as engaging in physical activity. One of the challenges in the developing social marketing programs for immigrant and minority populations is to find ways to help strengthen their consumption of their traditional foods, which can have a high nutritional value, but which may not be viewed as part of the mainstream to which they seek to belong. To address this, the consumption of these foods can be promoted within the target population as well as among other population groups. This can help serve as a way to strengthen cultural pride and identity among the members of the minority or ethnic group. By implication, health promotion practitioners need to learn about the foods and customs of the intended population and find ways to help encourage their adoption in a recommended diet[16]

4. The challenge of choosing behavior-change theories that go beyond individual-change models

One of the definitions of social marketing is that it is theory-based and draws on a wide range of behavior-change approaches. Critics maintain that an important question is whether social marketing strategies draw upon behavior-change models that go beyond those that aim to change individual-level behavior, or if they place the burden of change on individual will alone.[17] In many social marketing initiatives the dominant behavior-change theories and models used are cognitive or information-based approaches.[18] However, because minority groups are often economically disadvantaged and socially marginalized, it is particularly important to go beyond individual-change approaches. Further, critics note that health promotion initiatives that take place in diverse populations often reflect Eurocentric biases of individualism.[19] A related criticism is that focusing individual behaviors may lead to "victim blaming," which results from locating the causes and solutions to social problems within the individual, rather than in social and environmental forces.[20] Thus, social marketing interventions emphasizing individual responsibility may de-emphasize the role of structural factors such as limited resources to purchase nutritious foods, disadvantaged work conditions, and limited access to healthcare, which all contribute to the health problems' etiology.[21] Consequently, an important challenge is not to rely upon individual-level behavior-change approaches, and to expand the scope of the intervention itself so that it will aim to enhance people's sense of individual and social efficacy as well as make social and environmental changes. [22]

It should be noted that members of minority and immigrant populations are often well-aware that individual level changes are not likely to have a significant impact on the health and welfare of the community overall. One of the Ethiopian proverbs that guides program development in the *Tene Briut* program, which was created to advance the health of Ethiopian immigrants, is: "When little spiders spin their webs together, the communal web is strong enough to catch even the biggest of lions."[23] Another challenge is that programs with a social marketing approach that tend to focus on individual-level behaviors use cultural values and norms of minority populations as means to enlist the commitment of their members. However, they do not aim to strengthen these social norms and values for the sake of strengthening the community itself as a collective entity. Further, even if a program appeals to broad social values and norms, it uses them to influence individuals' behaviors, not the community as a whole. For example, a program may stress the role of having a family commitment, but it may not include components on how to strengthen the family in this community (including single-parent families headed by a woman that may be marginalized or stigmatized).

5. The challenge of using new and conventional media channels

Use of new and traditional media presents challenges for attempts to reach members of diverse minority and immigrant populations. In order to reach diverse populations, on the one hand, it behooves programs to use the media members of these populations prefer and that are available to them. However, part of the health-promotion challenge may be to encourage members of these populations to use new media as well. Commercial and social marketers study which channels may be most appropriate to gain access and reach to members of particular cultural groups. For example, the use of broadcast and electronic media was prohibited by religious leaders of ultra-orthodox communities. However, in the past decade, dozens of ultra-orthodox radio stations have emerged, many of them dealing directly with health issues; they are hugely popular, and many have call-in programs. These have received the approval of religious leaders, who now see the value of their contributions to the religious community.[24] A similar, but more complex situation emerges with the use of the internet among ultra-orthodox Jews. Whereas a staunch opposition to the use of the internet by some religious leaders persists, many have changed their minds and found ways to allow for its use. Ultra-orthodox websites have become a common phenomenon, and may address health issues directly or indirectly. Findings from a study by Barzilai-Nahon and Barzilai indicate that the internet has been culturally constructed, modified, and adapted to the needs of ultra-orthodox religious Jewish communities. However, the data indicate disparities in use within the community, with higher use among formally educated men, and a lower use compared to the overall Israeli population. [25] Nonetheless, it appears that access to the internet in the ultra-orthodox community is growing, and it has the potential of serving as a new channel to reach members of this community.

Similar to their preferences for print media, the Russian population in Israel also has a predisposition to prefer websites in Russian, and the healthcare providing organizations each have websites in the Russian and some in Arabic as well. However, current websites are not necessarily designed for cultural appeal to Arab users, both in terms of the type of information provided or the graphics used. Challenges that emerge in the use of the internet thus refer to questions of equity and cultural sensitivity: what is the obligation of health care organizations – whose existence is mandated by law – to provide equitable services to all residents in terms of providing information regarding health on the internet? Does this obligation include a requirement for "stations" with computers and internet access for populations who do not have access to computer technologies in their homes? Does this include an obligation to train members of socially disadvantages communities on the use of the internet and new media?

6. The challenge of moral relativism and harm reduction

The practice of social marketing necessarily must grapple with various ethical issues because it aims to influence people. A central issue of particular importance in the context of populations with diverse cultural beliefs and practices is the issue of "moral relativism." This refers to the dilemma of whether to respect particular cultural values cherished by members of a certain cultural group that conflict with moral precepts others consider to be universal.[26] This may be found, for example in health-promotion issues that relate to gender-role equity or contraception in the ultra-orthodox community. Further, a related dilemma is whether to enlist particular cultural beliefs or traditional gender roles that could advance the goals of a particular intervention, but that reinforce the group's particular conception of such gender roles. This dilemma occurred in the development of visual materials for older Ethiopian immigrants on the topic of foot care, where it was suggested to show a woman washing the foot of a man, as customary in Ethiopia. The rationale for this was that this image would culturally resonate with the intended population. However, Ethiopian women in focus groups objected to this, saying that they wanted to promote gender equity, but this type of image would contradict their goal.[27] In contrast, an intervention may challenge current values and norms in a cultural community, such as challenging the beliefs of certain religious groups regarding homosexuality, which they may view as a "sin" that should be punished. Further, different cultural groups may have a different moral understanding of certain practices or relationships. These may pose additional challenges in the development of interventions, for example, which concern the relationship between parents and their children associated with issues of privacy or personal choice.[28]

The challenge of harm-reduction can be illustrated in the following example. Arab families with small children in a community where it is traditional for men to smoke face the challenge of what to do when male visitors want to smoke when they come to visit their home. Tips can be offered to the hosts on how to respectfully ask the male guests to smoke in a designated porch outside the house without offending them. The hosts thus do not engage in an active effort to eliminate the practice of smoking, but do contribute to strengthen a social norm of unacceptability of smoking around children. A related challenge concerns asking members of a particular cultural group to abandon practices that have given them pleasure, may be connected to their identity, and serve important social purposes. [29] These practices, although unhealthy, may have cultural significance or emotional importance. Certain practices, such as smoking, might offer members of vulnerable groups not only pleasure, but also important coping mechanisms or serve social functions that are not easily replaced.[30] People who are less privileged economically are also likely to have fewer options for healthier substitutions for practices they enjoy but are considered unhealthy. In fact, they may feel that something socially and culturally important to them is being cast as "wrong," but that they cannot replace it with something that fulfills the same functions. One such example is smoking among men in the Arab community. For example, current data indicate that nearly half of the Arab men in Nazareth smoke, compared to 30 percent of the Jewish men in the Israeli population.[31] For many men smoking plays an important social role: it is an activity they may practice together and it can signify camaraderie and hospitality. The challenge here would be to go beyond the model of telling these men why they should not smoke in terms of the various risks of smoking and health and monetary benefits of quitting; it also goes beyond the challenge of providing them with smoking cessation opportunities. The challenge is whether the intervention can provide them with a culturally meaningful substitute for the social role that smoking plays in their cultural life, identity, and relations with others.

7. The challenge of going beyond a culturally-sensitive approach

The final challenge discussed in this essay is perhaps the most contentious: the benefits and drawbacks of the cultural sensitivity approach. Cultural sensitivity in health has been applauded for several reasons, primarily because it aims to respond to criticisms of how cultural and linguistic minorities have been treated in the health care context by adapting existing health communication practices to suit them better. Thus, culturally-sensitive programs aim to incorporate the cultural characteristics, values, beliefs, experiences, and norms of target populations in the design, delivery, and evaluation phases of the intervention.[32] Each component of a social marketing program for diverse populations thus is supposed to be informed by the group's culture, or even "tailored" to its particular members' beliefs and norms.[33] This corresponds – as elaborated above – to core elements in social marketing, which underscores the importance of customizing messages to the beliefs and desires of the intended populations, and to their conceptions of "costs" and "benefits." Thus, cultural-sensitivity efforts would focus on creating effective messages that are responsive to the values and beliefs of members of the culture. A central underlying assumption in this approach is that this type of cultural sensitivity would enable program designers to derive more effective messages and solutions.

However, though cultural sensitivity approaches may advance the well-being of some individuals, they have been criticized for mainly serving the establishment's agenda and not changing the group members' overall marginalized position.[34] An alternative to the culturally-sensitive approach, there is an approach that has been described as "culturally-centered." Activities would provide members with opportunities to express themselves and to engage in critical dialogues allowing members of marginalized cultural groups to have their voices heard by themselves and by decision makers. This process is supposed to enable the definition of problems from group members' own perspectives and to help construct possible health intervention solutions.[35] The following questions can help articulate issues that may be at stake when a program aims to be culturally-sensitive but may inadvertently be advancing another agenda: Whose goals and perspectives are prioritized in the program? Are structural-level factors acknowledged? Does the program focus on needs and perspectives as they are defined by the members of the community?

A prominent example from the Israeli context is the case of Bedouin communities in Israel. Numerous health initiatives attempt to influence their health-related behaviors, by encouraging, for example, the consumption of nutritious foods, consideration of genetic counseling in cases of consanguineous marriages, immunization of children. One may ask to what extent such programs that aim to be culturally-sensitive to the Bedouin culture also engage them in a critical dialogue about their inequitable living conditions and of the type of health care services available to them.

A culturally-sensitive approach that aims to address the actual needs of the members of the community thus needs to broaden the way it addresses goals and objectives. Community members' perspectives should not only be taken into consideration as a means to make the program's messages more efficient, but should provide the program's focal point. The program could strive to create a dialogical process to facilitate the articulation of problems and possible solutions as they relate to personal, communal and societal levels. One example can be found in the case of workshops conducted for members of the Ethiopian immigration on the topic of health rights. The group running the workshops assumed that the program should focus on explaining to participants information on health rights as they are presented in official documents. However, they soon realized that they needed to add more sessions, because the participants raised issues not addressed by the original program, e.g. about things they encountered in their own use of healthcare services.[36] A similar situation emerged in focus groups conducted for a study of people's knowledge and conceptions of health rights in Israel. In two groups conducted with Arab women in Jaffa it was found that the older women, who may have been knowledgeable about particular health rights, did not feel they would try to realize these rights, because they felt they could not manage the system.[37] Thus, having an actual impact on marginalized minority members' behavior necessitates more than describing health rights, even when it is done in a way that appears to be "culturally-sensitive." It needs to address issues that are of particular interest to this community, to enhance their sense of efficacy to obtain them, and to advance changes in structural and societal barriers.

LOOKING AHEAD

Social marketing is viewed by many in health promotion as a possible panacea for challenges in reaching diverse populations and influencing their health-related behaviors. Clearly, this conception needs to be both embraced and challenged. In many ways, the adoption of a social marketing approach can overcome some previous oversights in health education and health promotion efforts with "top-down" approaches in program design. Social marketing provides a vocabulary of "targeting" and "tailoring" to underscore the importance of attending to the particular wants, needs, beliefs, norms and customs of diverse populations. However, as critics maintain, developing programs that are culturally sensitive – in terms of the compatibility of their channels and messages to minority and marginalized groups' beliefs and norms – may not necessarily address the social change needs of these groups. This essay concludes with three comments about methods, goals and advocacy as they relate to social marketing and diverse and disadvantaged populations, by drawing on some of the challenges presented above.

Regarding methods, in order to find out what is really important to the population, it may behoove practitioners not only to be "culturally sensitive" to the group's norms and beliefs, but to help facilitate a process in which its members articulate their needs and discuss ways to address them. This may require a process to identify core causes of health and social factors that need to be changed on a more structural level.[38] For this purpose methodologies that go beyond traditional interviews or focus groups could help participants articulate their concerns and how they themselves frame their issues. Among such strategies are the *photovoice* method, story telling, using narratives,[39] drama and art, and community discussions using deliberative methods. In the *photovoice* method community members are equipped with cameras and use photographs to visually express their views of the social and environmental factors that affect the particular health problem as well as lives of individuals and the community as a whole.[40] Displaying and discussing the photographs helps promote a critical dialogue and shared understanding between the participants, who are members of the community of these societal and environmental factors and it can also serve as a way to influence policy makers and can lead to changes in the community, facilities, and resources.[41]

Regarding goals, a social marketing perspective for health promotion programs that aim to advance the health of diverse populations can underscore the issue of "cost" as it is viewed from the point of view of members of the population. This poses a challenge when working with diverse populations. Rather than beginning with the premise that one can convince people they "should" adopt a certain health-related practice, a social marketing orientation provokes people to think in terms of what is it that people need to give up in order for them to adopt the health recommendations? How would the adoption of the health recommendation resonate with their cultural identity? Would they need to change their customs? Could the program advance not only a particular practice but also address important issues for members of this population?

Finally, there is a tendency to view social marketing as a variation of advertising. It is not, and social marketing differs fundamentally from commercial advertising and marketing, even when it draws on some commercial techniques. The challenge is not to be prescriptive about what "should be done" even when it is highly desirable that particular behaviors for illness prevention be adopted. Instead, by providing information that offers choices and a basis for decision making, or through the use of drama, art and story-telling, interventions to promote health can present a dialogical approach for thinking about and discussing circumstances, options and consequences. For marginalized populations, this approach is of particular significance because it considers the role of tradition, gender roles, culture and acculturation. Similarly, the role of advocacy may become critical as well. [42] A social marketing approach that adopts an advocacy role will need to undergo a careful examination of its strategy and approach. It may aim to offer resources for members of marginalized groups to engage in a critical examination of their circumstances in order to build health and social capacities within the community and to advance their position in the larger society. For this, it may need to address the paucity of media available to the minority populations, [43] but not to remove the discourse among members of this population from the general public discourse, but, rather, to serve as a means to strengthen minority groups' identity and capacities. Further, social marketing programs in marginalized populations may need to examine the extent to which marginalized groups are included in the national media and to promote their inclusion so that their members will also have role models in the general media, and so that members of other groups in society will have the opportunity to learn about these groups and their culture as well.[44]

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Healthcare Interpreting – Legal Requirement, Necessary Evil, or Best Practice?

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"It seems that the rudimentary communication that takes place without an interpreter is quite inadequate for obtaining the type of information that must flow in the context of a medical encounter." [1]

1. INTRODUCTION

On October 9, 1997, in a unanimous decision, the Supreme Court of Canada ordered the Government of British Columbia to pay for sign language interpreters when Deaf people access healthcare services [2]. The ruling went further: It stated that governments could not escape their constitutional obligation to provide equal access to public services and that no disabled person would be prevented access to a government service, including education, training, health care and social services. The conceptual leap from *disabled* to *language-disabled* – i.e. those who do not speak or understand the majority language(s) – is at the heart of this paper, which calls for professional interpreting whenever the provider and patient do not share a language, and focuses on the situation in Israel. The provision of interpreters is presented not only a means of alleviating the distress of the patient, but as a way of allowing the medical practitioner to deliver the same standard of health care as s/he would deliver to a language-compatible patient. Clearly, the use of a shared language (whether that of the interlocutors or a third language shared by both) is the most effective approach to ensuring patient satisfaction and mutual comprehension [3] [4].[1] Unfortunately, however, it is not likely to become the default option "until the provider work force becomes more racially/ethnically and linguistically diverse."[5] While communication may be impaired and misunderstandings may arise even in the case of same-language dyads (e.g. in the presence of disparate religious and cultural concepts [6]), strategies for dealing with language incompatibility are particularly important in an increasingly multilingual world. These strategies include **nonverbal** communication; non-professional ("**ad hoc**") interpreting mediated by an "interpreter" whom the patient has brought along, by a passerby or by any bilingual without any specialized training in interpreting from among the hospital staff; or **professional** interpreting by someone expressly trained for this task, whether available on-site or at a **remote** location (e.g. via telephone or a video conferencing service) [7] [8].

In what follows I will focus on (1) the shortcomings of the *ad hoc* solutions and the merits of the more professional ones and (2) the situation in Israel, as it concerns attempts to come to grips with the problems posed by language incompatibility in provider-patient interactions.

2. BACKGROUND[2]

Apart from legal settings and educational interpreting for the Deaf (in both of which many countries, including Israel, provide some form of interpreting as a legal requirement) [10], medical settings are probably the most prevalent field of practice for interpreters in the community. It was in the field of health care that some of the earliest initiatives for the provision of community interpreting services were taken (e.g. the Hospital Interpreter Service was established in New South Wales, Australia, in 1974) and it was medical interpreters who, in the 1990s,

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[1] In the context of the Israeli healthcare system, the most salient example is that of Russian-speaking doctors and Russian-speaking patients; however, proponents of this solution are advised not to assume (1) that Russian-speaking doctors are available in sufficient numbers in all settings; (2) that Russian-speaking doctors are available in sufficient numbers in all specializations; (3) that Russian-speaking doctors make adequate interpreters; (4) that Russian-speaking doctors will readily assume this role whenever needed.

[2] Some of the background information provided here appears in the introduction to [9], written primarily by Pöchhacker.

formed the first professional organizations for community-based interpreting outside the judicial domain. In the United States, the Department of Health and Human Services' (HHS) Office for Civil Rights has responded affirmatively to complaints of discrimination by limited-English-proficient (LEP) individuals seeking health care, as part of its efforts to ensure language-accessible services and health care to all, and numerous hospital-based interpreter programs have been implemented as a result [11]. Such responses are in keeping with the growing empowerment of patients and the regulation of patients' rights (e.g. the frequently cited Title VI of the 1964 Civil Rights Act requiring all federally funded institutions to make "reasonable" attempts to provide meaningful access to language services for LEP patients), and demonstrate an awareness of the need to contend with language barriers and to ensure equal access to speakers of minority languages as well [12] [13]. Failure to do so is seen as a factor in prolongation of treatment, recurrent visits, re-hospitalization and a rise in complaints, as reflected in studies leading up to these landmark decisions.[3] Thus, for example, a telephone survey of 6,344 informants conducted by the Commonwealth Fund (www.cmwf.org) revealed lack of English proficiency to be a factor that accounts for a high level of misunderstandings and of dissatisfaction in relation to communication with the primary care physician and concluded that greater use of interpreters by hospitals could significantly reduce misunderstandings and related medical errors [14].

Not only comprehension but satisfaction with health care provision has been shown to be affected by patients' ability to communicate freely with their physician. In fact, the best predictor of overall satisfaction with hospital care is satisfaction with the physician [15] and a favorable perception of communication with him/her: "[...] part of what patients are responding to when they do not cooperate is not the medical treatment but how they are treated, not how they regard their required medical regimen but how they themselves are regarded" [16].

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[3] The studies cited here are a mere sampling. For additional sources, see, for example, www.a2hc.org , http://www.migrationinformation.org/integration/language_portal and http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3 (accessed 27 February 2008).

2.1. Questioning the effectiveness of *ad hoc* interpreters

Ever since the landmark review article [17] on language barriers in medicine in the United States, studies of the problems and effects of language barriers in medicine have been increasing. In many cases, the emphasis is on the shortcomings of inadequate interpreting [18] [19] [20] [21] [22]. Among other things, these studies refer to the problem of providing adequate health care in the case of mental health [23]. One of the earliest studies [24] found a higher rate of mistranslations (omissions, distorted questions, additions, etc.) in the interpreting of the two orderlies at a psychiatric hospital, who had been recruited as ad hoc interpreters, than in the renditions of a better-educated patient who had been recruited on a different occasion, and concluded that "an interpreter's apparent competence may readily be mistaken for true competence" (p. 263).

Language incompatibility between pharmacists and patients is yet another domain in which the need for proper interpreting has come to the fore [25].

2.2. The providers' perspective

Communication difficulties caused by the lack of a shared language are a source of dissatisfaction to the health care providers themselves as well [2] [26] [27]. The recruitment of bilingual paramedical personnel is often considered a more reasonable compromise solution than the use of chance bystanders, but difficult to implement for practical, organizational reasons [28] [29] [30] [31] [32] [33]. These studies and others place a growing emphasis on compliance-enhancing interventions, and on their ability to improve clinical outcomes and/or to reduce health-care costs [34].

Physicians surveyed in a qualitative study [35] on their perception of roles, agendas and communication strategies, indicated that time management and agenda-setting were more difficult in interpreted than in non-interpreted encounters; the rhythm of the encounter was slower; it was more difficult to keep the encounter on track and to "develop a relationship with the patient". Nevertheless, when questioned about the difference between professional and *ad hoc* interpreters, most physicians found that working with professionals was easier, because they "were perceived to rarely have their own agenda [and] the physician was able to maintain more control over the encounter process [whereas] family interpreters also performed caregiver functions."

2.3. Role definition and professionalization

Alongside the line of investigation focusing on errors in interpreted discourse and on their clinical significance, the literature abounds with attempts to delineate the interpreter's role and to define it, often aiming to debunk the myth of transparency and neutrality. The chief concerns in this context have to do with (1) the risk of impeding or overshadowing the role of the provider; and (2) the risk of disempowering or "upstaging" the patient. One of the earliest contributions to the literature on healthcare interpreting, published in *Mental Hygiene*, [36] sketched out three different interpreter roles in the medical interview setting, all of which have proven significant in the debate on interpreter use in health care: the interpreter may either take over the interview, serve as a mere tool to facilitate communication or work in partnership with the interviewing specialist. Equally significant has been the work of social scientists and medical anthropologists [37], who have attempted to describe and define the interactional role of persons serving as interpreters, and have highlighted the cultural complexities involved in the interpreter's task. The crucial issue of the interpreter's role, as captured in notions such as "cultural brokering" or "visibility", has emerged as a distinct thematic orientation [38] [39] [40] [41] along with a discussion of the pros and cons of professionalization; i.e. of training, supervision, monitoring, testing - and of course, payment for services rendered [42] [43]. This shift away from reliance on non-professional, ad hoc solutions is gradually gaining ground; in Israel too, there seems to be a groundswell of institutional awareness of the need to come to grips with the repercussions of language differences. Clearly, there is a need to address this problem on a systemic level and to professionalize the work of those who mediate between cultures and languages.

3. THE SITUATION IN ISRAEL

Israel is a multicultural, multilingual country with an unusually large array of ethnic, cultural and linguistic minorities and of individuals who are not proficient in the most prevalent official language, Hebrew. To the best of our knowledge, there has been no study of the proportion of non-Hebrew-speaking patients among those requiring hospital care in Israel – ethnic minorities (mainly Arabic-speaking), immigrants (speaking various languages, chief among them Russian and Amharic), the Deaf (some of whom are monolingual speakers of Israeli Sign Language), foreign workers, and other non-Hebrew-speakers who are in Israel either temporarily or permanently. In a small-scale survey [44] designed to elicit the views of physicians and medical students (n = 47), participants were asked about strategies for interviewing and treating non-Hebrew-speaking patients. The overwhelming response was a vague "We manage". Other findings related to the impact of linguistic and cultural incompatibility have emerged from sporadic studies, e.g. describing a trial intervention program [45] involving proactive measures (including the use of an interpreter) to strengthen communication, and found a marked improvement in the compliance rate: parents of Bedouin pediatric patients were far more receptive to therapeutic interventions when these were communicated in their own language.[4]

Indeed, many of the problems of provider-patient communication in Israel have been traced to issues that transcend language, per se. A study of health care delivery to immigrants from Ethiopia to Israel [1] found a sizable discrepancy between physicians' perceptions and those of the patients, and pointed to somatic expression of social stress as a cause of intercultural misunderstanding, and (not surprisingly) to difficulties in the diagnosis of severe depression. A later study focusing on perceptions of the quality of healthcare delivery to the Ethiopian immigrant population [47], found that Amharic-speaking diabetics were significantly less likely to report for routine tests (e.g. of feet and eyes), to receive referrals and follow-up care, to engage in interactions leading to changes in behavior, and to comprehend explanations provided by the physician, the nurse, the dietician and the pharmacist.

Speaking at a 2006 conference aimed at foregrounding the need for better access to health care for language minorities (http://www.a2hc.org/video_index.htm), Gal Rokanian, a Deaf mother, spoke (in Israeli Sign Language, interpreted into Hebrew) of the negotiations required in order to allow an interpreter to be present in the delivery room and to facilitate communication during the delivery of her two children as well as the need to train the medical staff towards acceptance of the interpreter as a legitimate participant in such settings.

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[4] And yet, referring to the same (Bedouin) population, Dr. Taleb Abu-Hamad, Chief of Primary Medicine, Southern Region, of the Clalit HMO, wrote [46]: "We expect clients to assume responsibility for their own health and in cases where they have trouble speaking Hebrew, let them bring along a relative to translate for them, like the Ethiopian population and the Russian population do" (my translation).

3.1. Local solutions

While most solutions to language incompatibility in the healthcare context in Israel are of the *ad hoc* variety, some are provided (whether paid or voluntary)[5] on a more regular and reliable basis.

3.1.1. Most institutionalized language mediation services in healthcare settings in Israel are those aimed at Amharic speakers. It is almost exclusively in the context of this community that two professional labels have come into being: *megasher* ("bridger", liaison)[6] and *meta'em* (co-ordinator, case-manager) [48]. Both positions are perceived as involving outreach; the latter includes case management and participation in health promotion campaigns, with language mediation as an integral part of the role, though not necessarily the main component. In some instances, particularly in the case of those employed by the Ministry of Health, the *megasher*, like the *meta'em*, is also seen as a professional – with the requisite training and extension courses; in other cases (e.g. as those working in some HMO's [49]), the post is perceived more loosely as one that requires nothing more than a bilingual background.

3.1.2. The above-mentioned study [47] led to the launching of a wide-ranging health promotion service, *Tene Bri'ut*, and to the introduction of its *Kol Ha-Bri'ut* (The Voice of Health) telephone interpreting service – the only such service available to date in Israel, currently serving a growing number of HMO clinics with a high proportion of Ethiopian patients.

3.1.3. A volunteer-based initiative of a different kind is that launched by the Department of Translation and Interpreting Studies at Bar-Ilan University and sponsored by the Council for Higher Education [50]. University students receive a 50-hour training course in the rudiments of community and healthcare interpreting and volunteer for four hours a week in a public service, mostly in a

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[5] An initiative of the Israel Translators Association designed to launch a volunteer healthcare interpreting service, while well-intentioned, did not materialize, primarily because of an incompatibility between the (almost exclusively European) languages offered by the volunteers and the diverse needs of the language-disabled population. The lack of a coherent logistical and administrative infrastructure further impeded the implementation of this service.

[6] The term is used with reference to the Caucasian community in the Negev region as well.

healthcare setting (including the municipal hospital, a pediatric hospital, a mental health clinic, Physicians for Human Rights (an NGO) and several well-baby clinics). As indicated in the students' written (weekly) reports, role definition and delineation pose a constant challenge. No less problematic are the predicaments posed by the need to explain, to elaborate, to make sure that the service provider's utterances have been understood by the client, and vice versa. The following excerpts from the students' own reports are typical:

Ayelet (Amharic speaker, volunteering at a well-baby clinic):

> *The nurse said to come back in a month, and the mother didn't come, so the nurse was upset. I told her that some immigrants from Ethiopia don't have the concept of "month", and suggested that she should tell her to count four Sabbaths and then come back. It worked.*

Niv (English speaker, volunteering at a well-baby clinic):

> *[…] The nurse asked the mother to be tested for HIV, and the mother started crying. The nurse asked me to explain to her that it was a standard procedure, and that she shouldn't be worried or offended, so I took her aside, and explained it until she calmed down. Maybe this isn't something I should be doing, but I felt it was the right way, especially since nobody else could have done it.*

Muhammad (Arabic speaker, volunteering in the oncological ward of municipal hospital):

> *[…] I knew that if the doctors followed their usual pattern for making the rounds, going from room 1 to room 9 in sequence, two of "my" patients would wind up without an interpreter, because I had to leave soon, so I asked the head nurse if the doctors would consider changing the sequence, and starting with rooms 7 and 9, to make sure that "my" patients would have interpreting. The nurse told me not to interfere with their routine.*

3.1.4. As in Canada, so too in Israel, it was the courts that were the most forceful in drawing attention to the implications of inadequate handling of the language gap. On January 8, 2007, Justice Darel of the Jerusalem Magistrate Court ruled in favor of the plaintiffs who had charged Poriah Hospital with negligence, in relation to the death of their unborn baby. Section 12 of the judgment stated:

> "It was incumbent on the defendant to provide the plaintiff with instructions in such away that they would be clear to her. […] The defendant had the responsibility of finding an individual who was fluent in Arabic, to convey the instructions so that they could be understood by the patient" (my translation).

Indeed, the Patient's Rights Act, enacted in Israel in 1996, stresses the need for clear and explicit communication in the course of treatment, complete understanding on the part of the patient and a valid process of obtaining the patient's consent to medical care (Section 13A). As patients grow more aware of the implications of this stipulation, and of the National Health Insurance Law, with its emphasis on availability and accessibility to all, it stands to reason that institutional failure to provide for full and equal access will figure more prominently in seeking legal redress. After all, the Act cannot be fully implemented without taking into account the issue of linguistic incompatibility.

4. COSTS

The costs incurred by the delivery and regulation of language services in a managed care environment are a topic of growing interest [51]. Indeed, attempts to quantify and measure the benefits of interpreter use and the losses resulting from poor communication are very problematic, since they involve attaching a monetary value to intangibles such as human dignity and rights, mutual understanding across socio-cultural divide, or patient satisfaction. Nonetheless, the authorities have begun looking at risk assessment as a motive for incorporating interpreting services into the relevant healthcare policies [52] [53] [54] [55] [56] [57].

In a plenary paper titled "Performance and policy: The case of healthcare interpreting" delivered at the Second Alcalá Conference (28 April 2005), Franz Pöchhacker, who had initiated a training course for healthcare interpreters in Vienna, lamented what he saw as the short-sightedness of the healthcare system in a society that had paid lip service to the need for language access but had failed to recognize the implications of the priority given to cost considerations: "[...] there is a group of people who have undergone some, albeit incipient, professionalization in the course of nearly 100 hours of training, including instruction in specific language pairs (Bosnian/Croatian/ Serbian-German, Turkish-German), but there is no willingness among hospital administrators to actually 'employ' these staff members based on their hard-won additional qualifications, let alone make administrative arrangements for an in-house interpreting service."

In each of the countries mentioned in this paper, and in many others, the cost of providing the service has proven easier to quantify than the cost of *not* providing it. Herein lies one of the difficulties of institutionalizing the move towards professionalization of the interpreting provided. Be that as it may, an extensive study [58] of provider-patient relations in the Israeli context has led to the conclusion that "Training translators would lead to more effective doctor-patient communication and might prove cost-effective by reducing the costs of unnecessary medical procedures and improving the health of patients, which also improves their social and economic productivity" (p. 350).

CONCLUSION

True, health care administered through an interpreter – no matter how professional – will continue to be a less than ideal solution; other things being equal, direct communication in a shared language will remain the preferred option. Perhaps it for this reason that the implications of language barriers or the pros and cons of professional interpreting were under-represented until recently in the medical and socio-medical literature.[7] Academic interest in this field, in fact, has been confined to the disciplines of discourse analysis and sociolinguistics, where the analysis of interpreting performance based on transcripts of authentic discourse has comprised an important line of research.

As in many other countries, so too in Israel, there are patients' charters speaking of the right to be informed; there are quality management and risk assessment schemes for hospitals; there is the legal requirement of informed consent; and the legal duty of physicians to give equal treatment; and yet, the use of professional interpreting as a viable solution and as one of the most reliable means of reducing the risk of not understanding has yet to gain institutional recognition.

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[7] A case in point is the inaugural editorial of *Communication & Medicine*, "interdisciplinary journal of healthcare, ethics and society" [59], in which the topic of mediated communication was conspicuously absent.

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The Critical Role of Health Care Interpreting: Views from the Literature, Promising Practices and Lessons Learned in the United States

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A growing body of research shows that patients who lack fluency in the dominant language in health care settings may suffer adverse outcomes that contribute to health inequalities. Many such patients are misdiagnosed, fail to take medication correctly and do not know how to adhere to treatment plans. Professional health care interpreting is an integral and necessary part of all efforts toward culturally competent health care and the reduction of health disparities. In the United States, several promising practices have emerged in this developing field, including widely endorsed national ethics and standards of practice for health care interpreters, as well as multi-faceted programs for providing interpreting services. This paper summarizes key findings from the literature and examines best practices and lessons learned regarding the effective delivery of health care interpreting services.

INTRODUCTION

This paper is divided into two main sections. The first explores recent research related to the role of interpreting in health care. The second discusses promising practices and lessons learned in the United States. Several key terms will be used throughout the paper and should be noted here. The word *interpreter* is used to refer to an individual who renders spoken information from one language to another. The term *interpreting* is used by health care interpreters to refer to the practice and the profession of interpreters, as opposed to the term *interpretation,* which is more frequently used to describe the rendering of a single utterance.[2] A *translator* renders *written* texts into another language. Interpreting and translation are thus two distinct professions that are often confused with one another.

Professional health care interpreter is defined for purposes of this paper as an individual who has met the following criteria: (1) demonstrated proof of language proficiency in the interpreter's working languages; (2) completed a minimum of forty hours of specialized professional training that includes ethics, professional skills (e.g. use of first person); knowledge (e.g. terminology,(3) follows a professional code of ethics and standards of practice; and (4) has passed a professional interpreting skills test.[3] The term *professional health care interpreter* is used interchangeably in this paper with *professional medical interpreter*.

The term *limited English proficiency*, commonly abbreviated as *LEP*, is widely used in U.S. health care to refer to individuals who do not speak English as their primary language and may have a limited ability to read, write, speak or understand English. The term encompasses linguistic minorities and indigenous groups but is most commonly associated with foreign-born individuals. *Language access* refers to "meaningful access to health services, language assistance during health encounters and equity in care for LEP patients".[4]

THE RATIONALE FOR PROFESSIONAL HEALTH CARE INTERPRETING

This section presents key information from recent research literature of special value to individuals working toward the reduction of health care inequalities among patients who do not speak the language of their health care providers.[5] In particular, the findings demonstrate that language barriers contribute to health and health care disparities, and that interpreters, by helping to overcome these barriers, help reduce health care costs, support patient-provider communication and trust, improve quality of care and help to decrease health disparities.

Professional interpreters also improve the overall quality of care provided to patients. A detailed 2007 review of the literature showed how in four key areas related to quality care (communication, utilization, clinical outcomes and satisfaction), the use of professional interpreters is associated with improved clinical care as compared to the use of informal, ad hoc interpreters such as family, friends or untrained bilingual staff. Furthermore, the study reported that professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that for patients without language barriers.[6]

Failing to use professional interpreters when they are needed, however, leads to severe challenges in health care. For example, an important paper published by Flores in 2006 showed that patients who face language barriers are less likely than others to have a usual source of medical care; frequently receive preventive services at reduced rates; have an increased risk of non-adherence to medications; are less likely than others to return for follow-up appointments after visits to the emergency room; and have higher rates of hospitalization and drug complications.[7]

When the use of interpreters decreases, so does the access to health care. In multivariate analyses, one recent study found that Hispanic and Asian/Pacific Islanders (API) members who needed (but did not consistently have access to) interpreters reported significantly worse provider and office staff communication, access to care, and health plan customer service compared with members who did not need interpreters. In contrast, the same study showed how the impact of using interpreters reduced White-Hispanic disparities in reports of care by up to 28 percent and White-API disparities by as much as 21 percent.[8]

Language barriers also can affect patients' trust in their providers and the health care system. A 2007 study found that Limited English proficiency appears to be related to feelings of being discriminated against in clinical and pharmacy settings, whereas communicating with health professionals in a common language is associated with increased trust and confidence.[9]

Interpreters can help reduce the costs of providing health care services. A 2002 study found that, among discharged patients who spoke limited English, return visits to the emergency department and visit charges were lowest for patients who received interpreting services. In addition, the use of trained interpreters was associated with increased intensity of emergency department services, reduced emergency department return rate, increased clinic utilization, and lower thirty-day charges, without any simultaneous increase in length of stay or cost of visit.[10]

In another study, when professional interpreters were needed but not provided, patients had higher costs for testing and were more likely to be admitted to the hospital and to receive intravenous hydration but showed no difference in length of visit. Decision making was most cautious and expensive when non–English-speaking cases were treated in the absence of a bilingual physician or professional interpreter.[11]

In addition to providing cost savings, interpreters appear to reduce health care disparities. For example, research carried out at an emergency department reported that using trained interpreters increased clinic utilization, decreased thirty-day total and emergency department return charges, and reduced disparities between English-speaking patients and non-English-speaking patients in a number of services provided. Professional interpretation time did not increase length of stay beyond that of English-speaking patients.[12]

Just as professional interpreters improve the quality of care, using untrained interpreters may increase medical errors. One study found that errors in medical interpretation averaged 31 per clinical encounter and that most errors had potential clinical consequences.[13] Those errors committed by untrained and informal interpreters, such as family or friends, were significantly more likely to have potential clinical consequences than those committed by hospital interpreters. The study therefore recommended that third-party reimbursement for trained interpreter services should be considered for patients with limited English proficiency.

However, in order to achieve the desired cost savings and improvements in health inequalities, quality language services need funding and training. One study highlights the critical importance of voluntary trust for open and effective communication, and therefore recommends not only providing adequate funding for interpreting services but also training clinicians, interpreters and administrative staff on how to communicate effectively with patients who need interpreters.[14]

Professional training is an absolute necessity for interpreters. For example, it is not sufficient for interpreters to possess adequate language skills. Training in ethics and professional skills is required, and skills such as cultural brokering (intervening to clarify a situation when a cultural misunderstanding causes a barrier to communication) are critical. Differences in culture and socioeconomic background appear to warrant special training in intercultural knowledge to enhance the skills of interpreters.[15]

Just as interpreters need specialized training, providers also need training in order to work with interpreters effectively. Clinicians report communication difficulties with patients who do not speak the same language that affect the physicians' ability to understand symptoms and treat disease, as well as their ability to empower patients regarding their healthcare. However, training clinicians to work with interpreters appears to greatly improve communication and clinical care for limited English proficient patients, and thus health outcomes.[16]

There are tremendous risks associated with providing interpreters who are not qualified to interpret in health care settings. The majority of studies have suggested that family members or friends should not provide medical interpreting services for several reasons. In general, there is a broad consensus of expert opinion that children, other family members, or friends of the patients should not interpret, for many reasons. First, they tend to interpret inaccurately, make errors, disrupt social roles, fail to deal appropriately with sensitive issues, misunderstand medical terms, and violate confidentiality.[17] Second, family members make frequent behavioral mistakes, such as responding to questions without allowing the patient to answer, volunteering their own information and opinions, and failing to interpret patients' comments, as widely reported in the literature.[18] Third, incompetent interpreters may lead to inaccurate interpretation and put health care providers and hospitals at risk for lawsuits.[19] [20]

In addition, untrained interpreters frequently distort the meaning of an utterance and may themselves influence the content of the messages being conveyed. Family members and untrained interpreters may be likely to misinterpret medical phrases, censor sensitive or taboo topics, or filter and summarize discussions rather than interpret with completeness.[21]

Another category of individuals who are frequently not qualified to interpret is ″bilingual″ clinicians, who often have inadequate language skills to communicate in another language, let alone perform the complex task of interpreting. In one study, medical residents who were not very proficient in Spanish reported using their inadequate language skills ″often″ or ″every day″ in patient care, even though many of them believed that LEP families under their care ″never″ or only ″sometimes″ understood them. Eighty percent of these providers also admitted to avoiding communication with such families. Although all agreed that hospital interpreters were effective, 30 out of 40 of these residents reported using hospital interpreters ″never″ or only ″sometimes.″ Instead, they tended to rely on their own inadequate language skills or to avoid Spanish-speaking families.[22]

As further evidence that untrained ″bilingual″ health care staff should not interpret, another study looked at bilingual nurses who had not been trained as medical interpreters but frequently interpreted for patients. Approximately one-half of the encounters studied had serious miscommunication problems that affected either the physician's understanding of the symptoms or the credibility of the patient's concerns. Nurses frequently slanted the interpretations, reflecting unfavorably on patients and undermining patients' credibility. The researchers concluded that errors occur frequently in interpretations provided by untrained nurse-interpreters.[23]

There is also a strong basis in the literature to support the idea that physicians require training on interpreting issues. When one group of researchers explored why certain physicians were not using interpreter services, their work revealed that physicians often were not aware of the need for an interpreter, believing mistakenly that their own language skills were sufficient or that the use of family or friends as interpreters was appropriate.[24] When providers are not well informed about interpreting, they can be reluctant to use trained interpreters even when they are available. In another study, most pediatricians report using untrained interpreters to communicate with limited English proficiency patients and their families.[25]

As this summary of key findings in recent research literature attests, strong evidence now exists to show how professional interpreters support the reduction of health disparities while also enhancing patient-provider communication, reducing costs, supporting adherence to treatment and improving health outcomes. Given that professional interpreting services are so important, the next section of this paper examines how they can be implemented and maintained.

THE PROVISION OF PROFESSIONAL HEALTH CARE INTERPRETING SERVICES

The Institute of Ethics of the American Medical Association issued the following guidance in 2006: "An organization should determine what language assistance is required to communicate effectively with the populations it serves, make this assistance easily available and train its workforce to access and use language assistance resources… [so that] individuals are better able to ask questions, explain symptoms, understand instructions, and provide informed consent." [26]

The topic of making effective language assistance easily available to patients is both broad and complex. For this purpose, many health care organizations employ full-time staff who work to ensure that language assistance is provided. Language assistance includes not only interpreting services, but other language-related services, such as translation, localization (converting information in multimedia formats, such as audio or web content, into formats suitable for other languages and cultures), as well as ensuring that access to signage and other venues in which information is provided can be accessed by patients of diverse languages.[27] However, given that professional health care interpreting is a vital piece of any language assistance program and the subject at hand, the following subsections will provide a general introduction to the three key components used by the majority of health care providers in the United States in order to make professional interpreting services available to patients: (1) professional on-site interpreters, (2) bilingual staff and (3) remote interpreting services (interpreting services provided remotely via telephone or video).

Professional On-Site Interpreters

The first and most common component of a language assistance program is to make health care interpreters available on site, or in person. Many hospitals in the U.S. hire one, several or many full-time interpreters for their most commonly requested languages. Some use contractors (such as language companies or individual freelancers) for all languages, or only for languages that are less common.

Some health care facilities in the U.S. employ at least one full-time employee who is charged with the management and coordination of the facility's interpreting services. The duties involve recruiting, scheduling, payroll and many other administrative tasks. However, these individuals, commonly called interpreting coordinators or interpreting managers, are also frequently tasked with verifying that the interpreters are in fact qualified to interpret. This demanding work entails screening interpreters for language proficiency, (ideally, with an external language proficiency test with proven validity and reliability),[28] procuring or providing interpreter training, testing the interpreters for interpreting skills—typically through an outside expert source—and creating policies and procedures for interpreters, including but not limited to the incorporation of a code of ethics and standards of practice. These coordinators/managers are often also charged with scheduling the interpreter appointments and training health care staff on how to work effectively with interpreters, programs that may be offered live or via web-based training.[29] To say the least, an interpreter services coordinator is typically multi-tasked and faces a challenging workload.

Bilingual Staff Interpreters

A second and extremely common component of professional interpreting service provision is the use of bilingual staff as interpreters. In the United States, there has been a great deal of discussion and controversy regarding this issue. In some cases, custodial and secretarial staff members are asked to interpret, regardless of their skills or qualifications. This practice has led to countless negative repercussions in the lives of patients. One Florida case famously resulted in a $71 million dollar lawsuit when a healthy 18-year-old male became quadriplegic due to one misinterpreted Spanish word. Unfortunately, the reality is that, in many places, health care interpreting is still frequently provided by *unqualified* bilingual staff who frequently hold other full-time positions as nurses, social workers, clerical staff, receptionists and cafeteria workers, among others. More often than not, these individuals have never been trained to interpret, are unfamiliar with professional interpreter skills, ethics and standards of practice – and may not even be bilingual in the first place.

However, there are also several important advantages to having bilingual staff go through the process of being trained and tested as health care interpreters. First, those who are not bilingual are eliminated and can do no further harm. Second, once trained, they are expected to perform at the level of professional health care interpreters and come to understand that interpreting is a true profession.

Thus, the challenges cited above do not mean that bilingual staff cannot serve as interpreters. They simply mean that the standards of quality for bilingual staff must be the same as they are for other professional interpreters.

Telephone Interpreting Services

A third component of an effective plan for providing language interpreting assistance to patients is access to professional health care interpreters who provide services remotely, via telephone or video. In the United States, a common practice is for organizations to contract with a commercial telephone interpreting provider that provides on-demand, round-the-clock access to interpreters for 150-250 languages within a matter of seconds. These are also frequently referred to in the literature by various other names, such as "telephonic interpreting providers" and "over-the-phone interpreting (OPI) companies."[30] Most commonly, these services are used as a supplement to on-site interpreters.

In some cases, telephone interpreting providers are reported to offer extensive training and certification programs for their interpreters.[31] However, there is not consistency in quality across all providers. Some companies are reported to provide minimal training for their interpreters, putting the consumer at increased risk. For this reason, in the procurement of telephone interpreting services, as well as language services in general, it is extremely important to make sure that the provider selected is committed to quality.[32]

A common myth that has sometimes surfaced in both research and practice in the United States is the notion that telephone interpreting removes the interpreter's ability to perceive non-verbal communication.[33] In fact, a wealth of non-verbal communication is communicated through tone of voice, hesitations, breathing patterns, vocal volume and other such auditory information. Telephone interpreters, when properly trained in these areas, can learn to process such non-verbal information.[34] It is true, however that telephone interpreters cannot process <u>visual</u> information, which may be of importance, depending on the setting.[35]

Yet there are advantages to having the interpreter be located remotely. For example, the lack of an interpreter's physical presence in patient-provider encounters has been shown in some cases to lead to increased non-verbal communication between the patient and provider.[36] Telephone interpreting also provides greater privacy, which may be especially important for reproductive and sexual health settings and in tightly-knit communities where the interpreter's identity may be better left unrevealed.[37] Still, more research is needed about what types of settings are most suited to telephone interpreting versus video and in-person interpreting.

Across the U.S., in-house telephone interpreting services are beginning to emerge as effective models within hospital systems and other large-scale providers of health care services in order to centralize resources and improve efficiency.[38] However, this practice necessitates that interpreters undergo additional and separate training in these remote methods of interpreting. A variety of courses are beginning to emerge to help interpreters master these skills.[39]

Typically, telephone interpreting (and health care interpreting in general) is performed using what is known as the *consecutive mode.* In this mode, the interpreter listens to an utterance, and when the speaker is finished, he or she renders the utterance into the language of the listener. This is different from the *simultaneous mode*, in which the interpreter listens and renders the information while the speaker is still speaking. In health care interpreting simultaneous mode is less commonly used, but is often necessary in emergency settings as well as patient education settings, especially when a large amount of information is being presented by a health educator, or when more than one patient is receiving information. In person, simultaneous interpreting has the disadvantage that it can be distracting to the patient and the provider. In patient education settings, this can present a problem, since the very fact that two people are speaking at the same time can make it more difficult for the patient to hear and process the information being provided.

Recently, researchers have reported interesting results of studies on simultaneous interpreting services that are provided via telephone.[40] In this form of telephone interpreting, the provider and patient do not hear each others' voices through the telephone, but instead hear the voice of the interpreter only, thereby eliminating some of the problems of interference with patient and provider comprehension when using this mode in person.

Various types of equipment may be used for telephone interpreting services. Speaker phones are common; however, some can interfere with the quality of communication and the interpreter's ability to process utterances. Speaker phones often pick up background noise and hinder normal conversational flow and turn-taking. Today, many telephone interpreting providers lease or sell analog phones with two receivers, also known as "dual handset phones" or "dual receiver phones", to their customers.[41] [42] [43] One manufacturer also sells this type of equipment to customers outright.[44] Some facilities install a dual receiver phone in the majority of rooms where a patient-provider encounter may take place, to ensure easy access to interpreting services.[45] Other facilities have fewer phones and store them in central locations.[46] Some commercial telephone interpreting providers also offer cordless phones with multiple receivers, offering both digital and analog versions.[47]

Wireless and digital solutions for telephone interpreting are becoming more commonplace. In some cases, it is common for providers and patients to wear wireless headsets when working with a remote telephone interpreter. Wireless headsets can be used for either consecutive or simultaneous telephone interpreting. Some telephone interpreters now use Voice over Internet Protocol (VOIP) communications over a Wide Area Network, using simultaneous mode.[48] Others have health care providers wear wireless clip-on devices that contain both a microphone and a receiver, enabling the interpreter's voice to come from the direction of the provider.[49] Some telephone interpreting providers have begun to integrate their services with no- or low-cost internet telephony services, such as Skype.[50] For health care workers who visit patients at their homes, pre-paid calling cards are also available.[51]

Video Interpreting Services

Another form of remote interpreting that is growing by leaps and bounds is video interpreting. Historically, video interpreting was introduced for the purpose of communicating with patients who were Deaf and hard of hearing. Like telephone interpreting, video interpreting is known by various names, including, "video remote interpreting (VRI)", "video medical interpreting (VMI)" and simply "interpreting via videoconference". Video interpreting is provided by various commercial providers, some of whom also offer telephone interpreting. Some offer video interpreting for spoken languages as well as sign language.

Equipment is essential for video remote interpreting. Some facilities invest in expensive videoconferencing equipment.[52] Others use laptops or regular computer monitors. The quality of the communication varies tremendously, depending on the equipment, whether or not dedicated lines are available, how many interpreting sessions are conducted simultaneously, time of day and the amount of data going across the lines. When the connection is inadequate, images and audio information may be distorted, or the connection may be interrupted or lost.

For sign language interpreting, the connection must be of utmost quality to enable patients to see intricate details of lip and hand movements and facial expressions. Deaf patients who have had negative experiences with inadequate technology are often reluctant to use video interpreting services again, and some advocacy organizations have protested the use of video interpreting for sign language.[53]

One potential concern with video interpreting is that the patient and the provider tend to look at the interpreter on the screen instead of looking at each other, potentially reducing non-verbal communication between patient and provider. Unlike on-site interpreting, video interpreting does not allow the interpreter to position him/herself in a way that is unobtrusive. With video interpreting, the interpreter often has minimal control over how he/she is "positioned" in the room or on the screen. As mentioned earlier, more research needs to be done on what types of interpreting are best suited to different scenarios.

For all interpreters, it is essential that individuals meet the minimum requirements described earlier in the areas of testing, training and adherence to professional standards and ethics. As supported by the studies cited above but also widespread anecdotal reports, unqualified interpreters typically make errors, change the message through distortion and omissions, give advice to the patient and/or clinician, stereotype or generalize about patients' culture, engage in side conversations with the patient and violate confidentiality.

CONCLUSION

This paper has provided an overview of important recent studies related to language access for patients and described how interpreting services are typically provided within the United States.[54] Providing professional health care interpreting is no small undertaking. It typically necessitates collaboration from many stakeholders and experts, including health care providers, managers of health care organizations, researchers, policymakers, patient advocacy groups, educators and working interpreters. Yet, as evidenced by research literature and ongoing developments in the field, professional medical interpreting plays a critical role in the delivery of health care services in an increasingly diverse world.

Utilizing qualified, professional health care interpreters can help to avoid tragic health outcomes. Quality interpreting improves accuracy of diagnosis, increases patient adherence to treatment plans, avoids unnecessary and costly procedures, increases patient satisfaction, reduces overall costs of providing care and enhances access to care. In this manner, health care interpreting ultimately serves to reduce health inequalities and promote access to quality care for linguistically diverse populations.

ENDNOTES

1. Both Ms. Kelly and Ms. Bancroft serve on the Board of Directors of the National Council on Interpreting in Health Care. However, the views expressed herein are those of the authors and do not constitute official Council positions.
2. The term *interpretation* can sometimes lead to confusion due to an alternate definition that relates to one's opinion of a given statement or action. Most professional codes of ethics strictly prohibit interpreters from providing their personal opinions regarding the content they interpret.
3. These four criteria may seem rigorous to those who do not actively work in the field of professional interpreting practice, especially for individuals residing in locations where no standards, training programs or tests are readily available for health care interpreters. However, the authors wish to emphasize that, given the extremely high risks associated with health care interpreting, these criteria are actually offered as a *minimum* set of requirements. To minimize risk and increase quality, additional measures of quality assurance and training should be put into place to guarantee interpreting services that are truly professional, given the fact that the health outcomes of patients often correlate directly to the quality of the interpreting services they receive (or fail to receive), as discussed in this paper.
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Health Literacy, Empowerment and Cultural Competency

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Health Literacy has been defined in several ways. The World Health Organization defined Health Literacy as "The development of the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health."[1] The United States Department of Health and Human Services defined Health Literacy as "The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[2] Nutbeam has identified a typology that defines three categories of health literacy: functional, interactive and critical.[3] More recently, Media Health Literacy has been defined as "the ability to identify health-related content in the media (explicit and/or implicit), to recognize its influence on health behavior, to critically analyze the content and to express intention to act or react as a result of exposure to health content."[4]

Kickbusch[5] has commented that efforts to improve health literacy must take into account methods for improving empowerment. The working definition of empowerment applied here is: "The ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies."[6] Health empowerment is the process by which the responsibility of the individual for his health increases, including the ability to define his or her health problem or situation, determine priorities for treatment, choose and apply the appropriate treatment alternatives. The foundations of empowerment lie in access to relevant and culturally appropriate health information, self-efficacy and mechanism for change. Significant effort has been invested in attempts to measure health literacy via readability studies and measures such as TOFLA (Test of Functional Health Literacy in Adults)[7] and REALM (Rapid Estimate of Adult Literacy in Medicine).[8] Yet these measures have concentrated on functional aspects of health literacy. Baker and colleagues in their early works introduced the scope of the issue of understanding the once considered simple instructions such as taking medication on an empty stomach, and how to make an appointment with a physician.[9]

Health literacy is dependent upon education, past experience with the health system, age, gender and finally cultural background. Thus, in order to serve the needs of people with low health literacy, the health system must become culturally competent and responsive. Cultural competence is "the capacity to function effectively as an individual and as an organization within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities."[10] Cultural competence in the context of health literacy, includes four aspects: a) **cultural awareness**, or sensitivity to values, beliefs and lifestyles that stem from one's culture; b) **cultural knowledge**, including educational foundation concerning worldviews of various cultures; c) **cultural skill**, or the ability to collect (verbal and physical) relevant cultural data regarding client's health histories and presenting problems, and d) **cultural encounter**, or cross-cultural interactions with clients from culturally diverse backgrounds.[11]

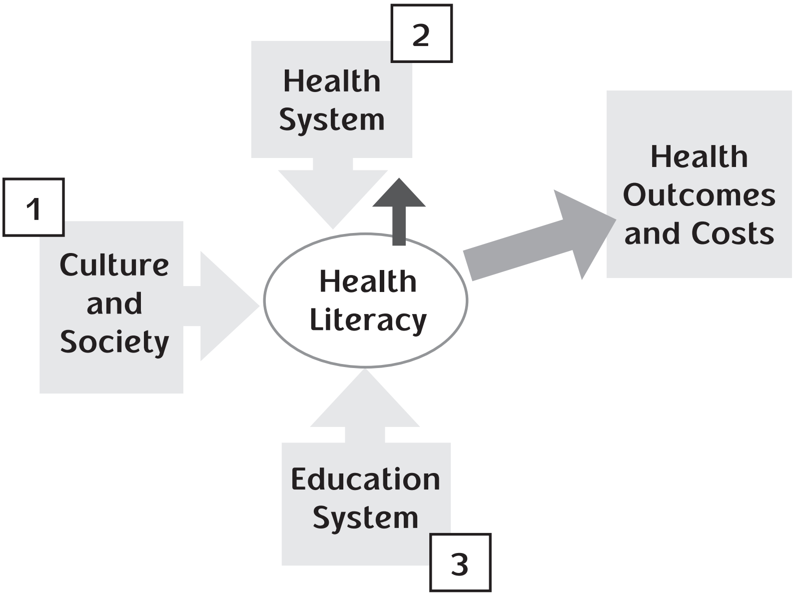
The notion of cultural competence and health literacy is extremely relevant in the Israeli context, particularly as it relates to immigrant, (e.g. Russian, Ethiopian) migrant (e.g. foreign workers from the Philippines and Eastern Europe) and co-existing cultures (e.g. Haredi or Arabic cultures). Health literacy has been acknowledged as a better predictor of overall health than is age, race, economic status, or educational level.[12]

What is the importance of understanding the association between cultural competency, empowerment and health literacy? This topic should be given attention for three specific reasons. Firstly, the concepts together form a basis for improving health indicators. Secondly the empowerment, cultural competence and health literacy "connection" has significance regarding the use of public resources for health care. The Institute of Medicine[13] estimated that the cost of low health literacy in terms of health costs, is approximately 50-73 billion dollars a year. These costs stem from increased need for repeated examinations, treatments, hospitalizations due to mistakes, misunderstandings, etc.

Finally the cost on the personal note is that of personal shame and harm to self esteem that is caused by the formidable encounter with the health care establishment. The lack of interpersonal communication avenues, culturally adapted to the individual, are the source of embarrassment and shame, so much so, that within certain cultural systems, the individual is prohibited from expressing his needs, neither to health care providers, nor to individuals in his immediate surroundings. Studies show that 40% of individuals that have low literacy report feelings of shame, 63% have never told a spouse and 53% have never told children of their special needs regarding literacy. [14]

In search of a theoretical model as a basis for intervention, the challenge is to understand the relationship between health, empowerment and health literacy within the cultural context. The above mentioned associations and the subsequent examples shown in this paper demonstrate that the associations are complex. As shown in Diagram 1[15] the cultural system, the educational system and the health care system all influence health literacy, which in turn influences health outcomes.

Diagram 1 – Potential Intervention Points



Western and traditional health systems

The relationship between the health systems and cultural systems can be understood using Foster's model of universal health systems.[16] This model maintains that every culture has a health system that includes four components: the cause of disease, symptoms, diagnosis and treatment/cure. In addition, each culture has a designated individual whose function is to treat exceptional health situations. Western medical systems usually function in a linear paradigm, with one component chronologically following the other. Furthermore, western medicine has embraced the notion of asymptomatic health situations. Traditional medical systems are known to embrace a more complex model, with the socio-cultural identity at the center of the system, and the cause, symptom, diagnosis and treatment branching out from this central identity, not necessarily in the same linear sequence.[17] Furthermore, it should be noted that traditional health systems do not recognize health problems that are not presented in the form of recognizable symptoms. When the western and traditional health systems confront one another, as in the case with migrants, immigrants and cultures in transition, the above mentioned two paradigms meet. Research has shown that the component of the traditional health system that is most flexible to change is the notion of treatment. The component that is least likely to change is the perception of cause of disease, as this is the aspect that is most associated with socio-cultural identity.

Within the context of the converging systems, strategies that have been recommended in order to enhance culturally appropriate health literacy include creating a shame-free environment, enhancing assessment techniques, improving culturally responsive inter-personal communication skills, creating and using patient-friendly written materials and signage, and developing and implementing sustainable, effective interventions. These interventions must include a staff training component, exemplified by the program developed by the American Medical Association and American Medical Association Foundation.[18]

The multi-cultural mosaic of the Israeli society has warranted the development of intervention strategies for enhancing empowerment based on culturally appropriate health literacy. Israel society is comprised of the veteran Jewish population that have lived in the country for 10 years or more, (63%), the Jewish new immigrant population (16%), the Moslem Arab population (15%), Christian Arabs (2%), Druze (2%).

Two specific interventions will be described including their results, one implemented among the Ethiopian immigrant population and the second among the older Arab population. The interventions were initiated by the Clalit Health Services, Israel's largest health service organization and the second largest non-governmental health service organization in the world. The organization has 1300 community care clinics, 14 hospitals, over 400 pharmacies, and hundreds of additional health service facilities. Clalit provides comprehensive health care to 55% of Israel's population, including 80% of Israel's elderly population, 80% of the Arab population, and a significantly higher rate of lower socio-economic status than the other health care organizations in Israel. The organizational structure allows for the cooperation between primary health community clinics and hospitals, and the collaboration with non-governmental organizations, community services and others.

Refuah Shlema

Refuah Shlema, a cross-cultural program for promoting health among Ethiopian immigrants in the primary care setting, was firstly developed in 1996. Since the immigration of the Ethiopian Jewish population to Israel in 1984, a tremendous need was evidenced for cultural bridging in the health system. Over 80,000 Ethiopian immigrants have resettled in Israel. In spite of significant investment made in health education and promotion among the Ethiopian community in the first decade, tremendous gaps in health communication were expressed by both the Ethiopian and the medical community. Significant adjustment problems exist due to cultural disparities, particularly regarding health and health care and navigation of the primary health care system.

Hence, the *Refuah Shlema* initiative was launched as a cooperative effort of Clalit Health Services and the Israel Joint Distribution Committee (JDC). Support was then given by the Ministry of Absorption, Palm Beach and Detroit Jewish Federations and later by the Israel Social Security Administration.

From its commencement, the program included three components:

1. employing Ethiopian immigrant facilitators on a full time basis, who have been trained to work as health cultural-liasons and cross-cultural mediators between patients and physicians;
2. training clinical staff with the aim of bridging inter-cultural gaps, by increasing awareness and sensitivity regarding Ethiopian perception of health and disease causation, and
3. cooperatively implementing health education activities for new immigrants.

The program was evaluated by the Brookdale Institute which published the main findings, in two phases.[19,20] The first phase included the following findings:

a. The program was effective in:
  1. Improving physician-patient relations,
  2. Improving knowledge regarding how to access medical specialists in the community and when to use emergency medical services
  3. Improving the ability to navigate the health system

b. No significant difference in expenditures in the clinics with cultural liasons as compared to matched clinics in which the program was not implemented

The second phase conducted a year later found:

1. improved perception of general well-being among the immigrants in the experimental clinics.
2. no difference in perceived well being among the diabetics and asthmatics.
3. some aspects of self care behavior were more positive as a result of the program, for example physical activity among diabetics.

In-service training for primary care staff regarding culturally sensitive health communication was conducted in 2007. Over 110 physicians, nurses, pharmacists, administrative staff participated in a 6-hour workshop conducted by health promotion specialists, medical anthropologists, primary care physicians and Refuah Shlema cultural liasons working in the clinics. The evaluation data of this workshop showed the participants reported increased awareness and sensitivity to the needs of the Ethiopian community as well as gaining tools and skills for improved communication with patients seeking their medical and administrative assistance.

After sustaining the implementation of *Refuah Shlema* for over a decade, the conclusions of implementation in nearly twenty clinics include:

1. A health cultural-liaison in primary care clinics can significantly bridge the communication gap in a multi-cultural setting supporting and empowering an immigrant population.
2. Specific improvements for asthmatics and diabetes in the present eclectic model were witnessed.
3. A model is needed in which the health cultural-liasons concentrate specifically on these groups with special health needs and invest significantly in health education and promotion of the community.

The wider application of cultural- liason model in the primary care system could make a significant impact on the cultural appropriateness and responsiveness of the health system.

Community Intervention for Diabetes Control Among Adult Arab Population

Cultural competency principles were applied to health literacy in the initiative for improving diabetes control among the Arab population in Israel. Type 2 diabetes mellitus is becoming more prevalent among cultures in transition from traditional to Western lifestyles. The prevalence of Type 2 diabetes in Israel is 5.9% of adult population. This is compared to the prevalence of diabetes in non-Hispanic white populations in the Western world which is noted to be 8 %.[21] The prevalence of diabetes in Israeli Arab population is noted to be three times higher than the Jewish population.[22] The high prevalence of diabetes among this population in Israel has been attributed to change in lifestyles including physical activity and nutrition. Complications due to diabetes are also high due to cigarette smoking among males. The goals of the national intervention program were:

- To increase awareness of the Arab community regarding diabetes and the importance of treatment, while reducing the stigma held regarding chronic disease.
- To develop and apply lifestyle change methodology, culturally tailored to the Arab community.
- To promote change in health behaviors: nutrition, physical activity, smoking, self care and foot care.

The national intervention program initiated by the Clalit included 4 main stages:

1. **Establishment of a national inter-disciplinary team** consisting of professionals from the fields of health promotion, family medicine, diabetology, nursing and nutrition. This team was established in order to assess and define needs and to develop the strategy of the intervention program.
2. **Development of culturally appropriate health promotion tools** on the topics of eating habits, physical activity, smoking cessation, self-monitoring and self-care.
3. **Program implementation**

   The program, conducted from 2001-2003, was open to the entire community living in Arab towns and villages, as it focused on healthy lifestyle, pertinent to all residents, not only diabetics. Over 6,000 residents participated in the program which was implemented in over 20 communities.

Lectures and discussions were conducted with community health professionals and individual lifestyle instruction was given on the topics of physical activity, nutrition, smoking cessation and foot care.

According to the Clalit chronic disease register, Clalit treated during that time 170,000 diabetics. The process evaluation of the program showed that the reach of the health promotion program was 9% of adult diabetics registered in Clalit Health Services.

The impact and outcome evaluation of the program was conducted by telephone interview of a representative sample of the participants regarding the following indicators: change in health behavior, attitudes towards diabetes, satisfaction and change in HbA1C. The results of the evaluation showed that the attributed contribution of the event showed significant reported behavior change as a result of participation in the program.

Diabetes control measured by hemoglobin A1C among participants from the Arab population in the health promotion program showed that HbA1C measure decreased significantly in the intervention population, from the >9 measure to the more normal measures. Similar reductions were not observed in the comparison population.

The main results and conclusions of the initiative were:
1. There was an expressed need for in-depth community programs, above and beyond community events.
2. The Arab community in Israel expressed great interest in ongoing health promotion interventions regarding lifestyle and chronic disease prevention.
3. The primary care clinic was noted as an appropriate setting for health promotion events particularly regarding chronic disease prevention.
4. Individual lifestyle counseling was recommended as part of the community initiative as well as in-depth behavior change workshops.

All of the above-mentioned conclusions have been applied in the national diabetes program strategy, emphasizing self-management and maintenance.

Health Literacy, Cultural Competence and Technological Breakthroughs - How Accessible Are They?

Technological solutions to health literacy, while closing cultural chasms, have only recently been developed. Examples of computer programs designed to prepare patients for surgical procedures include such examples as *Emmi.*[23] This initiative provides pre-operative health information and education materials. The program facilitates patient/doctor communication, and educates through non-threatening, interactive and easily understood internet presentations. It offers access to relevant information – it can be viewed from any server, during all hours of the day, and as frequent as necessary. This program also allows patients to ask questions, and be surveyed. The objective of the initiative is to provide clear, concise, easy to understand language (6th-grade reading literacy & 5th-grade health literacy). It provides the basis for knowledge retention, as patients read, hear, and see the information. Furthermore the information is available in multiple languages.

Recommendations for future areas of action

In light of the above–mentioned experience, the following are recommendations for policy and actions:

1. Develop standards for appropriate messages and applying them in the development of materials using formative research.
2. Make more efficient use of culturally appropriate mass media and education-entertainment
3. Develop and implement policy for promoting cultural and literacy competence among professionals in the health field.
4. Change current procedures to promote community involvement and collaboration with key stakeholders.
5. Redesign bureaucratic procedures to become more user–friendly, based less on sophisticated written communication.
6. Develop text-free educational methods based on learning styles of non-readers.
7. Include migrants, immigrants and other ethnic minorities in national health surveys, in large enough samples to evidence special needs.
8. Continually exploring new strategies for people with limited health literacy to take control over their health, particularly through developing partnerships among various sectors.

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Health Communication at the Population Level – Principles, Methods and Results

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ABSTRACT

There are significant challenges to communicating relevant health information at the population level due both to the complexity of the health information that needs to be communicated and to the difficulties of effectively communicating and influencing diverse audiences. The need for effective communication about health promotion is particularly acute in modern society where there are significant health risks. Yet, the health communication process is tremendously complex, especially for reaching the most vulnerable populations, those groups of people who are most likely to suffer from significantly higher levels of morbidity and mortality than other segments of society. These vulnerable populations, typically the poorest, lowest educated, and most disenfranchised members of modern society, are heir to serious disparities in health outcomes. Vulnerable populations often have health literacy difficulties, cultural barriers, and economic challenges to accessing, making sense of, and utilizing relevant health information. Care must be taken to develop culturally sensitive communication interventions for reaching and influencing vulnerable populations. Major challenges to population level health communication will be examined and culturally-sensitive communication strategies will be suggested for reducing health disparities and promoting public health.

Vulnerable Populations and Health Communication

There are many significant health risks confronting the public today, including the risk of heart disease, cancer, diabetes, stroke, HIV/AIDS, and other serious health threats.[1,2] Effective health communication is needed to help those members of the public who are at greatest risk (most vulnerable) for these threats to recognize, minimize, and respond effectively to these potential health problems.[3,4] It is particularly important to effectively communicate clear and accurate information about the potential harms and benefits of prescription drugs that consumers use for many health threats due to widespread misinformation and confusion concerning the appropriate use of medications that often lead to dangerous errors in medication usage.[5,6,7,8] Unfortunately, current efforts to educate the public about the harms and benefits of prescription drugs are insufficient to help consumers make informed decisions about their best health care choices. [5,6,7,8]

The need for effective communication about health risks and benefits is particularly acute, yet also tremendously complex, for reaching the most vulnerable health care consumer populations who are at greatest risk to suffer significantly higher levels of morbidity and mortality than other segments of the population.[9,10] These vulnerable populations, typically the poorest, lowest educated, and most disenfranchised members of modern society, are heir to serious disparities in health outcomes, resulting in alarming levels of morbidity and mortality, especially in comparison to the rest of the public.[9,11,12] Vulnerable populations often have significant health literacy difficulties and are challenged by intercultural communication barriers to accessing and making sense of relevant health information.[13,14,15] These consumers are often confused and misinformed about the correct use of prescription drugs, which can lead to serious medication errors and resultant health problems.[16]

Members of vulnerable population who suffer significant health disparities are desperately in need of relevant, accurate, and timely health information about prescription drugs and other health issues.[17,18,19] Members of these vulnerable groups often include elderly, immigrant, socio-economically deprived, and minority health care consumers.[11,20,21] Many vulnerable immigrant consumers in the US are non-native English speakers and encounter serious language barriers and health literacy challenges that necessitate adaptive, culturally-sensitive communication strategies to provide them with needed health information.[22,23,24,25] Furthermore, consumers with serious and chronic medical conditions, as well as individuals who confront physical and mental disabilities, are often particularly vulnerable to health risks and have unique communication needs that have to be adequately addressed to provide them with the relevant health information they need to preserve their health.[26] This article examines strategies for using culturally-sensitive communication programs for providing vulnerable consumer populations with the relevant health information they need to evaluate health risks, make informed health care decisions, and direct their health behaviors.

Focus on Cultural Issues

Consumers' unique cultural backgrounds and orientations have powerful influences on their communication practices that must be carefully accounted for in strategic health communication efforts.[27] It is critically important to identify and examine the relevant cultural issues that are likely to influence the ways consumers, particularly members of vulnerable populations, respond to communication about the harms and benefits of prescription drugs. [22,24,26] Several of the key cultural variables that influence health communication outcomes include the unique health beliefs, values, norms, and expectations that different consumers bring to health situations.[26] It is also important to assess consumers' culturally-based language skills and orientations, their health literacy levels, their motivations to seek health information, and their unique media use patterns.[28,29] Examination of these key cultural factors provides relevant information for determining how to best design and deliver key messages for effectively communicating complex health information to diverse populations.[22,24,26] Culturally-sensitive health communication is essential to providing vulnerable consumers with relevant information about the risks and benefits of prescription drugs.[30,31]

Strategic Health Communication

Health education messages must be carefully designed to be effective. The critical factor in strategic message design is adapting health education messages to meet the unique needs and communication orientations of specific audiences. This means that effective health communication efforts should adopt a consumer orientation to health education.[32] Careful audience analysis is essential to identifying the salient consumer characteristics for guiding message design.[33] Messages should be designed to appeal to key beliefs, attitudes, and values of targeted audience members, using familiar and accepted language, images, and examples to illustrate key points.[24] It is wise to pre-test sample health education messages with representatives of targeted audiences before implementing health communication intervention programs. Formative evaluation data gathered through message pre-testing is essential to refining health education messages.[34] This is a form of user-centered design, where health education messages are shaped and refined by representatives of the actual audiences targeted in health communication interventions.[35] Pre-testing is also a strategy for increasing audience participation in health education efforts, which can increase not only the cultural sensitivity of health communication efforts, but can also enhance audience receptivity and cooperation with the health promotion effort.[36] Involving consumers, their family members, key members of their social networks, and community representatives can increase the support and social encouragement for paying attention to, accepting, and utilizing health education messages.[34,37]

To be most effective it is wise to plan multiple message strategies for reaching vulnerable audiences with health education information, utilizing the communication principles of redundancy and reinforcement to enhance message exposure and impact.[38] Multiple messages can help to capture audience attention, reinforce message content, and illustrate key health education concepts. The use of vivid imagery in health communication interventions through the use of narrative and visual illustrations can also reinforce message content, especially to audiences with limited health literacy and problems with numeracy that make it difficult for them to understand statistics and numerical risk estimates.[34,39,40,41,42]

A powerful new approach to designing health messages to meet the unique needs of individual is the use of tailored communication systems, where relevant background information from an individual informs customized use of messages for that person.[43] Typically, tailored communication systems employ interactive computer systems that gather relevant background information from consumers on key communication variables through questions posed to these individuals, including questions eliciting information about individual demographic, psychographic, and health belief/behavior information. Once key background information is gathered from the individual, the information is used to select specific messages stored in a library of messages that match the unique background features of users. In this way, information about the individual health risks and orientations of a specific consumer, for example an elderly, Japanese, female health care consumer with a history of breast cancer and diabetes, will automatically be selected and content-appropriate health information will be provided by the tailored health information system to the user. As the consumer continues to interact with the tailored health information system, providing the system with additional background information, the computer program is able to continually refine information responses to this consumer to match his or her unique personal characteristics and interests.

In addition to developing strategic messages that match the cultural orientations of at-risk consumers, it is critically important to determine the most effective communication channels for reaching targeted populations of consumers. The best communication channels to utilize are those that are close, familiar, and easily accessible for targeted audience members.[44] For example, it is important to employ communication channels that are easy for members of the intended audience to use. It would be a serious error to develop an online health education website for consumers who do not have access to computers and are not so phisticated computer users. Communication channels that are dramatic and memorable can have strong influences on audience attention and interpretation of health messages.[44] Health educators should consider using communication channels that can be accessed over time, channels that can retain important information for later review, and even interactive channels that enable consumers to ask questions and receive clarifications about complex health information.

It is important to decide what the best sources are for delivering key messages about the potential benefits and harms of prescription drugs.[34] It is crucial to identify the most credible sources of health information for members of the intended audiences.[44] Decisions need to be made about whether it is best to utilize familiar sources of information, expert sources, or perhaps peer communication may be most influential with different audiences. Just as with the use of strategic messages, it is a good idea to pre-test different information sources and different communication channels with target audiences.[34]

Evaluating Communication Interventions

A critical juncture in communicating risk and benefit information to vulnerable audiences is evaluating how well different communication strategies work to educate targeted audiences about important health issues.[44] It is important to assess how well consumers really understand the risks and benefits that are being communicated and what difference communication programs are making in promoting informed consumer decision-making. A first step is to establish clear baseline measures of consumer understanding before introducing new health education programs. These baseline measures can be used as a starting point for tracking the influences of communication efforts.[45] Feedback mechanisms, such as consumer surveys, focus groups, hotlines, help-desks, and comment cards, should be introduced as integral parts of communication interventions for tracking and evaluating consumer understanding of health messages. The data gathered through these feedback mechanisms can be used to refine health communication programs and track progress in health education.

Policy and Practice Implications for Strategic Communication

What policies and best practices are needed to guide effective communication of prescription drug information to vulnerable populations? First and foremost, communication interventions to educate vulnerable populations need to be strategic and evidence-based. This is too complex a process to be handled without careful planning and data. It is also critical for health educators to adopt culturally sensitive communication practices to reach and influence vulnerable populations. Community participative communication interventions are a valuable strategy for integrating consumers' perspectives into health education efforts and building community commitment to health communication interventions.[36,37] It is a good idea to consider introduction of relevant communication technologies, such as tailored information systems, to support health education efforts.[14] It is also a good idea to incorporate health communication training for both health care providers (educators) and consumers to enhance the quality of cross-cultural communication efforts.[15,46]

Several lessons have been learned from past efforts to increase the effectiveness of health communication interventions with vulnerable populations.[15,24,25] These include:

- Involving and empowering vulnerable and at-risk consumers in health communication efforts;
- Developing inter-organizational partnerships to support intervention efforts;
- Providing appropriate training and support for both consumers and providers;
- Designing culturally appropriate messages and materials for communication efforts;
- Focusing on the family and the community for delivering and reinforcing messages, and;
- Providing consumers with choices and options for promoting their health.

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The Evolution of the Tene Briut[1] Model – Developing an Intervention Program for the Ethiopian Immigrant Population in Israel and its Challenges and Implications

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1. INTRODUCTION

A 12-year-old girl from an Ethiopian immigrant family was admitted to the emergency department of the Hillel Yaffe Medical Center in Hadera, suffering from abdominal pains. Medical tests showed that her glucose levels were extremely high and she was referred to the diabetes unit. Although she received extensive explanations from the medical staff about the severity of her medical condition she did not return for follow-up treatment. This prompted the medical staff to make a home visit, accompanied by an Ethiopian doctor. This resulted with a decision to use the services of an interpreter for further communication with the girl and her family. However, the interpreter herself did not understand why the girl had to check her blood sugar levels and to inject insulin on a daily basis. This case made it clear to the medical staff that focusing on the family was insufficient, and that their work had to be community-based, because the idea of chronic disease in general, and diabetes in particular, was new to the Ethiopian community. That was the beginning of Tene Briut.

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[1] In Amharic *tene* means health and the combination with the word for health in Hebrew signifies health basket, and is compared to a hand-made Ethiopian jewel basket, where a special, precious object is kept. Thus, the name of the project and its logo express the importance we give to preserving and protecting health

1.2 Brief history of the Ethiopian immigrant community in Israel

Since the establishment of the State of Israel in 1948, Jews from all over the world have immigrated to Israel. One ethnic group about which relatively little was known – the Jews of Ethiopia – arrived only recently. Two waves of immigration took place: the first between 1984-1985, following an arduous journey through Sudan, facing bandits, dangerous animals, harsh weather, hunger and disease. Many died on this journey and those who survived were eventually flown to Israel from Sudan. The second wave took place in 1991. Those immigrants traveled from their villages to Addis Ababa, the capital of Ethiopia, but only after several years were they permitted to leave. Within a few hours, 14,000 Jews were airlifted to Israel. In Israel, Ethiopian immigrants were placed in "absorption centers"[2] and subsequently moved to various towns. The dramatic transition from an Ethiopian village to a modern urban lifestyle entailed many cultural and social hardships. As the nuclear family replaced the extended family structure, cultural gaps between parents and children emerged, and the traditional patriarchal system began to erode. Day-to-day existence in Israel differed as well: activities common in Ethiopia were no longer relevant in Israel. Even dietary staples changed drastically. In addition, modes of employment changed substantially; men no longer work in agriculture, many are unemployed or work mainly in menial low-paying jobs. Currently small groups of Ethiopian immigrants continue to arrive and reside temporarily in "absorption centers".

1.3 Creating programs to address the unique health needs of the Ethiopian immigrant population

Clearly the different cultural background of the Ethiopian immigrant minority in Israel and their limited Hebrew language proficiency requires the provision of special resources to address their unique needs(1-3). Israeli public and government agencies were cognizant of the unique needs of the Ethiopian immigrant population and upon their arrival the immigrants were sent to live in "absorption centers". Some of the issues that these agencies sought to address related directly to health, in particular issues of hygiene, use of medication, HIV, and

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[2] A place where new immigrants live, as an intermediate stage on their way to permanent housing. They receive physical services, study Hebrew and learn to orient themselves to life in Israel.

tuberculosis. Further, when it was clear that there were serious communication challenges in the patient-doctor encounters and that Ethiopian immigrants tend to conceive and manifest their symptoms in ways that differ substantially from what Israeli doctors are used to,(4-5) a program of para-professional healthcare liaisons was initiated and implemented in about a dozen community clinics, as a collaborative effort between a public agency, the Ministry of Health and health services provider organizations. They received special training to help both in interpreting and in cultural mediation(6). The Israel Ministry of Health also created a program of liaisons that mainly focused on HIV and tuberculosis. However, there was clearly still a need to further identify the kinds of challenges Ethiopian immigrants face in the healthcare system and for a program that would focus on diabetes and other chronic diseases. This emphasis was deemed important because for the Ethiopian immigrants these diseases were "new" and often devastating phenomena. The Tene Briut project was initiated when its founding physician felt there was a need for a program that could help create an overlap between the world of healthcare providers and that of the Ethiopian immigrants(7). From the outset of the project the Tene Briut team studied the literature, collected data to identify and document health-related difficulties, and summarized the challenges that emerged in the adaptation of the immigrants from Ethiopia to living in Israel. Following are the five major challenges that emerged:

1. A drastic change in the Ethiopian immigrants' morbidity profile:

The data indicate that whereas there was a significant reduction in various types of infectious diseases, various chronic diseases and health challenges appeared which had been mostly unknown in this population in Ethiopia(8). These include the following: Obesity (the BMI rose from 17-19 to 24)(9-12); a decline in fitness accompanied by a sharp increase in Type 2 diabetes 0 to 0.4% on arrival in Israel to 17% after ten years in the country(10-12), as well as an increase in Type 1 diabetes (13); an increase in average blood pressure readings and in the number of people suffering from hypertension(9, 12, 14, 15). Among Ethiopian patients with diabetes mellitus, the lipid profile, which had been normal at the time of immigration, is approaching that of other ethnic groups(15-16). Further, a sharp increase in asthma cases has also been documented(17).

2. Absence of the concept of chronic disease, including diabetes:

Chronic diseases associated with Western countries' lifestyle were literally unknown to the Ethiopian immigrant populations from the rural areas. Thus such diseases were not part of the medical system they were familiar with and their cultural concepts of health and illness. In a study conducted in the Hadera region only 50% of those interviewed had heard of diabetes and two-thirds only after they had immigrated to Israel. Most did not know of a patient who was managing appropriately his or her medical condition(18).

3. Under-utilization of health services provided by the National Health Insurance Law:

Findings from study conducted by the researchers affiliated with Tene Briut and sponsored by the Israel National Health Policy Institute indicate that Ethiopian immigrant patients received relatively fewer physical examinations such as blood pressure readings or foot examinations, fewer blood tests and urine analyses, and their metabolic parameters were lower(15).

4. Communication difficulties between healthcare providers (HCP) and Ethiopian immigrant users:

In the study mentioned above, Ethiopian immigrants tended to rate lower than the comparison group of patients from other backgrounds, in their ability to comprehend their doctor's explanations and in their comprehension of the pharmacist's instructions and they also reported a lower frequency of discussions about diabetes with the nurse. The issue of trust also becomes critical in Ethiopian immigrant-HCP relations, when some Ethiopians feel they are discriminated against, not taken seriously, or not understood.

5. High frustration among the medical staff treating the Ethiopian immigrant population:

HCP typically comment on their difficulty of communicating with Ethiopian immigrants, both because of the limited proficiency of Hebrew among older and recently arrived patients and because of cultural differences. They are aware that many among the Ethiopian immigrants have different concepts of medical care and diseases and feel unequipped to address these conceptions. Such cultural gaps often result in a misunderstanding of the explanations provided by HCP to Ethiopian immigrant patients about issues such as diabetes and its treatment. Furthermore, many of the Ethiopian immigrants find it difficult to adapt to the administrative aspects of the healthcare system. In addition, economic and logistical factors may reduce their access to healthcare services and to medical technologies that members of other populations utilize more readily.

These particular needs and challenges served as an impetus for the development of the Tene Briut project and its method and activities. In the following sections we present an overview of the project, its rationale and activities, and how it evolved from a project led by a non-Ethiopian physician within a hospital setting to an independent organization led by Ethiopian-Israeli professionals. The description of the activities includes several ethical and moral issues that arose, as well as particular challenges and directions for the future.

2. THE TENE BRIUT PROJECT

Tene Briut is a health-promotion initiative aimed to provide the Ethiopian immigrant population in Israel with new concepts and perceptions regarding their health, such as chronic disease, latent disease, preventive behavior and preventive medicine (immunization, early detection, adoption of health-promoting lifestyles). The program was initiated in 1998. One of its goals is to foster a sense of self-efficacy at the individual and collective level, and to promote Ethiopian community members' health through prevention activities and disease management. For this purpose Tene Briut developed culturally-inspired resources that could be used in various settings to disseminate information and to enhance community members' health literacy as well as awareness of early diagnosis opportunities and Western methods of treatment. The outreach activities to the community are done mainly in Amharic, and incorporate in the programs issues that were raised by members of the community. The program is implemented mainly by Ethiopian-Israeli medical professionals. Its activities typically consist of sessions that take place in a community setting in which on-going activities organized by various organizations already take place; for example, sessions with women at well-baby clinics, groups of senior citizens, etc. This approach was adopted as a means to both strengthen the group itself and to promote more effectively the specific goals and objectives of the program by having them adapted to each particular population. In parallel, Tene Briut works with non-Ethiopian HCP to increase their awareness of the cultural factors that relate to Ethiopian immigrants and healthcare, and to enhance their familiarity with the differences in health conceptions and the difficulty Ethiopian immigrants have in utilizing health services.

2.1 Development of the Tene Briut Model

Tene Briut began as a local 'experiment' to identify and help address the problems inherent in providing medical treatment to patients from a different cultural background. It did not begin with a systematic design. Only after work had begun in the field did the genuine need and depth of the particular needs of the Ethiopian population became more evident. The project found itself trying to fill a vacuum, and embarked on a process of establishing an organizational structure. In what follows, we describe six stages of this process and some of the changes made along the way.

Stage 1: Learning about the community:

We needed to become familiar with the Ethiopian immigrant community beyond the cold medical data. We first appealed to the non-medical professionals (welfare, National Insurance and absorption workers, as well as teachers) dealing with the Ethiopian community. We listened to their stories, experiences, descriptions of events and the difficulties they faced, which gave us a wider and more general view of their lives. These meetings introduced us to key young people within the community, members of Maksam[3] an NGO[4] that provided us with first-hand information about the needs, opinions and concrete problems of the Ethiopian community in its encounters with Israeli culture and society. They helped us understand the difficulties Ethiopian immigrant have in grasping the implications of chronic and latent diseases. For example, patients tended to regard chronic diseases as those that doctors are unable to cure, and this would negatively impact on their esteem for the doctor, who is supposed to be able to cure the illness. Further, a latent disease is not considered real when there are no external symptoms, and one of the activists defined it as "a disease of bad numbers". Maksam members also introduced us to influential members of the community, with whom we met in small groups to deepen our knowledge of Ethiopian culture. Later, some of them helped evaluate the instructional materials developed by Tene Briut.

Stage 2: Initial information gathering:

In addition to these meetings, a questionnaire-based study was carried out with a representative regional sample of Ethiopian immigrants. The study examined beliefs, perceptions, attitudes and knowledge of health and chronic disease, especially in the realm of diabetes. In addition, physical examinations were performed, including blood tests and urine analyses.

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[3] http://www.maksam.org/index.html,

[4] Non-governmental not-for-profit association

Stage 3: Setting up a steering committee:

Members of the project's steering committee were chosen from representatives of the Ethiopian community and from major Israeli organizations that come in contact with Ethiopian-immigrants. The committee was composed of representatives from the municipality, the community itself, government agencies, healthcare provider organizations, not-for-profit organizations, the medical center, academia, and philanthropic organizations. The group convened to discuss the case of the 12-year-old girl described above and the difficulties that had arisen in the attempt to treat her. After focusing on needs and goals, members of the group volunteered to serve as an *ad hoc* committee, and eventually became part of the steering committee of the project.

Stage 4: Determining goals for health promotion, research and advocacy:

The overall goals determined by the committee were to ensure that Ethiopian-immigrants used healthcare services to the same extent as other groups in the population and manifested the same level of following recommended treatment regimens. For this purpose four main objectives were specified and for each several activities were designed to address it:

1. ***Health care professionals:*** To enhance the awareness and capacities of HCPs (nurses, pharmacists, physicians, medical administrators, etc.) to provide culturally-sensitive health care to members of the Ethiopian immigrant population. Activities included providing HCPs with information about the Ethiopian community's health-related cultural beliefs and customs and tailored training sessions for professional teams in hospitals, community clinics and training institutions. A recent project allows for HCP to use a medical telephone interpreting service (described in 2.4.6).

2. ***Ethiopian immigrant community:*** To provide members of the Ethiopian immigrant community with new concepts regarding health care (chronic disease, latent disease, preventive medicine, etc.), information about patients' rights and to advance health-promotion activities in the community as a whole: This was to be implemented through a wide range of outreach community activities conducted by the Tene Briut staff, (described in 2.4.1) and a radio program about health in Amharic on the national public radio (described in 2.4.5).

3. Data on needs: To document healthcare needs of the Ethiopian immigrant community in Israel: Researchers affiliated with Tene Briut, utilized Tene Briut's facilities to engage in research in order to gather data and information about morbidity, and to pinpoint particular health-related needs of the Ethipian community. An important goal is that these data could be utilized to influence policy-makers and affect public opinion.

4. Influence policy: To influence the public agenda regarding healthcare of the Ethiopian immigrants in Israel. This included influencing the agenda of medical professionals and decision makers. Activities included participation in various professional conferences, news media coverage in the written and electronic media, serving on professional committees, organizing a national conference of Ethiopian-Israeli health workers to raise consciousness and empowerment (described in 2.4.2) and advocacy activities among legislators[5] and volunteer organizations.

Stage 5: Recruiting and training of the "core group" of "Health Trustees":
The group of Ethiopian healthcare professionals who form the heart of the project consists primarily of Ethiopian immigrant nurses (male and female) who worked in their profession in Ethiopia and had successfully been integrated into the hospital system in Israel. In their professional capacity, they had not been familiar with healthcare work at the community level. Also, the project's medical areas of activity were new to most of them. They joined for several reasons. To begin with, many of them were already involved on a daily basis, in bridging the gap between HCP and patients in their own families or deparments, and felt committed to the project's goals. Some regarded themselves as lucky to have integrated into Israeli society and felt that they had a mission to represent those who could not do the same. Some had parents with diabetes and believed they would gain a better grasp of the disease and its management. In addition, most understood the potential for personal advancement through participation in the project. This group received formal training, officially recognized by the Ministry of Health as an in-service course in the field of chronic Western morbidity (diabetes, obesity, hypertension, nutrition, fitness, etc.). In this course they were taught to deal with developing and evaluating educational materials, and they were provided

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[5] Israel's Parliament

with training in public speaking and teaching. Subsequently they obtained experience in speaking to large audiences. When the course was over there was a graduation ceremony attended by key professional and political figures. The group continued to meet regularly for updates and feedback sessions. Its members also went abroad to study health promotion for minority groups at Vanderbilt University[6] as part of the Jewish Agency's Partnership 2000 program. Members of this group serve as the community's "sensors" and play a vital part in finding suitable solutions and responses to the health promotion challenges. For example, they can identify messages that might reinforce a stigma in relation to a particular disease. The project's evaluation report (described in 2.5) noted that "the health trustees, who are the main human resources of the Tene Briut project, had undergone an empowering experience and were, enriched both personally and professionally… The group received a lot of input…which made them unique compared to many other projects in which Ethiopian immigrants work… the administrators and leaders put a premium on nurturing this population, and cultivated a unique group of people capable of making a contribution that extended far beyond the confines of the project."

Stage 6: Transition from an organization led by a non-Ethiopian physician to an independent organization led by Ethiopian-Israelis:

The organizational transition of Tene Briut from a medical-center sponsored project that was led by a non-Ethiopian doctor to an independent organization let by an all-Ethiopian immigrant staff illustrates some of the challenges and dilemmas that may take place in the establishment of similar initiatives. Once it was clear the goal was to establish Tene Briut as an ongoing and independent organization, the vision was to eventually turn the executive committee into its managing committee, and that the non-Ethiopian (franze[7]) professionals would not be the ones who manage it. This process began to take place after the conclusion of an external evaluation study[8], with the guidance of an organization that supports social-change organizations (SHATIL[9]). Thus, the original steering committee, which at first consisted of nearly all non-Ethiopian Israelis, was turned

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[6] http://www.mc.vanderbilt.edu/reporter/index.html?ID=2447

[7] *Franze* is the word the Ethiopians use to describe "others," that is, people with white skins.

[8] Mertens-Hoffman company Sep 2004 …"So far, only a limited effort has been done to further this aim and enable the realization of this goal".

[9] http://www.nif.org/programs-and-partners/shatil/

into an advisory board, and handed over its management role to the Ethiopian staff members. Tene Briut had officially become a registered NGO.

The major challenges associated with this transitional process included finding and recruiting administrators who are members of the Ethiopian immigrant community and capable of "working within both worlds". It was important to have staff members who have communication and administrative skills that can enable them to navigate and advance the organization's goals within the Israeli system, as well as to be able to maintain an intimate link with the adult and new immigrant community and their traditional beliefs and sensitivities. Another challenge was to overcome a resistance that recurred among various members of the team itself, who appear to minimize the ability of someone from "their own" (an Ethiopian immigrant) to be able to successfully manage and lead the organization. Thus the challenge of initiating an organization that aims to advance the health and welfare of its own minority or immigrant community is twofold: on one hand it needs to strengthen the self-efficacy of members of the larger community to manage health issues. On the other hand it needs to strengthen the self-efficacy of the team members on their ability to successfully manage and lead the organization.

2.2 The Development of culturally-sensitive instruction materials: Pragmatic, moral and ethical issues

One of the major assumptions underlying the community approach adopted by Tene Briut was that a supportive community can help change unhealthy practices and perceived norms that can be detrimental to members' health. This meant that some of the traditional norms and values held by the community would need to be challenged. For example, in Ethiopia, overeating and obesity had been viewed as something positive and physical activity for adults as undignified. Thus, Tene Briut had to find ways to challenge these conceptions and offer an alternative. The tools it developed to disseminate information included dance, music, drawings and sculpting as well as print media, lectures and videos which were not only tailored to the culture of the community members, but focused on their particular needs as they emerged in meetings with community members (20-21). Thus a traditional storyteller format was used to talk about diabetes. Allegories and examples from daily life in Ethiopia were incorporated into presentations and materials. Materials and discussions also referred to traditional foods and cuisine as well as to the size of the meals, their composition and to the changes that took place since the Ethiopian immigrants' arrival to Israel.

2.2.1 Developing instructional presentations for the general public:

At the outset of the program there was no clear idea which methods could be used to provide the Ethiopian immigrant population with information about health issues. Because most of the adult immigrants had not been exposed to a formal educational system, the effectiveness of transmitting information and new concepts through lectures was not something that was considered as an obvious method. Nonetheless, it was decided to replace the traditional story-teller with a lecturer and to use computerized presentations with visuals. Thus, formal presentations were created that depicted situations and characters from community life as well as metaphors to explain medical and physiological concepts. The Tene Briut team eventually developed a series of presentations that deal with various topics including nutrition that referred both to traditional Ethiopian diet as well as Israeli food, knowledge of the basic food groups and constructing a balanced diet; physical activity and the use of leisure time and recreation, oral hygiene, and a presentation on diabetes; detection, prevention and treatment as well as possible complications.

2.2.2 Educational videos:

At the end of the 1990s, during the initial stage of the project and following a specific request from the representatives of the community, we produced an Amharic-speaking educational video about diabetes, in a narrative form. We learned that as a result of the high unemployment rate, many adults were exposed to long hours of television and video viewing, but there were very few programs available in Amharic. The community representatives claimed that an Amharic-speaking video that would incorporate pictures, scenery, art and music would awaken memories of their former homeland and prompt them to watch it again and again. As a result, one third of the movie said nothing about health or diabetes, but spoke of life in Ethiopia, the journey to Israel and the difficulties the Ethiopian immigrants have in adapting to the new country. Diabetes was presented as one of the major difficulties associated with immigration. The video showed images from the world of agriculture to explain what happened to the body when a person has diabetes. The narrator used many traditional proverbs to reinforce the viewers' responsiveness to his recommendations. The video was well received, elicited strong emotional reactions and after it was shown in community settings members of the community would purchase a copy of the video. Another video was a humorous video addressing the issue of obesity.

2.2.3 Formative evaluation and on-going assessment:

In order to assess its own activities Tene Briut employs various methods for formative and process evaluation, which is a critical element in the development of intervention materials and resources (22). The on-going assessment is meant to help ensure that the issues and materials are viewed by the intended audience as pertinent, relevant, and that the explanations are understood. The assessment is carried out on the individual and group level and includes interviews, observations and informal discussions. For example, during lectures in the community we documented the questions asked and the answers given including requests for clarification, questions that reflected difficulty in understanding, or the desire for more information than what was provided in the lecture. One case illustrates this process: When Tene Briut began to give lectures on nutrition and the lecturer said that the human body was composed mainly of water, audience members became agitated because the notion that their bodies were mostly water was difficult for them to accept, despite their esteem for the lecturer. Consequently, the presentation was changed, and the concept was presented in a way that would be more acceptable to them. In another case, when evaluating the immediate responses to the instructional movie called "Even a Meadow can be a Jungle" we learned that the video succeeded to raise interest, provide medical information, as well as elicit a strong emotional response and identification among older audience members. This was observed both through viewers' verbal expression and non-verbal (e.g., leaning toward the screen, placing the hands over the chest, facial expressions and hearing their exclamations after the video was over). In group and individual interviews that followed, participants remembered explanations about the patho-physiology of diabetes that was presented visually and explained verbally in the video and it was evident that they had understood the explanation. Participants recognized the importance of identifying the disease and the damage it was liable to cause. They understood the meaning of a latent disease represented in the video as a leech penetrating the throat of a cow and causing its death with no external symptoms. However, it appeared that the video did not succeed in explaining the chronic nature of diabetes and these findings underscored the need to reinforce this crucial concept during the lectures. Various ethical dilemmas arose during the production of the materials and their distribution, some of which are mentioned in the description of the various materials below.

2.2.4 Resources for Health Professionals:

One of the resources produced by Tene Briut is a booklet for HCPs on the issue of food and nutrition. Any lifestyle-related intervention in a multicultural context requires a familiarity with community members' eating habits, and the types of foods and the ingredients they consume. Yet, these factors were unfamiliar to the HCP working with Ethiopian immigrants. Tene Briut therefore began with a workshop for clinical dieticians to acquaint them with the types of foods Ethiopian immigrants ate. We then discovered that there was no detailed information about what their diet consisted of, nor of the nutritional values of their foods. Further, there was a need for information on how they prepare their traditional foods in Israel and how often or how much of these foods they actually consume. Therefore, Tene Briut had to carry out its own research, including asking women for their recipes. We learned that traditional foods are a regular part of their diet, but found out that there were substantial changes in the quantity and frequency these foods were consumed in Israel. This is because the wider availability of products that were rare in Ethiopia (such as meat), and the relatively high cost of foods that were inexpensive in Ethiopia (such as fish). Consequently a booklet called "Not by *Ingera*[10] alone: the diet of Ethiopian-immigrants" was produced for Nutritionists. This booklet contains pictures and a description of foods eaten by Ethiopian immigrants, including tables of ingredients and nutritional values, a description of nutrients frequently lacking in the diet, and recommendations for nutritional adaptation. The booklet was developed in cooperation with the nutrition department of the Ministry of Health and was distributed by the National Association of Dieticians to every clinical dietician in the country. In addition, the booklet is distributed on demand to clinics that serve large Ethiopian-immigrant populations[11].

2.2.5 Print materials for community members:

It is increasingly common to provide individuals with print materials with information on health issues, even for populations with low literacy skills. The format used to convey the information was using a narrative style of a series of pictures like a comic strip, in which an older Ethiopian man was depicted (23-25). The colors and style were those that would appeal to the older population, and the tub for washing of the feet was drawn in a way that it would remind the viewer of the custom of washing feet in Ethiopia.

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[10] The Amharic name of their bread like product

[11] This booklet can also be downloaded at http://www.health.gov.il/Download/pages/ethiopia.pdf where it appears in graphic format

2.3 Tene Briut activities

2.3.1 Lectures in community settings:

Tene Briut offers lectures and workshops on an on-going basis, in various settings, some of them as single events or as a series of lectures. These activities, held in collaboration with the healthcare clinic liaisons and others are offered to *ad-hoc* or structured groups that meet for other purposes. The major settings are immigrant centers in the various towns[12], community clinics, hostels, community centers, and absorption centers. The activities include a combination of a lecture and a question and answer session. In certain cases, blood sugar levels are tested. This is important for diagnosing new patients, but its main objective is to send the message that there is no stigma attached to diabetes and that it can be diagnosed in a public setting as well. An attempt is made to return to the same groups for several consecutive meetings.

2.3.2 A National Conference of Ethiopian-Israeli Professionals:

In 2001, in preparation for embarking on a nationwide activity, Tene Briut, in collaboration with the JDC in Israel, Tel Aviv University, the Ministry of Health and Clalit Health Services, organized a one-day conference and workshop, the first of its kind, for Ethiopian-Israeli healthcare workers. The objective was to disseminate information about chronic Western morbidity among the Ethiopian community, to develop new initiatives in promoting health and health education, and to establish a network for these professionals. One challenge was that there was no comprehensive list of Ethiopian-Israeli health professionals. Participation in the conference was enthusiastic, and the attendance was triple the number that was anticipated, with 220 individuals attending. One of the most prominent messages to emerge from the discussion was the call to Ethiopian-Israeli health professionals to take the initiative and assume a larger share of responsibility for the quality of life and health of the members of their community and to pay more attention to the issue of mental health.

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[12] Urban centers are intended to provide comprehensive responses for the issues important to Ethiopian-Israelis. They are operated by the Ministry of Immigration and Absorption.

2.3.3 "Health Days":

Tene Briut conducts one-day events in community and organizational settings, usually in collaboration with local groups. One of the main purposes of these "health days" is to locate individuals with diabetes and to raise awareness regarding the importance of prevention and early detection of chronic diseases. These events also provide an opportunity to involve the entire local population, including those who are not Ethiopian-immigrants. On health days there are lectures in Amharic, arts and crafts activities for children and young people, fun on inflatable jumping toys, group gymnastics and large-scale testing often performed by volunteer physicians who are themselves immigrants from other countries. The tests include weight, blood-pressure, blood glucose, vision and teeth and sometimes even early breast and colon cancer screening.

2.3.4 Cooking classes:

The project has initiated, encouraged and supported cooking classes for women in various locations in Israel. These are always held in collaboration with the local women's organizations such as Women's International Zionist Organization (WIZO), Na'amat or in community centers. The objectives of the courses are to acquaint the women with modern kitchen conveniences and traditional and Israeli recipes. The lessons include basic instruction in nutrition, balanced diet, home economics and the importance of physical activity.

2.3.5 A monthly radio health program:

Because a large majority of the Ethiopian immigrant population has low literacy and Hebrew proficiency skills, in particular the older population and the more recent immigrants, the radio programs in Amharic serve as an important tool for transmitting information to these groups. In cooperation with the government radio station there is a live broadcast in Amharic every month featuring a program about health with topics we decide on and in response to the needs of the Ethiopian-immigrant population. Listeners are encouraged to phone in. A study of the activity of Tene Briut found that the program was very important for the older population, most of whom do not speak Hebrew. A large percentage of them listen to the program and have said that they find it an important source of health information.

2.3.6 Kol L'Briut [Call for Health]: the telephone interpreting service:

In addition to cultural gaps, one of the main obstacles to patient-caregiver understanding is the language barrier. One unique solution has been the work of Ethiopian-immigrant *megashrim* (liaisons) who serve as liaisons as part of the *Refu'ah Shlema* (literally: Full Recovery) project (6)[13] but their number is limited, they are present in less than a dozen clinics and they cannot provide an immediate response when several patients in a clinic need them at the same time. Therefore, it has been decided that a medical telephone interpreting service can provide a viable alternative. Long-distance interpreting services have existed abroad since the 1950s, and they have progressed in keeping up with communications technology (27). Today there are also video interpreting services. Telephone interpreting eliminates geographical distances, and it seen by many as more convenient because it ensures anonymity. This also reduces the interpreter's emotional stress (28).

The idea of providing medical telephone interpreting services was proposed after a study carried out by Tene Briut (15, 19) and brainstorming session with Clalit Health Services and the Ministry of Health. It does not aim to replace the role of the health liaisons. Its goals and role definition are slightly different: to provide a tangible, immediate response to communication needs in the provider-patient interaction. Tene Briut recruited Ethiopian-Israeli nurses to perform this service, thus setting an international precedent, because medical interpreters do not usually work in the field of health care. In collaboration with the Department of Translation and Interpreting Studies at Bar Ilan University, the group received training in healthcare interpreting. The curriculum was chosen after a study of similar courses abroad, and was adapted to conditions in Israel and to the profiles of the future interpreters. It ran for 60 hours and included lessons on medical terminology, differences in perceptions of health and illness in Israel and Ethiopia, strategies of interpreting, note-taking and memory-enhancing techniques and how to correct translation mistakes. A significant amount of time was devoted to simulations of telephone interpreting. The participants' medical background was an advantage, but they had to be reminded not to confuse their own daily work as diagnosticians and HCPs with their role as interpreters, during which they were not supposed to diagnose but rather to give linguistic support to

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[13] The project has been in operation throughout the country, although in limited form, for ten years. The liaisons ("megashrim") not only translate, but also promote community health through direct contact and transmit information about the health system and the procedures involved in medical treatment.

the physician or nurse and the patient. For example, it was necessary to help them learn to resist the obligation some of them felt regarding having to explain to the patient the meaning of the healthcare issue. It was stressed that their role was confined to bridge the gap between the parties, linguistically and culturally, and to making sure the patient understood what the caregiver was saying, but not to take on the role of caregiver.

The medical telephone interpreting service has been operating for community clinics in a limited pilot format since May 2007. Before the introduction of the service all participating clinical staffs were introduced to different features of the phone interpreting medium: the lack of eye contact, the importance of briefing the interpreter beforehand, etc and the advantages of using a professional interpreter instead of a family member. Thus, an important challenge is to find ways to enable health care providers to use the service skillfully. The assumption is that they will realize how it can eventually contribute to efficient consultations, reduce the number of unnecessary visits, and lower frustration levels on both sides. In addition, the service needs to be advertised within the community and its members should be encouraged to ask for it as part of their right to medical treatment. The objective of Tene Briut is to expand the service to more clinics while establishing the rules for its use, and to examine the possibility of making it available to hospitals.

2.4 Influence and impact

The impact of a program that aims to create changes in awareness among both the population of immigrants and the healthcare system is difficult to gauge, in particular because its goals and objectives have evolved as the program developed. One of the main accomplishments of Tene Briut, as noted by an external evaluation team was that "it put the issue of the prevention and detection of chronic illness in the Ethiopian community on the map" of the Ethiopian community and decision makers in the health care system. The evaluators also noted that Tene Briut created a "box of tools" for this purpose, and trained a group of indigenous professionals to work within the community as role models, advocates and leaders.

2.5 Recognition, cooperation and funding

From its inception, Tene Briut's guiding principle was to use resources effectively, and to cooperate with any local or national organization that showed an interest in its objectives and activities. The organization works in collaboration with women's organizations, especially in the cooking classes (WIZO, Na'amat, Hadassah), Rotary volunteers in Hadera (who helped raise funds for the educational movie), the community television channel, which accompanied and videoed some of the activities, etc. The Tene Briut staff seizes every opportunity to promote itself, including urban health conferences, health-promotion conferences, gatherings of Ethiopian-immigrants, etc. In such cases, a booth is set up with a display of informational materials, a description of the project's needs and summaries of studies.

2.6 Continuity and the future

Tene Briut's continuity depends on the kind of new goals it takes upon itself as an independent organization that aims to promote the health of the Ethiopian immigrant community in Israel. There are both new and old challenges it may embark upon, and it may forge new collaborations, perhaps, with a stronger advocacy orientation. It currently operates an innovative and complex medical interpreting service and conducts dozes of outreach activities monthly. Yet, its programs and interventions may need to be further adapted to the various populations *within* the community, and to be continuously evaluated and updated. To succeed in the latter, Tene Briut may need to maintain and expand its collaborative relations with a wide variety of organizations and agencies. Further, one of its goals is to advance and mobilize awareness of the public – including professionals, public figures, lawmakers and administrators – to the particular needs of the Ethiopian immigrants, and their health rights according to the National Health Insurance Law. This law mandates equity in the provision of health services for all Israeli residents including minority populations. This poses additional challenges to its current mode of operation in terms of advocacy and a social-change orientation. Following are four challenges and dilemmas regarding Tene Briut's future goals and activities:

1. Ethiopian-immigrants form a relatively small segment of the population but they have unique needs. To what extent should a non-government organization such as Tene Briut take upon itself the development of

educational materials that perhaps should be created by organizations or government agencies who have the mandate to provide care to Ethiopian-immigrants (e.g., health provider organizations, hospitals)?

2. Tene Briut activities may be fulfilling roles that should be taken by the government or the agencies that are mandated by law to provide healthcare services and receive government funds for this purpose – what is the government's responsibility in terms of services such as interpreting services, educational workshops? What kind of role should an independent NGO take in the provision of such services and what should its relationship be with government agencies that help fund these services and are supposed to supervise and monitor the quality of the service given?
3. Ethiopian-immigrants are not the only minority group in Israel; there are others with special needs. Should Tene Briut operate independently or form a coalition with similar groups?
4. To what extent should the goals of an organization such as Tene Briut include advocacy and activity to change the social and economic status of Ethiopian-immigrants, and what should be the boundaries of its advocacy goals?

3. CONCLUSIONS

This chapter has described the beginning and transformation of the Tene Briut project from an initiative by a non-Ethiopian healthcare provider and a project affiliated with a medical center to an independent organization run mainly by Ethiopian-Israelis. Following are seven underlying principles that have implications for other types of interventions that aim to promote the health of minority populations. (1) A developmental process that begins with studying and researching the health-related problems through the analysis of personal experiences, surveys, interviews, of the intended population and articulating them in the goals and objectives of the program. (2) Working in collaboration with the relevant organizations and agencies including; municipal, government, health provider organization, social and welfare agencies, and academia and involving all those concerned in the creation and implementation of a viable model. (3) Integrating influential members of the immigrant or minority community to form a support group for the project's goals. (4) Enlisting professionals from within the immigrant or minority population to take full responsibility for administration of the project and offering them training to enhance their capacities both as presenters in outreach activities to the community and leadership and advocacy skills. (5) Developing and applying a wide range of culturally-sensitive tools that draw on a formative evaluation process that engages people from the community and have an added value to the population beyond particular health messages, so that they are purchased and viewed in their homes. (6) Working on both a local and national level, by taking advantage of mass media outlets that enable reaching individuals and groups, and providing interactive sessions, such as callers to a radio program. (7) Providing training, capacity enhancing interventions and tools for health care professionals working with the immigrant/minority population; this includes raising their awareness regarding difficulties faced by the immigrant populations in adaptation, acculturation and social discrimination and economic hardships, and to the differences in the population members' ability to avail themselves of healthcare services. This may include the provision of services such as translation, workshops, and warm-lines.

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Culturally and Linguistically Appropriate Service Standards and the Training of Practicing Health Professionals

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ABSTRACT

Published in 2000 in the United States, the Culturally and Linguistically Appropriate Services (CLAS) Standards, or "CLAS Standards," are an important landmark. CLAS Standards have shaped the development and content of cultural competence training for practicing health care professionals in the U.S. The standards were developed by the federal Office of Minority Health to target three key areas: language, culture and organizational support for cultural competence. Standards for accreditation and for cultural competence education and training have been developed to support the CLAS standards. CLAS-based training standards address three key goals: to increase providers' knowledge, broaden their attitudes and enhance their skills in the delivery of quality health care to culturally and linguistically diverse populations. Recent research supports effective training in these areas. Among others, the interactive approaches that have proved successful in such training include open discussion, case studies, small group activities, role plays, PowerPoint slide presentations, film vignettes, handouts of effective strategies, planning guides and cultural competence checklists. Such knowledge and experience may serve individuals and organizations that seek to develop training to support standards for cultural and linguistic competence in health care.

INTRODUCTION

> *Cultural and linguistic competence 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.*[1]
>
> U.S. Office of Minority Health

Perhaps no document in the United States has had a greater impact on the development of cultural competence training than the publication known as the "CLAS Standards,"[2] which are federal Culturally and Linguistically Appropriate Services (CLAS) Standards for health care. Developed over several years during the 1990s by federal agencies working with a broad spectrum of stakeholders, the 14 standards were published in 2000 by the U.S. Department of Health and Human Services Office of Minority Health to guide the delivery of quality health care services to culturally and linguistically diverse populations. Since the final CLAS standards report was issued in 2001, this document has exerted enormous impact on the delivery of human and social services as well. The complete report is available online.[3]

The CLAS standards represent the first national standards for cultural competence in the U.S. Based on years of research, preparation and input from across the country, the 14 standards were developed and shaped by a broad group that included government agencies, private community-based nonprofits (large and small), patients, hospitals, indigenous groups, interpreter services, refugee resettlement agencies, representatives from a host of culturally diverse groups, social justice networks and countless other organizations and individuals. As a result, any training in the U.S. that purports to guide health care professionals in the delivery of culturally competent care is increasingly expected to ground itself in the CLAS Standards.

The 14 standards are organized by theme:
1. Culturally Competent Care (Standards 1-3)
2. Language Access Services (Standards 4-7)
3. Organizations Supports for Cultural Competence (Standards 8 -14)

See Table 1 for a summary of the standards.

Table 1: The CLAS Standards

Standard 1

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

Standard 2

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

Standard 3

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

Standard 4

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

Standard 5

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

Standard 6

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

Standard 7

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

Standard 8

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

Standard 9

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

Standard 10

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

Standard 11

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

Standard 12

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

Standard 13

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

Standard 14

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

Challenges for Training Practicing Health Care Professionals on the CLAS Standards

Ideally, all U.S. health care professionals would receive training on cultural competence, including the CLAS Standards, during the course of their medical education. The reality is that health professions schools have only recently begun to require such training, and it is often minimal. As a result, practicing health care professionals increasingly rely on continuing education programs to receive cultural competence training. Obstacles in the way of providing cultural competence training fall into several categories:

1. *The inability of cultural competence training to fully address the need*
    - Simply providing such training is no guarantee of its effectiveness.
    - Available programs vary widely in quality and content.
    - Staff who support health professionals must also be trained, including administrators, front-line and support staff, bilingual staff, interpreters and patients.
    - These various groups require various kinds of training: curricula tailored to their needs.
2. *A lack of funding*
    - Effective training in cultural competence can be expensive to develop or purchase.
    - Funding for health care is in crisis.
3. *Time constraints*
    - Health professionals have little time to attend training.
    - If no continuing education credits are offered, individuals may be less motivated to attend, yet obtaining accreditation for a training program can be arduous and expensive.

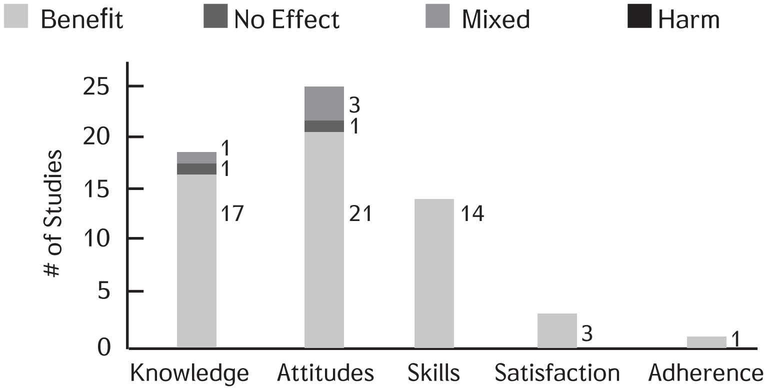
- The subject of cultural competence and the CLAS Standards is too broad for a brief session, yet health care professionals are frequently reluctant to attend longer training.
- Many practicing health professionals mistakenly think that they already know about cultural competence and do not need such training.
- Online training may not be as effective as on-site training, but it is a viable option that is not widely used (though it has grown more common recently).[4]

Research on Cultural Competence Training

> *Most studies of cultural competence training used self-administered tools that have not been validated. The results of cultural competence training could be interpreted more accurately if validated tools were used.*
>
> Aysegul Gozu et al (2007)[5]

Does cultural competence training work? A growing body of research documents the effectiveness of cultural competence training. However, that research is of uneven quality.[6] As illustrated in Figure 2 below, it appears that cultural competence training has a significant effect on health care professionals' attitudes and knowledge; a somewhat less significant impact on their skills; and a smaller impact on patient satisfaction and patient adherence to the treatment plan. While hundreds of studies address the question of effectiveness, we are in urgent need of more rigorous, widely replicated research studies that can provide a definitive answer.

Table 2: Effects of Cultural Competence Training



Beach *et al* (2007).[7]

Furthermore, many in the field question the research that we currently do have, regardless of its quality or rigor, suggesting that it controls inadequately for the assumptions of those who carry out the studies as well as the assumptions of the subjects studied:

> *Existing measures* [of cultural competence] *embed highly problematic assumptions about what constitutes cultural competence. They ignore the power relations of social inequality and assume that individual knowledge and self-confidence are sufficient for change. Developing measures that assess cultural humility and/or assess actual practice are needed if educators … are to move forward in efforts to understand, teach, practice, and evaluate cultural competence.*
>
> Kumas-Tann *et al* (2007)[8]

In order to offer trainers and educators in the field a better understanding of how to carry out effective training and standardize such training while ensuring that it supports the CLAS Standards, a vital document was published in 2003. Entitled *Principles and Recommended Standards for Cultural Competence Trainings of Health Care Professionals*,[9] this publication lays down clear guidelines for training. It addresses both what such training should include and how to present it. Central to this document are goals and principles for such training (Table 3).

Table 3: Goals and Principles of Cultural Competence Training[10]

GOALS of CULTURAL COMPETENCE TRAINING

1. Increased self awareness and receptivity to diverse patient populations;
2. Clinical excellence and strong therapeutic alliances with patients;
3. Reduction of health care disparities through improved quality and cost-effective care.

TRAINING PRINCIPLES

Cultural competence training should be organized around:

- KNOWLEDGE
- SKILLS
- ATTITUDES

State of the Field

Cultural competence training in the U.S. today is a potpourri of programs. In essence, anyone can proclaim that he or she is a cultural competence trainer. Any hospital can appoint a staff member (whether qualified or unqualified) to develop or lead such programs. No accreditation body certifies trainers or holds them to ethical codes.

The quality of programs varies, and training itself occurs in many contexts. Increasingly it is embedded in health professions curricula, but other options exist. They include:

- Grand rounds.
- On-site trainings for all/some health care staff.
- On-site training for targeted groups (e.g. clinicians, social workers) or treatment teams.
- Webinars and online training modules.
- Distance learning and e-learning programs.

Training Formats

1. *Length*

   The length of a training is variable. In the U.S., trainings or workshops may last from 45 minutes to five days. A growing number of federal grants require such training, but often a half day program satisfies that requirement. It is exceedingly difficult in half a day to effect measurable changes in participants' skills and attitudes. While there is no consensus among cultural competence trainers on what the minimum length of a program should be, most would agree that a day or more is vital: *It is necessary to allow adequate time out for staff to disengage from the intensity of their everyday work and to engage in cultural competence learning. Those involved in delivering training … should have time to establish trust and rapport and to be aware of wider organisational factors which impact on the training.*

   Papadopoulos (2004)[11]

2. *Teaching methods*

As the standards for a training document[12] cited above makes clear, a variety of different methods is required to effect changes in participants' attitudes, knowledge and skills to ensure that they understand and can apply the CLAS standard in their daily work. A growing consensus supports a move away from trainings centered on a series of PowerPoint slides (still the most commonly used teaching method in continuing medical education) toward a variety of methods.[13] Among the accepted and common training methods in the U.S. are the following:

- Diversity icebreakers
- Case studies
- Video excerpts from VHS tapes, DVDs and CD-ROMs, or online videos
- Discussion in large and small groups
- Role plays
- Demonstrations (e.g., how to communicate through an interpreter)
- Activities for pairs or small groups
- Written exercises such as quizzes
- Debates

In part, the goal of using a variety of methods is to ensure that the message reaches participants from multiple perspectives. Another goal is to leave participants with a memorable and positive experience that reinforces healthy associations about the diverse populations addressed in the training, in order to undermine the stereotypes, biases, assumptions and negative attitudes that often prevail about those populations.[14]

3. *Preparation*

When preparing for cultural competence training, organizations may wish to conduct a needs assessment of their participants, their patients and of their own organization (CLAS Standard 11). Gathering input from the local community and patients will help to ensure that the training is relevant to the local needs. It is also important to determine the cultural and linguistic demographics of the community. As part of this process, the organization may need to develop community partnerships (CLAS Standard 12). During this process, it may be helpful to select community stories, examples, anecdotes and case studies from the target populations for the trainer to share with participants.

4. *Planning and logistics*

There are many practical issues to consider when planning for training. Anyone intending to set up a training will need to:

- Set a date.
- Conduct basic needs assessment.
- Determine goals and objectives.

- Recruit/select and invite participants.
- Try to limited numbers, if possible, to 35 or 40.
- Schedule a full day if feasible.
- Avoid "classroom set-up" (straight rows of chairs) in the room, as this often makes adults feel they are "back in school." For groups of 25 or fewer, U-shape set-up is ideal.
- Plan for audiovisual needs in a multimedia format

Possible seating arrangements include round tables; a V- or U-shaped set-up for tables and chairs; amphitheater style; and a double semi-circle, among others. If classroom set-up is unavoidable, an aisle should be kept open between two sides of the room so that the trainer can move freely up and down that aisle.

Other recommendations from the field[15] include:

- Measure staff performance against current needs.
- Design training to address that gap.
- After implementing the training, assess its effectiveness.
- Measure what health care staff have transferred from their training to their work

5. *Execution of a training*

It is exceedingly important for trainers to focus on practical and relevant information in a training, for several reasons. One is that participants often tune out if the information is distant from their real-life experience. Another is that unconscious biases against the populations addressed may be reinforced, not undermined, if the information presented is not relevant to their work. Finally, if the information is not practical, most likely it will not be used.

In addition, trainers may want to consider the following:

- Avoid information overload.
- Solicit open, lively discussions, for these can truly influence participants' attitudes.
- Include various types of small group activities.
- Vary format and pace and watch out for participant fatigue.
- Keep in mind that a training is not like a conference or a lecture. To be effective, it must engage and involve the active participation of those attending.

6. *Common training errors*

Overload: The single most common error seen in cultural competence training by the authors is information overload with too few activities designed to effect changes in attitudes or skills.

Narrow focus: In the U.S., some trainings focus exclusively on immigrants. Yet cultural competence training is intended to address services to all culturally diverse populations.

Pedagogical/condescending tone: It is extremely important for trainers to avoid the following:

- Telling participants what to think or how to feel.
- Simply standing in front of a series of PowerPoint slides and lecturing.
- "Political correctness": taking a stand that participants should not say certain things.
- Pre-empting honest discussion by making it painfully clear what the trainer's biases are.

"Recipe trainings": A significant problem has emerged in the U.S in the many requests for "cookbook" or "recipe" trainings, i.e., trainings that describe the cultural characteristics of specific populations (e.g., Hispanics, African Americans) followed by a series of tips about how to serve them. Cultural competence experts decry such trainings because they reinforce stereotypes instead of educating others on the negative impact of stereotypes. In addition, culture is far too vast, and patients are too idiosyncratic, for a list of "tips" on how to serve a given population. Tips cannot substitute for quality, patient-centered care. There is no recipe book for cultural competence. As Papadopolous *et al* have noted: *The workers need not be, as is often assumed, highly knowledgeable about the cultures of the people they work with, but must approach culturally different people with openness and respect – a willingness to learn. Self awareness is the most important component in the knowledge base of culturally competent practice.*[16]

Other challenges:

- If a prior backlash of "political correctness" taints the training; people may be prejudiced against the training before walking in the door.
- Many cultural competence trainings are mandatory, creating further resentment.
- Some poor training has further given the field a bad reputation in certain areas.
- Many health care organizations use in-house trainers who lack expertise and experience.

As White and Hoffman[17] aptly put it: *Faculty development is particularly important because most instructors have not themselves been taught culturally competent care. Faculty must be able to teach and to model culturally competent* *care. Both faculty and students must improve their knowledge, skills, and attitudes, all of which are a substantial challenge, especially the last.*

Yet while many obstacles face cultural competence trainers who seek to support the CLAS Standards, a growing number of programs do support the standards. This momentum helps to create coherence in the field and support quality training.

In the authors' view, the single most decisive influence on cultural competence training in the U.S. today has been the CLAS standards. For the foreseeable future, the CLAS standards will continue to exert this influence. They may in this way support organizations seeking to create, expand or enhance training programs to reduce health inequalities and improve quality of care for culturally and linguistically diverse populations.

ENDNOTES

1. U.S. Department of Health and Human Services, Office of Minority Health (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. Washington, D.C.: HHS, p. 4
2. *Ibid*.
3. http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

4 .Among reputable, accredited programs are the free, well received (and often entertaining) nine hour programs by the U.S. Office of Minority Health: *A Physician's Practical Guide to Culturally Competent Care* (at http://www.omhrc.gov/templates/content.aspx?ID=2805&lvl=2&lvlID=12) and *Culturally Competent Nursing Care: A Cornerstone of Caring* (http://www.omhrc.gov/templates/content.aspx?ID=5036&lvl=2&lvlID=12). Another online training program that is relatively inexpensive and worthy of mention is *Communicating Through Healthcare Interpreters* (at http://www.vlh.com/shared/courses/authors/1705_author.cfm), developed by highly regarded experts for the Rush University Medical Center. Finally, *Quality Interactions®: A Patient-Based Approach to Cross-Cultural Care* is a fee-based e-learning program developed by well known experts and available at http://www.qualityinteractions.org/.

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14. Those willing to test their own unconscious prejudices about diverse populations may participate anonymously, online, in a fascinating Harvard project at www.projectimplicit.org.
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16. Papadopoulos, I., Tilki, M., Lees, S (2004). Promoting Cultural Competence in Healthcare Through a Research-Based Intervention in the UK. *Diversity in Health and Social Care*, 1(2): 107-116(10).
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Graduate and Undergraduate Cultural Competence Education

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ABSTRACT

Residency training programs, medical schools, and other health professions education programs in the United States are recognizing the importance of preparing future practitioners to provide culturally competent patient-centered care. These curriculum transformation efforts are being driven in part by existing national accreditation requirements and emerging standards and guidelines promulgated by various professional organizations. In this paper, the key dimensions of cross-cultural patient-centered care are defined, emphasizing the critical role played by communication in fostering trust, mutual understanding, and a therapeutic alliance during diverse clinical encounters. The findings from a recent national survey of resident physicians' preparedness to provide cross-cultural care are reviewed, and implications discussed for health care and medical education policy. Selected undergraduate medical school initiatives are identified, including the Association for American Medical College's (AAMC) new Tool for Assessing Cultural Competency Training (TACCT). A model for cultural competence education, drawn from the transcultural nursing field, is presented that can help guide curriculum development. Educational content, strategies, and resources that can be used to improve cross-cultural awareness, knowledge, skills, encounters, and desire are described. The paper concludes with an exploration of challenges related to developing, implementing, evaluating, and sustaining cultural competence curricula in academic medical centers and health care organizations.

Background

In the United States, a series of influential reports from the Institute of Medicine (IOM) have helped to increase awareness about the need to train health professionals to provide more culturally competent, patient-centered care. In particular, the IOM Report, Crossing the Quality Chasm: A New Health System for the 21st Century[1] emphasized the importance of health care being safe, effective, patient-centered, timely, efficient, and equitable. The IOM Report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,[2] recommended that healthcare providers should be made aware of racial and ethnic disparities in healthcare. In addition, all current and future healthcare providers can benefit from cross-cultural education. The case for bringing together the work going on patient-centered care and cultural competency movements has been made in an excellent Commonwealth Fund Report.[3]

Interest in health professions education and cross-cultural health care has been a longstanding concern of the socio-behavioral sciences. There is an extensive body of published literature from disciplines including medical anthropology, medical sociology, multicultural psychology, and health communications to name just a few. Other speakers will be sharing relevant findings from these fields during the conference.

Let me define a few key terms. Patient-centered care refers to "providing care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions"[1] Important dimensions of patient-centered care identified through focus group and in-depth interviews include: "respect for patient values, preferences and needs, coordination and integration of care, information and education, physical comfort, emotional support, involvement of family and friends, continuity and transition, and access to care."[4]

Groups such as the Picker Institute http://www.pickerinstitute.org, the Planetree Health Alliance http://www.planetree.org; and the Institute for Family-Centered Care http://www.familycenteredcare.org have worked with hospitals, ambulatory care settings, and other health care organizations in championing and developing programs that facilitate the delivery of patient- and family-centered care.

In 2005, the Commonwealth Fund launched a Patient-Centered Primary Care initiative (http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=11936), and has supported research into "how medical homes promote equity in health care" (http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814). The American Medical Association's Ethical Force program has developed a variety of important tools and resources designed to improve patient-centered communication with vulnerable populations (http://www.ama-assn.org/ama/pub/category/11929.html). Recently, a Patient-Centered Primary Care Collaborative has formed that consists of "a coalition of major employers, consumer groups, and other stakeholders who have joined with organizations representing primary care physicians to develop and advance the patient centered medical home." (http://www.pcpcc.net)

Cultural competence has been defined in a variety of ways depending upon whether the focus is on clinical, organizational, or systemic issues. Clinical Cultural Competence refers to "the level of knowledge based skills required to provide effective clinical care to patients from a particular ethnic or racial group."[5] Practitioners also need to cultivate cultural humility – "a lifelong commitment to self-evaluation and self-critique," "redressing power imbalances" in relationships with patients and colleagues, and "developing mutually beneficial partnerships with communities on behalf of individuals and defined populations"[6]

Becoming a Cultural Competent Physician and Health Care Professional

Cultural competency has been a core component of educational programs in fields such as nursing, social work, and mental health for several decades, and now is increasingly being integrated into medical, oral health, pharmacy, allied health, and public health curricula. The California Endowment has published a helpful monograph, Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals,[7] based on a national study of different training programs. The Working Group on Professional Training and Development of the World Health Organization-Health Promoting Hospitals International Task Force on Migrant-Friendly and Culturally Competent Hospitals,(www.mfh-eu.net) is also preparing Recommended Standards for Cultural Competency in Professional Training and Development for Health Care Providers (May 2006).

In terms of Professional Medical Organizations, the following are some of the specialty groups in the United States that have published guidelines and/or policies relating to the care of culturally diverse populations: Society of Teachers of Family Medicine; American Academy of Family Physicians; American Osteopathic Association; American Academy of Pediatrics; American College of Physicians; American Psychiatric Association; American College of Obstetrics and Gynecology; American College of Emergency Physicians; and American Academy of Orthopaedic Surgeons. Cultural competency training is also increasingly being integrated into continuing education and professional development programs,[8] and is a requirement for physician licensure in several states.[9]

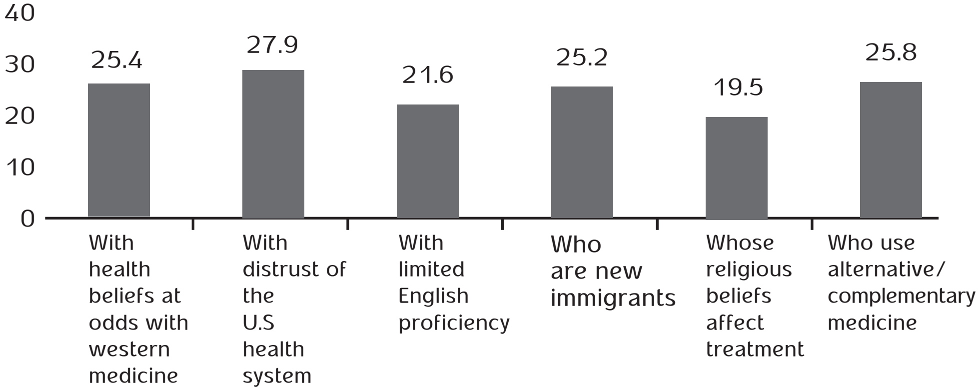
Residency Training programs are increasingly addressing cross-cultural and diversity-related health care issues as they respond to the Accreditation Council for Graduate Medical Education (ACGME) Outcomes Project: General Competencies (Medical Knowledge, Patient Care, Interpersonal and Communications Skills, Professionalism, Practice Based Learning and Improvement, and Systems Based Practice). The Professionalism - General Competency, for example, requires 1) a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and 2) sensitivity and responsiveness to patients' culture, age, gender, and disabilities. http://www.acgme.org/outcome/comp/compFull.asp#5 A number of cultural competency/ health disparities educational programs and curricula have been published.[10-11]

In a recent national survey of 2,047 residents in emergency medicine, family practice, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, or general surgery, Weissman, et al. (2005) found that at least one of five resident physicians are not prepared to deal with cross-cultural issues, although there was variation across the specialties (See Figure 1).[12]

Figure 1

At least One of Five Resident Physicians Are Not Prepared to Deal with Cross-Cultural Issues

Percent or resident physicians very or somewhat unprepared to treat patients...



Source: J.S. Weissman et al. , 'Residant Physicians' Prepardness to Provide Cross-Cultural Care." Journal of the American Medical Association 294 (September 7, 2005): 1058-67

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The following recommendations were made: "1) Cross-cultural curricula should be integrated into all graduate medical education (GME); 2) Cross-cultural curricula in GME should build on what is learned in medical school, focus on practical tools and skills, and be based on a set of standard principles that are useful across clinical disciplines; 3) Faculty development (including for attending physicians and fellows) in cross-cultural education is essential to the training and mentoring of residents in cross-cultural care; and 4) Evaluation of resident physicians' general and cross-cultural communication skills is essential and should be mandatory and formalized."[13]

Significant efforts are underway to integrate and assess cultural competency training in undergraduate medical school curricula.[14-17] The Liaison Committee on Medical Education (LCME) has published the following accreditation requirement for medical schools: "ED-21. Faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments," and "ED-22. Medical students should learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery." http://www.lcme.org/functionslist.htm The Association of American Medical Colleges (AAMC) has developed a Tool for Assessing Cultural Competency Training (TACCT)[18] http://www.aamc.org/meded/tacct/start.htm which has the following domains:

I. Cultural Competence Rationale, Context and Definition
II. Key Aspects of Cultural Competence
III. Impact of Stereotyping on Medical Decision-Making
IV. Health Disparities and Factors Influencing Health
V. Cross-Cultural Clinical Skills

The National Heart, Lung, and Blood Institute (NHLBI) has funded a National Consortium for Multicultural Education for Health Professionals that currently has 18 participating academic health centers http://culturalmeded.stanford.edu/about/collaborative.html. The American Medical Student Association's Achieving Diversity in Dentistry and Medicine initiative has developed model cultural competency and ethnogeriatrics curricula. http://www.amsa.org/addm Recommended core curriculum guidelines have also been published relating to 1) culturally sensitive and competent health care and 2) teaching about racial and ethnic disparities in health and health care.[19-20]

Campinha-Bacote, a transcultural psychiatric nurse, has proposed a useful conceptual model and acronym (*ASKED*) that can help guide curriculum development:
A – Awareness; **S** – Skill; **K** – Knowledge; **E** – Encounters; **D** – Desire.[21-22]
These dimensions have been defined as followed:

> "Cultural awareness is the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures …. This awareness process must involve examination of one's own prejudices and biases toward other cultures and in-depth exploration of one's own cultural background."

> "Cultural skill is the ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a

> culturally specific physical assessment."
> "Cultural knowledge is the process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures .... [T]he process ... also involves obtaining knowledge regarding specific physical, biological, and physiological variations among ethnic groups."
>
> "Cultural encounter is the process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds."
>
> "Cultural desire is the motivation of health care providers to 'want to' engage in the process of cultural competence."

Koehn has emphasized the need for developing transnational competence and has identified five core skill domains — analytic, emotional, creative, communicative, and functional — that are important for health professionals to care effectively for migrant populations.[23]

A growing number of cultural competency educational resources are also becoming available including monographs/articles, seminars/workshops/courses, grand rounds/conferences, curricular materials/simulations, community immersion experiences, multimedia — videos/CD-ROMs/DVDs, and websites/distance learning/blended learning.
Examples of the latter include:

Management Sciences for Health - The Provider's Guide to Quality and Culture http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Ethnomed http://www.ethnomed.org

DiversityRX http://www.diversityrx.org

Curriculum in Ethnogeriatrics http://www.stanford.edu/group/ethnoger

Office of Minority Health - A Physician's Practical Guide to Culturally Competent Care http://cccm.thinkculturalhealth.org

Office of Minority Health – Culturally Competent Nursing Care: A Cornerstone of Caring https://ccnm.thinkculturalhealth.org

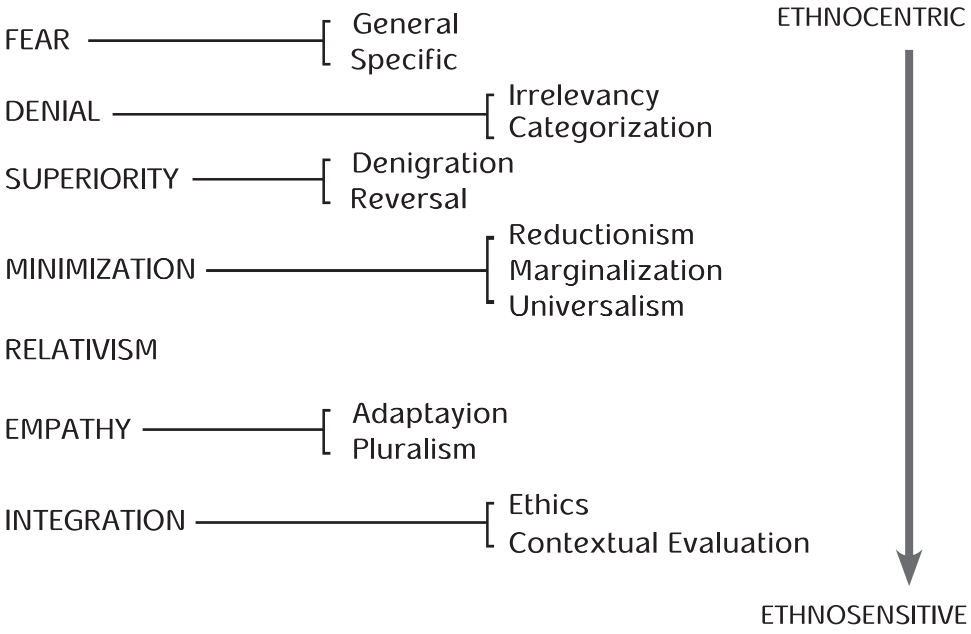
Health Resources and Services Administration – Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency http://www.hrsa.gov/healthliteracy/training.htm

Manhattan Cross Cultural Group – Quality Interactions: A Patient-Based Approach to Cross-Cultural Care http://www.qualityinteractions.org

A variety of developmental models of ethnosensitivity[24] have also been proposed (e.g., see Figure 2).

Figure 2

Developmental Model of Ethnosensitivity (Adapted from Bennett)



Borkan JM, Neher JO: "A Developmental Model of Ethnosensitivity in Family Practice Training," Family Medicine 1991; 23:212-217

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Research into the effectiveness of clinical cultural competency training is still relatively in its infancy, but several promising assessment tools have been developed and utilized in a number of settings with medical students, residents, practicing physicians, other health care professionals/staff, and patients,[2,16,20,25-32] While systematic reviews of the literature have found that cultural competency education can improve communication with patients from other cultures, and is associated with increased health care provider knowledge of patients' different cultures, improved provider attitudes and skills, and higher patient satisfaction with physicians, direct links have not yet been found between training and improved patient health outcomes. The need for employing more rigorous study designs, using both quantitative and qualitative methods, establishing the reliability and validity of data collection tools, and engaging in careful data analysis and interpretation has been called for.[33-35]

Becoming a Culturally Competent Academic Medical Center and Health Care Organization

Cultural competency training is facilitated when it takes place in a supportive environment. Organizations can be characterized (using colloquial language) as being:

- "No Talk and No Walk"
- "Talking the Talk"
- "Walking the Talk"
- "Walking and Talking"

A comprehensive and excellent resource that can assist academic health centers in becoming more culturally competent is the Health Resources and Services Administration's monograph: Transforming the Face of Health Professions Through Cultural & Linguistic Competence Education: The Role of the HRSA Centers of Excellence[36] (http://www.hrsa.gov/culturalcompetence/curriculumguide).

Educators also need to focus their efforts in transforming the multiple curricula that learners are exposed to and which can facilitate or impede learning:[37]

- Explicit Curriculum
  "formal," "co-," or "extra-curricular" activities
- Implicit Curriculum
  "hidden" curriculum

- Null Curriculum
  "what is left out of the curriculum"

The powerful impact, in particular, of the "hidden curriculum" needs to be addressed, otherwise else change efforts can be undermined and become non-sustainable.[38]

Núñez[39] has identified a number of key strategies needed for successfully integrating cultural competence into a medical school curriculum: 1) Top Down and Bottom Up Support; 2) A Needs Assessment from the Faculty; 3) Format Work Groups; 4) Maximum Use of Resources; 5) Identify Power Base of Change (Internal and External) and 6) Integrate Change Within the Current System. There will likely be many lessons learned given the variety of curricular change efforts underway in medical schools and residency training programs in response to the LCME and ACGME accreditation requirements and other external forces.

THE FUTURE

As we move forward in addressing the issue of cultural competency, here are some challenges that need to be addressed:

- How do we generate interest, deal with resistance, and support the desire to become more culturally competent?
- How do we measure "cultural competence" and "cultural humility"?
- How do we evaluate the effectiveness of clinical cultural competency educational programs?
- How do we deal with "hot button" and "cold button" issues, and prevent "burnout?"
- How do we partner with communities in developing, implementing, and assessing the impact of cultural competency training?
- How do we provide high quality cultural competency training within a budget?

Important points to remember relating to cultural competency educational programs include:

- Create a learning environment that fosters safety, trust, and respect
- Within-group diversity is often greater than between-group diversity
- There is no "cookbook approach" to treating patients
- Avoid stereotyping and overgeneralization

- An assets and strengths-based perspective is important to maintain
- Every encounter is a cross-cultural encounter

As has often been stated, cultural competency is an ongoing journey and not a final destination. Our academic health centers and health care organizations are complex adaptive systems, navigating between order and chaos in an uncertain world. An ecological perspective is needed in the work ahead if we are to become authentic and empowered learning communities that can successfully train physicians and other health professionals to provide culturally competent, patient-centered care. The important take-home message is: "Adding wings to caterpillars does not create butterflies – it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation."[40]

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Cultural Appropriateness of Health Services: Definition of Standards for Health Services, and for the Training of Health Professionals in Cultural Competence (CC), with the Objective of Reducing Health Inequality

A POSITION PAPER

This position paper was prepared for discussion at an International Workshop of the Israel National Institute for Health Policy and Health Services Research held at the Dan Caesarea Hotel on 9-10th October 2007. It was discussed at the workshop and updated subsequently. It is a translation of the original Hebrew version.

Aims of Position Paper:

1. To bring to discussion at the International Workshop the subject of "The Cultural Appropriateness of Health Services" in relation to the cultural background of the Israel population and to ensure the Cultural Competence (CC) of health professionals.

2. To stress the potential contribution of a planned approach to Cultural Appropriateness, to the reduction of health inequality and health services inequality. While it is clear that it is not possible to eradicate health inequality, as the major causes are related to the socio-cultural disparities in the country, there is little doubt that the Health Services, and the health professionals in them, have a central role in reducing the inequality. This includes two major entities:
   a. Preventing the development of the health effects of socio-economic inequality
   b. Treating existing health inequality

3. To examine various components of "Cultural Appropriateness" and their

contribution to the welfare of the individual, the family, and Israel society, taking into consideration the organizational and economic realities of the Health Care System (HCS).

4. To promote the framing of HCS policy regarding Cultural Appropriateness of health services including the definition of the standards required to achieve the goals in the future.

The Israel Background

Health services in Israel are provided, within the framework of the National Health Insurance Law (NHIP) to a very socially and culturally heterogeneous population. In order to meet the defined objectives of the Law of "justice, equality and solidarity" it is necessary to define the standards by which the services will meet the varying needs of different population groups.

Health care professionals constitute the central core of the delivery of health services and thus the importance of their CC in order to provide services appropriate to the differing needs of the culturally varied population. This is of relevance to health equity of the different groups in society.

There is substantial evidence of the existence of inequality in health status between different groups in the population, and in addition in access to and quality of the services. This inequality is found in life expectancy, mortality, morbidity, disability, and health-related behaviour. These differences are related to many of the population characteristics that place individuals and groups at risk (age, gender, socio-economic status, religion and degree of religiosity, education, geographical region, ethnicity, and employment status). It should be stressed that there is also evidence that many of the disparities are widening over time.

While acknowledging the premier role of socio-economic and cultural disparity to the development and increase of health inequality, studies internationally and in Israel have stressed the role of the health professionals in the development of the inequality as well as their critical responsibility for its reduction. In a country such as ours health professionals interact with a very culturally, socially and economically heterogeneous population. They are frequently characterized by very different perceptions of health and disease that have important implications for all stages of the clinical process. This requires that the health professional receive appropriate training to facilitate effective functioning. In addition we should be aware of the fact that the health professionals themselves have an equally varied cultural background, and that it is frequently very different from that of their patients. At the interface between the patient and provider are a wide spectrum of promotive, preventive, diagnostic, treatment, and rehabilitative activities, all of which require appropriate professional training in order to function with patients very different socially, culturally and linguistically from themselves. Most service frameworks do not have a defined policy in this connection and training possibilities are limited.

This Paper relates to the following subject areas:
- Defining policy to ensure Cultural Appropriateness of health services
- The need to define the standards for Cultural Appropriateness in the functioning of health services
- The training of professionals who have completed their basic professional education. These professionals, who are already functioning in the services, are a high priority as they are the role model for the next generation
- Academic training in CC at different levels
- The need for research both on Cultural Appropriateness in health services and regarding the planned evaluation of relevant activities.

I. Determining of Policy:

The institutions responsible for determining health policy (Ministry of Health and the Health Funds) should define their policy regarding;

a. **Health Inequality in Israel:** This should relate both to its presence and extent as well as the impact on the individual, the family, the HCS, and society as a whole. In addition it will define the planned action that will be taken to reduce health inequality. This will include the activities of the different service frameworks (hospitals, community clinics).

b. The planning and provision of health services **Culturally Appropriate** to the population served.

"**Cultural Appropriateness** refers to the appreciation of the diversity that results from ethnic, cultural and language differences between groups in the population, and the ability to relate to these differences and to take them into consideration. Especial importance is given to differences related to socio-economic status, religious belief and degree of religiosity, behavior patterns, language understanding, and processes of decision making. Considering the importance of all these factors to the health of people and to the functioning of health professionals, it is incumbent on the health services to adapt their preventive and treatment activities to the different population groups that they serve."

Adapted from: Encyclopedia of Public Health. Copyright 2002 by the Gale Group, Inc.

c. The role and functioning of health professionals in the provision of equitable and quality service in line with the health needs of those requiring it and Culturally Appropriate to them.

d. The need to ensure the **Cultural Competence** of all health professionals.

The Commonwealth Fund in 2002 added to the Definition of Cultural Appropriateness that of Cultural Competence:
"The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients' social, cultural, and linguistic needs.
The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or language proficiency."

e. Any change in the defined areas will require the **Allocation of Appropriate Resources** (budget and manpower) that are usually needed over extended time periods and are not one-time. In this connection there is need to relate to:

- To give a high priority to the issues raised in this document, as part of the total activities of the institution, and to allocate resources accordingly. The issues raised here should not be seen as an addition to those handled at present but as part of the needs to be addressed and the resources allocated accordingly.

- The possibility should be considered of covering part of this through the extension of services as deliberated in the "Health Basket Committee" – e.g. item IIh (language) below.
- The source of these resources will be either within the institution (change in functioning or alternative budgetary use) or from the outside. Many of the participants in the deliberations were of the opinion that there is a definite possibility of covering a substantial part of the costs within the present resources.

II. Definition of Standards in Health Care Institutions

The Ministry of Health and the Health Funds will determine (in coordination) the recommended standards in order to ensure the Cultural Appropriateness of all the services under their responsibility. The need to provide a legal basis for this will be considered at a later stage. The standards include:

a. Each health care institution will encourage an appreciation of the factors that will ensure health equity and the implications of health inequality. This will include the relevance of socio-cultural disparity to the development of health inequality.

b. A health care institution supplying services to the population will ensure the **physical conditions appropriate** to the cultural background of the target population. This will enable appropriate access and utilization of the service.

c. The health provider will determine that the patient has an **adequate understanding** of the different constituents of the treatment process including the right to refuse a recommended action. This is an important element in ensuring quality care.

d. It should be recognized that a patient may have **different priorities or beliefs** from those of the provider. This should be taken into consideration in determining the treatment recommended and the information supplied to the patient and family.

e. There should be a planned and ongoing program for the **training of workers** of all professions and at all levels in **Cultural Competence.** This will occur in the different functional frameworks in both hospitals and community services with a view to adapting them to the characteristics of each service.

f. Each community health service region and hospital will appoint someone **responsible for CC** in the service. He/she will be responsible for the ongoing CC training programs, and for the adherence to the institutional policy in this connection. One of the functions will be to provide a support framework in CC for the health professionals and to act as a link with the different groups in the community. The person responsible will also act to set up an advisory group of representatives of the diverse population served.

g. In order to set up the training programs it is necessary to **Train the Trainers** – who will fill the responsible role in each service framework**.**

h. Language:

- **Signs** (directional and informative) placed in a health service facility should appear in the major languages of the target population
- **Material distributed** to people coming to the facility should be translated into the major languages of the target population and be appropriate culturally
- **Data** on spoken language, country of birth, date of migration, and educational level, will be routinely collected on the user population. Such data exists in the National Insurance Institute. An effort should be made for it to be available to the health services in order to identify people at special risk, plan appropriate intervention and provide surveillance of the institution's functioning.
- The health service should aspire to provide a **professional interpretation service** (in-house, on call, or by telephone). The interpreting will be by persons who have undergone specific training in medical interpreting and not family members or passers-by. The use of minors as medical interpreters should stop completely. A possibility is to specially train members of the staff as trained interpreters in their languages. The service should be provided in the major languages of the target population as assessed. Patients whose language is not one of those frequently spoken should be provided with a telephone interpreter service so that as far as possible, there will be language communication between patient and provider. Such interpreter services will be provided gradually over time in order to allow for interpreter training and in line with the language priorities. Data from international research studies, presented at the workshop, indicate that the cost associated with problems in understanding language are considerable and include, amongst others rehospitalization, unnecessary tests, low

compliance with treatment instructions, etc. The saving, as a result of interpreter services, would go a long way to covering their cost. These issues have not as yet been studied in Israel.

- While Cultural Appropriateness and CC include far more than only language, there is little doubt that the mutual understanding of language is a key to successful Cultural Appropriateness of health services.

i. The different components of cultural Appropriateness will be routinely assessed as part of the overall service evaluation program. The possibility should be considered of including them in the routine activities of "Risk Management" and Quality Assurance in the institution.

j. The Ministry of Health, with the collaboration of the Health Funds, operates a project on "Quality Indicators in Community Services". Consideration should be given to the inclusion of Health Inequality measures as well as the measurement of the Cultural Appropriateness Standards.

k. It is recommended to create a central bank of methods for developing Cultural Appropriateness of health services as well as the methodologies for training health professionals in CC. This framework will include both international and local Israel experience.

l. The degree to which a health service has developed Cultural Appropriateness should be measured as part of the ongoing assessment of services provided.

m. Following the experience with waves of immigration to Israel over the years it is recommended that the need for and content of Cultural Appropriateness be planned as early as possible in relation to the migration.

III. Defining standards for the training of Medical Residents

The Scientific Council of the Israel Medical Association will require that every Medical Resident will take part in a training program (to be determined) at some time during his/her Residency period. It will include:

a. The existence, extent and reasons for the development of **Health inequality** and the physician's role in its prevention and reduction.

b. The provision of the necessary experience and tools that will ensure the development of the **Cultural Competence** of each physician. There will be a special accent placed on the improvement of inter-personal (provider/patient) communication skills

These subjects will be included in the different residency examinations.

III. Defining standards in Academic Institutions

The content and recommendations of this document will be discussed with the Committee of Deans of Medical Schools, Forum of Heads of Nursing Schools and the heads of all academic frameworks training health professionals, including health administrators at different levels of the health services. The details will be brought to the notice of the Council for Higher Education. The following should be included in the teaching programs:

- The understanding of the existence, extent and reasons for the development of health inequality
- The implications of health inequality for the individual, family, HCS, and society as a whole. Its health, social, functional and economic significance will be stressed.
- The relevance of the cultural background to the understanding of the processes involved in health and disease, and the need to adapt the functioning of health professionals to the differing needs of different people. This is an important constituent of the right of everyone to health care.
- These components will be included in the teaching related to health promotion, disease prevention, diagnosis at different stages of disease development, medical treatment, prevention of physical mental, functional and social disability, and rehabilitation
- The provision of the necessary experience that will ensure the development of the **Cultural Competence** of each health professional. There will be a special accent placed on the improvement of inter-personal (provider/patient) communication skills

These subjects will be included in both internal and external examinations as well as those for professional licensing.

IV.Research

Research Institutes will encourage research in the different areas outlined in this paper by the provision and identification of research funding. Following the discussions in the workshop and afterwards stress should be laid on controlled examination of the impact of lack of understanding in the provider/ patient encounter, and this at all stages of the clinical process. The economic implications of this should also be examined.

VI. Pilot Project

As a first step it is suggested that a pilot project be undertaken in two hospitals and a number of community frameworks in order to test the methodology and identify the problems in introducing Cultural Appropriateness and Cultural Competence in the Health Care System.

הלימה תרבותית של שירותי בריאות: קביעת סטנדרטים לשירותי הבריאות ולהכשרת אנשי מקצועות הבריאות בכשירות תרבותית, במטרה לצמצם אי-שוויון בבריאות

נייר עמדה

נייר עמדה זה הוכן לקראת סדנה בין-לאומית של המכון הלאומי לחקר שרותי הבריאות ומדיניות בריאות אשר התקיימה במלון דן קיסריה ב-9-10 באוקטובר 2007. המסמך נדון בסדנה ועודכן לאחר מכן.

מטרות נייר העמדה הן:

1. לדון בנושא ההלימה התרבותית של שירותי בריאות בישראל ולהבטיח "כשירות תרבותית" של אנשי מקצועות הבריאות.
2. להדגיש את החשיבות שיש להתייחסות מתוכננת לנושא, לצמצום אי-שוויון בבריאות ובשירותי בריאות בישראל. ברור שאין אפשרות לחסל באחת את אי-השוויון בבריאות, שכן הסיבות העיקריות לאי-השוויון נמצאות מחוץ למערכת זו, ונעוצות באי-שוויון חברתי-כלכלי במדינה. **עם זאת, אין ספק שלשירותי הבריאות, ולאנשי המקצוע** העובדים בהם, תפקיד מרכזי בצמצום אי-השוויון בבריאות. תפקיד זה כולל שני מרכיבים עקרוניים:
   א. **מניעת התפתחותו** של אי-שוויון בבריאות כתוצאה מאי-שוויון חברתי-כלכלי.
   ב. **טיפול** באי-שוויון קיים בבריאות.
3. לבחון את ההיבטים השונים של הלימה תרבותית ואת תרומתם לרווחת הפרט, המשפחה, והחברה הישראלית בכלל, בהתחשב במציאות הארגונית והכלכלית של מערכת הבריאות.
4. להביא לניסוח מדיניות של מערכת הבריאות בנושא הלימה תרבותית של השירותים תוך קביעת סטנדרטים להשגה כיעד עתידי.

רקע

למרות הישגים מרשימים במערכת הבריאות בעשורים האחרונים, יש ראיות רבות לקיומו של אי-שוויון במצב הבריאות בין קבוצות אוכלוסייה בישראל, וכן בנגישות ובאיכות של שירותי הבריאות. שירותי הבריאות בישראל ניתנים, במסגרת חוק ביטוח בריאות ממלכתי, לאוכלוסייה מגוונת מאוד מבחינה תרבותית וחברתית. כדי לעמוד ביעדים המוגדרים בחוק של "צדק, שוויון ועזרה הדדית" קיים צורך לקבוע סטנדרטים אשר יבטיחו את התאמת השירותים לצרכיהן של קבוצות האוכלוסייה השונות.

היות ואנשי מקצועות הבריאות מהווים את עמוד התווך של מתן שירותי בריאות למגוון קבוצות באוכלוסייה, נודעת חשיבות מרובה ל"כשירות התרבותית" המאפשרת להם לספק שירותי בריאות שיתאימו לאוכלוסיות מרקע תרבותי שונה ובעלות צרכים ייחודיים, מבחינה לשונית ותרבותית. להתאמה התרבותית של שירותי בריאות לקבוצות אלו השלכות לגבי שוויון במצב בריאות של הקבוצות השונות.

אי-השוויון בבריאות בא לידי ביטוי במדדים של תוחלת חיים, תמותה, תחלואה, נכות, והתנהגות בריאותית, וזאת לפי תכונות שונות המעמידות את הפרט וקבוצות אוכלוסייה בסיכון (גיל,

מגדר, מעמד חברתי-כלכלי, דת ודתיות, השכלה, אזור גיאוגרפי, מוצא, מצב תעסוקתי). יש להעניק תשומת לב מיוחדת לבני גיל הצעיר מאוד ולבני הגיל המבוגר מאוד ולנכים פיזית או נפשית.

מעבר לחשיבות המרכזית של אי-שוויון חברתי, כלכלי, ותרבותי במדינה, לקיומם ולהתרחבותם של פערים בבריאות, המחקר בעולם ובישראל מצביע על תרומתם של אנשי מקצועות הבריאות להיווצרותו של אי-השוויון, ועל התפקיד המשמעותי שעשוי להיות להם בצמצומו. במדינה כשלנו עובדים אנשי מקצועות הבריאות עם קהל מגוון מאוד מבחינה תרבותית, חברתית וכלכלית, וההתמודדות עם תפיסות שונות של בריאות וחולי מחייבת הכשרה מתאימה. יש להביא בחשבון שגם לאנשי המקצוע רקע תרבותי מגוון משלהם, העשוי להיות ולעתים שונה מאוד מזה של מטופליהם. מדובר בקשת רחבה של תחומי עשייה: קידום בריאות, מניעת מחלות, אבחון מוקדם, היענות לטיפול רפואי, מניעת מוגבלות ושיקום. אולם אנשי המקצוע אינם זוכים לרוב להכשרה נאותה בכל הקשור לעבודה עם אנשים השונים מהם מבחינה חברתית, לשונית או תרבותית. ברוב השירותים הללו אין למעשה מדיניות מוצהרת או כתובה בנושאי הלימה תרבותית, ואפשרויות ההכשרה מעטות ביותר.

נייר עמדה זה מתייחס לתחומים הבאים:

- קביעת מדיניות להבטחת הלימה תרבותית של שירותי הבריאות
- הצורך בקביעת סטנדרטים של הלימה תרבותית בשירותי בריאות
- הכשרת אנשי מקצוע אשר סיימו את לימודיהם הבסיסיים, ומתפקדים בשירותי הבריאות. אנשי מקצוע אלה מהווים אוכלוסיית יעד מיידית ועיקרית, ומודל לחיקוי (role model) לדור הבא
- הכשרה אקדמית בתחום הכשירות התרבותית בשלבי הלימודים השונים
- הצורך במחקר בנושאים הקשורים להלימה תרבותית של שירותי הבריאות וכן הערכה מתוכננת של שירותים אלו

I. קביעת מדיניות:

על המוסדות האחראים לקביעת מדיניות במערכת הבריאות (משרד הבריאות וקופות החולים), לקבוע מדיניות ביחס ל:

א. **התמודדות עם אי-השוויון בבריאות בישראל**, היקפו והשלכותיו מבחינת הפרט, המשפחה, מערכת הבריאות והחברה כולה. עליהם לבחון דרכים לצמצום אי-השוויון בבריאות, בכלל זה באמצעות המסגרות המספקות שירותים לאוכלוסייה (בתי-חולים, מרפאות קהילתיות).

ב. תכנון ואספקה של שירותי בריאות המאופיינים בהלימה תרבותית (**Cultural Appropriateness**) לרקע התרבותי של קבוצות האוכלוסייה המקבלות שירותים אלה.

הלימה תרבותית (Cultural Appropriateness) מתייחסת להכרה בשונות הנובעת מהבדלים בין קבוצות מבחינה אתנית, עדתית, לשונית או תרבותית, ולניסיון להתייחס לשונות זו ולהתחשב בה. במיוחד מדובר בהתחשבות בהבדלים הקשורים במעמד חברתי-כלכלי, באמונה דתית ומידת דתיות, בדפוסי התנהגות, ברמות הבנה לשונית ובדרכי קבלת החלטות. לאור חשיבותם של כל אלה לבריאות האדם ולתפקודם של אנשי מקצועות הבריאות, מוטל על שירותי הבריאות להתאים את הפעילות המניעתית והטיפולית לאוכלוסיות היעד המגוונות שאליהן הן מכוונות.

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ג. **תפקידם ותפקודם של אנשי המקצוע** באספקת שירות שוויוני ואיכותי, בהתאם לצרכים הבריאותיים (פיזיים, נפשיים וחברתיים) והמתאפיינים ב**הלימה תרבותית** לכל אדם הזכאי להם.

ד. הצורך להבטיח **כשירות תרבותית** (**Cultural Competence**) בקרב כלל אנשי מקצועות הבריאות.

ב-2002 הוסיף ה-Commonwealth Fund להגדרה של **Cultural Appropriateness** את מושג **הכשירות תרבותית** (**Cultural Competence**):

"יכולתה של מערכת הבריאות להעניק טיפול למטופלים השונים זה מזה בערכיהם, אמונותיהם והתנהגותם, תוך שימוש בשפה המובנת לדוברים, ובכלל זה התאמת הטיפול הניתן לצרכים החברתיים והתרבותיים השונים."

"היעד הסופי הינו קיומה של **מערכת שירותי בריאות, לרבות אנשי המקצוע הפועלים בה**, המסוגלת להעניק את הטפול האיכותי ביותר לכל חולה ללא קשר לגזע, מוצא, רקע תרבותי ושפה."

ה. כל שינוי בתחומים שיוגדרו, צריך שילווה **בהקצאת אמצעים** מתאימים. בדרך-כלל אין מדובר בהקצאה חד-פעמית אלא בהשקעה לטווח ארוך של תקציב וכוח אדם. בהקשר זה, יש להתייחס ל:

- מתן עדיפות גבוהה לנושאים הנדונים במסמך זה, כחלק ממכלול הפעילויות המתקיימות במוסד, והקצאת משאבים בהתאם. אין לראות בהקצאה לנושאים הנדונים במסמך זה תוספת לקיים, אלא חלק מן הצרכים, ולקבוע קדימויות בהתאם לכך.
- יש לשקול אפשרות של כיסוי הוצאות מסוימות מתוך ההקצאה של הרחבת שירותים אשר נדונה ב"ועדת הסל" – למשל סעיף **II ח** (שפה) למטה.
- מקור האמצעים יהיה בתוך המוסד (שינויים בתפקוד כוח אדם או ניצול חלופי של תקציב קיים) או מחוצה לו. לדעת רבים מן הנוכחים בדיונים, קיימת במערכת הבריאות אפשרות סבירה לכיסוי מרכיב משמעותי מן ההוצאות הדרושות מתוך המשאבים הקיימים.

II.קביעת סטנדרטים במוסדות שירותי הבריאות:

משרד הבריאות וקופות החולים יקבעו (תוך תיאום ביניהן) את הסטנדרטים המומלצים כדי להבטיח הלימה תרבותית של כלל השירותים שבאחריותם. בהמשך יישקלו האפשרות או הצורך לעגן אותם בחקיקה. סטנדרטים אלה כוללים את הקביעות הבאות:

א. על כל מוסד במערכת הבריאות לטפח **מודעות** לנושאים הקשורים לשאיפה לשוויון בבריאות, ולהשלכותיו של אי-שוויון בבריאות. זאת, תוך הכרה במשמעות של שונות חברתית ותרבותית להיווצרות אי-השוויון בבריאות.

ב. על כל מוסד בריאותי המספק שירותים לאוכלוסייה לדאוג ל**תנאים פיזיים מתאימים** לרקע התרבותי של אוכלוסיית היעד, וזאת כדי לאפשר נגישות וניצול השירות בצורה מרבית.

ג. **הבנה בין מטפל למטופל:** באחריות המטפל לוודא כי המטופל/ת הבינ/ה באופן ממצה את כל הקשור בטיפול, לרבות הזכות שלא להסכים לטיפול המוצע. היבט זה מהווה מרכיב חשוב בהבטחת טיפול איכותי.

ד. יש להכיר בכך שלמטופל עשויים להיות סדר עדיפויות ואמונות שונה מזה של המטפל, ולהביא עובדה זו בחשבון בקביעת דרכי הטיפול ובמתן ההנחיות לחולה ולמשפחתו.

ה. יש לקיים מסגרת מתוכננת וקבועה ל**הכשרת עובדים**, בכל הרמות ובכל תחומי המקצוע, בנושא ה**כשירות התרבותית**. תוכניות הכשרה אלו תופעלנה במסגרת בתי-החולים ובשירותים קהילתיים שונים, כדי להתאים את תוכנן למאפייני השירות.

ו. יש למנות **"אחראי כשירות תרבותית"** בכל מחוז של שירות קהילתי ובבתי-החולים. גורם זה יהיה אחראי להכשרה המקצועית השוטפת בנושאי כשירות תרבותית, וליישום המדיניות המוסדית בנושא התאמה תרבותית. אחראי הכשירות התרבותית יקיים **מסגרת לתמיכה** באנשי המקצוע בנושאים הרלבנטיים וישמש כתובת לייעוץ. האחראי יהווה גם **ערוץ תקשורת מול נציגי הקבוצות השונות באוכלוסייה**. שיתוף נציגים מאוכלוסיית היעד ישפר את ההבנה ההדדית ואת הקשרים בין האוכלוסייה לבין שירותי הבריאות.

ז. כדי לבנות מערכת הכשרה יש הכרח **להכשיר את ה"מכשירים"** – אחראי הכשירות התרבותית – בכל מוסד. למטרה זאת ניתן לשקול שימוש בכלים כגון סימולציה, בשיתוף עם מס"ר (המרכז הארצי לסימולציה רפואית).

ח. **שפה:**

- יש **לשאוף לכך שניתן יהיה להתמצא בין כותלי המוסד הרפואי** בלא תלות בשפה מסוימת. יש לתכנן **שילוט** המוצב במוסד בשפות של אוכלוסיות היעד העיקריות.
- החומר המחולק לפונים לשירות יתורגם לשפות של אוכלוסיות היעד העיקריות ויותאם תרבותית לאוכלוסיות אלה.

- יתבצע איסוף שיטתי של נתונים על צרכני השירות באשר לשפה מדוברת, ארץ מוצא, שנת עליה ורמת השכלה. במוסד לביטוח לאומי קיים מסד נתונים מעודכן בנושאים אלו. יש לפעול להסדר שלפיו מידע זה יועבר לשירותי הבריאות ויהווה בסיס גם לאיתור אנשים וקבוצות בסיכון, לתכנון פעילות התערבות, ולמעקב אחרי פעילויות שביצע המוסד.
- יש לשאוף להפעלת **שירות מתורגמנות מקצועי** (מתורגמני-בית, על-פי קריאה או טלפונית). התרגום יתבצע על-ידי מתורגמנים אשר הוכשרו לכך ולא על-ידי עוברי-אורח או בני-משפחה (בכל מקרה, השימוש בקטינים כמתורגמנים רפואיים לעת מצוא ייפסק כליל.) דרך אפשרית היא **להכשיר**, כמתורגמנים מקצועיים, את **עובדי המוסד השולטים בשפות שונות**. שירותי התרגום יסופקו בשפות העיקריות של אוכלוסיות היעד (כולל שפת סימנים לאנשים חירשים) וזאת בהתאם להערכת הצרכים של אוכלוסיות היעד. לפונים אשר שפתם אינה אחת מן השפות העיקריות בישראל יינתן תרגום טלפוני, לכל הפחות, כך שלא ייווצר מצב שבו אין המטפל והמטופל מסוגלים לתקשר ביניהם.
- יש הכרח שתוכן מסגרת ברורה להשגת שירות התרגום (מכל סוג שהוא) במוסד. שירותי התרגום יופעלו בצורה הדרגתית ומתוכננת כדי לאפשר הכשרה של המתורגמנים. נתונים מחקריים מחו"ל, שהוצגו בסדנה, הראו שעלות התקלות הנגרמות בשל בעיות הבנת שפה הינה גבוהה (ומתבטאת, בין היתר, באשפוזים חוזרים, בדיקות מיותרות, אי-היענות לטיפול ועוד). בטווח הארוך, חיסכון בנושאים אלו יכסה את ההוצאות של שירותי תרגום. נושאים אלו עדיין לא נחקרו בישראל.
- אף שנושא ההלימה התרבותית והכשירות תרבותית מכסה תחום רחב יותר מנושא השפה, אין ספק ש**הבנת שפה מהווה המפתח להלימה תרבותית מוצלחת של שירותי בריאות**.

ט. יש מקום לשקול את הכללת הפעילויות האלו במסגרת הפעילות המוסדית של **ניהול סיכונים והבטחת איכות השירות** וכן של **השתלמות תוך-שירות** של צוות המוסד.

י. במסגרת שירותי הבריאות הקהילתיים קיים פרויקט **"מדדי איכות" של משרד הבריאות**. יש לשקול לכלול בפרויקט זה מדדי אי-שוויון בבריאות, וסטנדרטים להלימה תרבותית של שירותי בריאות.

יא. מומלץ ליצור **מאגר מרכזי של כלים** להבטחת הלימה תרבותית של שירותי בריאות ושיטות להכשרת אנשי מקצועות הבריאות לכשירות תרבותית. מאגר זה ירכז את הניסיון בישראל וגם בחו"ל, לרבות תוצאות של מחקרי הערכה.

יב. מידת ההלימה התרבותית של מוסד רפואי תימדד בעת ביצוע **הערכה שוטפת** של השירותים הניתנים.

יג. לאור הניסיון של קליטת גלי עליה בישראל והתוצאות הבריאותיות במהלך השנים, יש להדגיש את הצורך לתכנן התייחסות להלימה תרבותית של שירותי בריאות מוקדם ככל האפשר.

III: קביעת סטנדרטים להכשרת רופאים מתמחים

המועצה המדעית של ההסתדרות הרפואית תחייב כל מתמחה להשתתף במשך ההתמחות **בהשתלמות אשר** תכלול:

1. **למידה של נושא אי-השוויון** בבריאות ותפקיד הרופא בצמצומו ובמניעתו.
2. הקניית כלים ל**פיתוח כשירות תרבותית** אצל הרופא תוך שימת דגש על שיפור היכולת לתקשורת בין-אישית בין המטפל למטופל.

נושאים אלו יהוו **מרכיב בבחינות** שלב א' ושלב ב' של כל תחום התמחות.

IV: קביעת סטנדרטים במוסדות אקדמיים

1. נושאי מסמך זה יידונו עם ועדת הדיקנים לרפואה, פורום מנהלי בתי הספר לסיעוד ומנהלי תוכניות הכשרה של כל מקצועות הבריאות האחרים, כולל אנשי המנהל ברמות השונות. בהמשך יובא הנושא לידיעת המועצה להשכלה גבוהה. יש לכלול בתוכניות הלימודים את:
   - הכרת ההיקף והכרת הסיבות לאי-שוויון בבריאות במדינה.
   - השלכותיו של אי-השוויון בבריאות על הפרט, המשפחה, מערכת הבריאות והחברה כולה. משמעות זאת היא בריאותית, תפקודית, חברתית, וכלכלית.
   - משמעותו של הרקע התרבותי להבנת תהליכי בריאות וחולי ולהכרה בצורך להתאים את תפקוד אנשי המקצוע לצרכיה השונים של אוכלוסייה הטרוגנית, כפי שמשתמע מן הזכות של כל אדם לשירותי בריאות.
   - הכללת תחומים אלו בהוראה של קידום בריאות, מניעת מחלות, אבחון חולי בכל השלבים, מתן טיפול רפואי, מניעת מוגבלות פיזית, נפשית, תפקודית וחברתית, וכן שיקום.
   - הקניית כלים לפיתוח כשירות תרבותית של כל אנשי מקצועות הבריאות, אשר בבסיסו פיתוח יכולות בתקשורת בין-אישית.
2. הכללת הנושאים שהוגדרו לעיל בבחינות פנים-מוסדיות, בבחינות חיצוניות ובבחינות רישוי ממשלתיות.

V: מחקר

הנושאים אשר נדונו בנייר עמדה זה לא נחקרו רבות בישראל. על מכוני המחקר לעודד מחקרים בתחומים המוזכרים במסמך זה, על ידי העמדת קרנות לרשות החוקרים. בהמשך לדיוני הסדנה יש להדגיש את הצורך בבדיקה מבוקרת של השפעתו של חוסר ההבנה בשיחת מטפל-מטופל על בריאות המטופל, בכל שלבי התהליך הקליני. נוסף לכך, יש לבדוק את המשמעות הכלכלית של מצבי אי-הבנה מעין אלה.

VI: פרויקט חלוץ

כשלב ראשון מוצע לבצע **פרויקט חלוץ (פיילוט)** בשני בתי-חולים ובכמה מסגרות בקהילה (או בכל מסגרת מתאימה אחרת) כדי לבחון את השיטות להחלת התאמה תרבותית של הטיפול הרפואי, ולאתר את המכשולים לביצוע מיטבי של היעדים שהוגדרו לעיל.

Report from the one-day "Workshop on Cultural Competence in Action: "Overcoming Language and Cultural Barriers in Health Care" held in the Israel National Institute on Thursday October 11, 2007

This additional workshop was planned as a practical experience in Cultural Competence training and followed on the two-day Workshop in Caesarea. The two reports were prepared by those who conducted the workshop and two of the participants.

I. TRAINERS PERSPECTIVE:

Marjory Bancroft, Director, Cross-Cultural Communications, USA
Nataly Kelly, Senior Analyst, Common Sense Advisory, USA

ABSTRACT

This session replicated a cultural competence workshop designed for U.S. health care staff and adapted it for an Israeli audience. In general, such programs are attended by health care professionals, allied health professionals, administrators, social workers, bilingual staff, program managers and front-line staff. This sample workshop addressed two key areas: language and culture. By means of its varied, interactive format, the workshop aimed to engage its audience and offer knowledge about cutting-edge developments in the field. The workshop also promoted clear communication and beneficial health outcomes for all patients.

SUMMARY OF THE WORKSHOP

The larger aim of the workshop was to reproduce, to the extent possible, an experience for Israeli health care staff of attending a cultural competence workshop in the U.S. The intent was to showcase training that adheres to national standards, guidelines and principles on cultural competence as elaborated by U.S. federal policy and regional initiatives. The objectives included modeling skills for overcoming language barriers, demonstrating effective strategies to address cultural differences and developing a cultural competence plan. In addition, participants were able to take away potentially helpful approaches to such training and adapt them to the local needs of Israeli audiences.

Following a general introduction to cultural competence, the first part of the workshop was devoted to improving linguistic communication. In many health care settings, patients and health care staff do not share a common language. Health care organizations therefore need to assess the languages spoken by patients in the area and also be familiar with issues of health literacy (the ability to understand and use health information to promote health), and how to serve patients who do not understand the health care provider's language? A focus on best practices ensued. In general, research, international policy and best practices dictate that where a language barrier exists, interpreting services should be provided. *Anyone who serves as an interpreter should, however, first be tested for language proficiency and receive training in professional health care interpreting.* In too many cases, the assumption that anyone who speaks two languages can interpret has proved dangerous. Using untrained interpreters – including bilingual staff – has led to misdiagnoses, medication errors, delayed treatment, poor adherence to treatment, poor quality of service, costly and unnecessary tests, and dangerous or disastrous health outcomes. Therefore, four basic best practices were presented, following the assumption that *all the following persons have been tested for language proficiency and professionally trained to interpret in health care settings:*

Bilingual staff: (a) staff interpreters who interpret full time; or (b) health care staff who happen to be bilingual and are asked to interpret, occasionally or often.

Contract interpreters: professional interpreters who interpret on an hourly basis. They may work for a language agency or contract directly with the facility.

Telephone interpreters: Interpreters who provide interpreting over the telephone. In the U.S., these services are often provided through a language company that offers the service around the clock for 150 to 170 languages. However, many hospitals have in-house telephone interpreters, and some countries such services are managed by the government.

A "language bank": A group of volunteers, bilingual employees or low-cost community interpreters listed by language with their contact information to be called as needed.

The risks of using family members or friends to interpret – particularly children – were discussed in detail, since research has shown the dangers of using family and friends. As a matter of policy, health care safety and best practice, *family and friends should never be used to interpret except in dire emergencies*. Workshop members also learned and practiced basic skills for working effectively with interpreters through role play.

Following lunch, the workshop was devoted to cultural differences, their impact on health care and how to provide culturally responsive care and communicate effectively. The initial focus was on self-assessment, since it is commonly assumed that culture is the "problem" of other people and that our own cultural norms, rules and values are the only acceptable ones. Through a variety of activities, participants examined their cultural assumptions with a view to better understanding and connecting with patients.

The workshop then turned to practical strategies such as developing cross-cultural communicative skills, for example: take time; note eye contact and body language; establish a relationship before "getting down to business"; ask how the patient wishes to be addressed; show respect (especially for older clients); and ask how the patient views/understands problem; learn family dynamics The use of cultural mediators to provide cultural input was recommended. These may include bilingual staff, community advocates, ethnic leaders, local interpreters and health promoters.

Another common best practice is to consult culturally diverse communities, e.g., ethnic leaders, community-based organizations, local advocates, faith-based groups, etc. Health care and community-based organizations can also work together to share cultural competence resources, knowledge and assets, for example, by creating a "translation memory," a database of commonly used terms and phrases within documents or multilingual patient education materials. The attendees also discussed how to create a resource library of multilingual materials available for sharing across many organizations.

As always, the patient is the only true cultural "expert" on his or her own experience, and this premise was emphasized. However, many cross-cultural resources now exist, e.g.: I Speak" posters and cards (to identify a patient's language); assessment tools; cultural/ethnic health profiles; multilingual patient education; and training videos and DVDs.

Throughout the day, diverse presentation formats were utilized to engage interest and provide time for practice, discussion and reflection. These formats included lively discussions, video vignettes, anecdotes, demonstrations, small group activities, role plays and other exercises that promote a collaborative and participatory learning experience. Such training often undermines the hostile reactions that can sometimes accompany cultural competence training. In addition, a lively, interactive format helps to provide memorable opportunities for positive interaction, a broadening of perspectives and the cultivation of genuine appreciation for the rich and rewarding role that cross-cultural encounters play in the lives and work of practicing health care providers.

II. PARTICIPANTS PERSPECTIVE:

Diane Levin, Clalit Health Services, Israel
Liora Valinsky, Maccabi Healthcare Services, Israel

The workshop was attended by a large group of multi-disciplinary professionals from a wide range of organizations.

Among the participants were family physicians and psychiatrists, nurses, health promotion professionals, dieticians, social workers, sociologists, language interpreters and others.

Among the organizations represented were: the Ministry of Health, Clalit Health Services, Maccabi Health Services, Leumit Health Services, Hadassah Hospital and Hebrew University School of Public Health, the Gertner Institute, the Israel Joint Distribution Committee, Brookdale Research Institute, Bar Ilan University, Haifa University, Ben Gurion Medical School – School of Public Health, Kaplan Nursing School, Hadassah Hospital Nursing School, Beer Yaacov Psychiatric Hospital, Tene Briut Organization and others.

The workshop began with a "break the ice" exercise in small groups. A lecture/discussion followed focusing on the topic of identified needs of culturally adapted health services. Specifically, the number of different languages spoken in Israel, the official languages and policy in public institutions regarding the use of different languages was discussed. The vast experience of the participants was expressed through examples of the daily situations in which the cultural gap between the patient and the provider takes its toll on the effectiveness of care and services.

The next session was on the different strategies for overcoming language barriers were presented and described in detail. Emphasis was placed on the need for language interpretation services.

A short film was screened that demonstrated the problems of using existing untrained staff who are spontaneously asked to translate, for the purpose of interpreting. This includes maintenance staff, clerical workers and other professional providers. The latter have particular difficulty in interpreting because of the challenge of translating without adding their professional opinion and recommendations.

Practical aspects of using interpreter services were presented and discussed, including positioning of the interpreter and its influence on physician-patient communication. A group exercise followed in which the entire group split into small 3-member group simulations in which one person was assigned to be the provider, one person the care receiver and the third an interpreter. The interpretation exercise was conducted in 2 different languages for the purpose of demonstration and then discussed by the entire group.

Cross-cultural resources and tools were presented for staff training and for practical use in interpreting, including "I speak" cards and posters.

The next session focused on culture and patient care, particularly on how culture, above and beyond language, affects health care. The issues of generalizations, stigma and stereotype were explored and discussed. A movie was shown in which the patient was ultra-religious (Haredi) and how this influences the health communication with the provider. One of the interesting moments of the day was the reactions to the film on "Haredi" issues. Several participants expressed discomfort, and even outrage at the way the Haredim were depicted in the educational film. The workshop leaders commented on the fact that when a film is shown that depict the cultural background of workshop participants, there is always a general feeling that the film exaggerates their culture, and this is an important component of cultural adaptation: cultural humility.

Best practices for overcoming cultural barriers were presented including non verbal communication, printed material, working with community groups and mediators, etc. In addition, resources of cultural/ethnic health profiles were presented and a discussion ensued regarding the need to exercise caution in using these resources so as not to stigmatize and stereotype the patient and his/her family. An all-group exercise was conducted in which one half of the group was challenged to welcome the other half of the group, without speaking. During this exercise the issue of the importance of body language particularly in relation to overcoming cultural barriers was experienced by participants. The concept of the meaning of the word "culture", and its relation to groups that are differentiated not only by the cultural background and language barriers but also by education levels, professions, and, in particular physical disabilities such as deafness or speech impediments was discussed at length.

Finally the wrap-up session included firstly a small group discussion, to define three strategies recommended for promoting culturally competent health services. The participants recommended a variety of action items, ranging from legal initiatives, policy, training, mass media initiatives, setting quality indicators and many others.

In summary, the one-day workshop was rich in opportunities for increasing knowledge and awareness of the need for cultural competency among health professionals, as well as for building skills in health communication in a variety of health care settings in Israel. The need for setting policy and allocating appropriate resources, as well as building an infrastructure within the health system that allows use of appropriate resources, was a running theme throughout the day, which of course, could be the basis for continuing discussion and action on this crucial issue in Israel.

WORKSHOP PROGRAM

Tuesday, October 9, 2007, Caesarea

Welcoming Remarks **– Chaim Doron**
– Leon Epstein

10:00 - 13:30 ***Cultural & Social Disparity: Health and Health Care Implications***

The objective of this session is to bring to all the participants an overview of the issues to be raised. This will include the data on health inequality, a summary of the link between this and socio-cultural disparities.

Chairperson: **Yoram Blachar**
10:00 - 10:30 **Leon Epstein** (Israel) – The Israel Reality

10:30 - 11:15 **Joseph Betancourt** (US) – The IOM studies, their importance in defining the race, ethnicity, social/cultural disparities relevance to health inequalities; the links to quality of care and the safety of patients

Chairperson: **Meir Oren**
11:30 - 12:15 **Jürgen Pelikan** (Western Europe) – The background to the development of the European Migrant Friendly Hospitals Program and its link to the Health Promoting Hospitals

12:15 - 13:15 **Robert Like** (US) – Cultural Competence: Implications for Clinical Practice, Health Care Organizations, and Public Policy

14:30 - 18:00 *Health Communication at the Population Level*

This session will focus on communication at the different levels of the Health Care System and the population, i.e. at the total population, the institutional and the individual levels. It should be realized that while the HCS may wish to convey messages to the heterogeneous population as a whole it finally is aimed at the individual and the family.

Chairperson:	**Zvi Stern**
14:30 - 15:00	**Nurit Guttman** (Israel) – The Challenges of Social Marketing of Health: Issues in a Culturally & Socially Diverse Population – the Case of Israel
15:00 - 16:00	**The Critical Role of Language** – Translation & Interpretation: A basic need for Health Communication **Miriam Schlesinger** (Israel) – The need in Israel **Nataly Kelly and Marjory Bancroft** (US) – Interpreter services both face-to-face and remote telephone/video interpretation and quality assurance
16:00 - 16:30	**Diane Levine** (Israel) – Health Literacy
Chairperson:	**Boaz Lev**
16:45 - 17:30	**Gary Kreps** (US) – Health Communication at the Population Level – Principles, Methods and Results
17:30 - 18:00	**Discussion**

Wednesday, October 10, 2007, Caesarea

09:00 - 13:00 *What Has and Can be Done?*

The objective of the morning session is to provide an insight into what has been done in CC and the results, to the extent they exist.

Chairperson:	**Jack Habib**
09:00 - 09:45	**Jürgen Pelikan** (Austria) – European Migrant Friendly Hospitals Project
09:45 - 10:30	**Joseph Betancourt** (US) – Boston Health Disparities Project/MASS General
10:30 - 11:00	**Anat Jaffe** (Israel) – Diabetes in immigrants from Ethiopia
Chairperson:	**Miriam Hirschfeld**
11:15 - 12:00	**Marjory Bancroft and Nataly Kelly** (US) – Culturally and Linguistically Appropriate Services Standards and the training of practicing health professionals in CC
12:00 - 12:45	**Robert Like** (US) – Graduate & Undergraduate Cultural Competence Education
12:45 - 13:15	**Film: "Hold Your Breath" and discussion**

14:15 - 16:30 *Initiating a Program Nationally in Israel*

This plenary session will be devoted to a discussion based on a position paper with a view to developing both policy and action in Israel. The Paper will be available to all participants at the meeting.

Chairperson: Avi Israeli

Introduction: Leon Epstein

Open Discussion

TRAINING DAY PROGRAM

Thursday, October 11, 2007, NIHP, Tel Hashomer

Cultural Competence in Action: Overcoming Language and Cultural Barriers in Health Care

Trainers: Marjory Bancroft and Nataly Kelly

09:00 - 12:15 *Language and Communication*

09:00 - 09:45 Cultural Competence and Health Inequalities

- **Goal:** Examine the impact of cultural competence on patient care and outcomes.
- **Objective 1:** Describe a rationale for linguistic and cultural competence in health care.
- **Objective 2**: Explore strategies for overcoming communication barriers.
- **Objective 3**: Develop a plan for culturally proficient care.
- **Overview of cultural and linguistic competence**
  - The role of language and culture in health disparities and inequalities
  - How language and culture affect access to care

09:45 - 10:30 A Rationale for Linguistic and Cultural Competence in Health Care

- The case for health communication and quality care
- The legal case: how language laws drive patient care
- The case for patient safety: adherence, medications and patient outcomes
- The business case: how language barriers affect costs, revenue, liability, unnecessary tests and public health

- The role of health literacy
- Standards and accreditation

11:00 - 12:15 **Practical strategies for overcoming language barriers**

- Language assistance in health care: contract interpreters, bilingual staff, telephonic services and "community language banks"
- International best practices for quality communication in health care
- How to work with interpreters and bilingual employees: basic skills
- Resources for health literacy

12:15 - 16:30 *Culture and Patient Care*

12:15 - 13:15 **Cultural communities in health care**

- How culture affects health care
- Bias and stereotypes
- The impact of culture on health outcomes

14:00 - 15:00 **Best Practices for Overcoming Cultural Barriers**

- Community-based strategies
    - Identifying underserved populations
    - Developing community partnerships
    - Communicating with communities
- Patient care
    - Communication skills and models
    - Reception areas/intake practices
- Organizational policies and procedures
    - Why policies and administrative support are vital
    - Organizational and employee self-assessment
    - Training and professional development
- Resources for cultural competence

15:15 - 16:30 **Developing a Cultural Competence Plan**

- Participant self-assessment
- Group planning exercises
- Next steps

LIST OF WORKSHOP PARTICIPANTS

Agmon-Snir Hagai	The Jerusalem Inter -Cultural Center
Aharonson Zeev	Meuhedet Sick Fund
Auslander Gail	School of Social Work, Hebrew University of Jerusalem
Aviram Alik	Israel National Institute for Health Policy Research
Avramov Rita	Hadassah Medical Organization
Balik Chaya	Sheonbrun Academic Nursing
Bin Nun Gabi	Ministry Of Health
Birkenfeld Shlomo	Israel Medical Association
Bisharat Bishara	Nazareth Hospital
Blachar Yoram	Israel Medical Association
Chinitz David	Hebrew University-Hadassah, School of Public Health
Cohen Arnon	Clalit Health Services
Cohen Celine	The Israel College
Daoud Nihaya	Ben-Gurion University of the Negev
Davidovitch Nadav	Ben-Gurion University of the Negev
Dekel Bianka	Israel National Institute for Health Policy Research
Doron Chaim	Israel National Institute for Health Policy Research
Ehrenfeld Mally	Tel Aviv University
Elroy Irit	Myers JDC Brookdale Institute
Epstein Leon	Hebrew University-Hadassah, School of Public Health
Fogel Ronit	Kaplan Nursing School
Geva Hana	Meuhedet Sick Fund
Golan Agneta	Ben-Gurion University of the Negev
Goldberg Avishay	Ben-Gurion University of the Negev
Gross Revital	Myers JDC Brookdale Institute
Grotto Itamar	Ben-Gurion University of the Negev
Guttman Nurit	Tel Aviv University
Habib Jack	Myers JDC Brookdale Institute
Hagoel Lea	Carmel Medical Center
Heymann Tony	Maccabi Healthcare Services
Hirschfeld Miriam	Emek Yezreel College
Horev Tuvia	Taub Center for Social Policy Studies in Israel
Ismail Shuruk	Yad Hanadiv
Jaffe Anat	Hillel Yaffe Medical Center
Kaplan Giora	Gertner Institute
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Karplus Miki	Ben Gurion University of the Negev
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Litvak Ziva	Israel National Institute for Health Policy Research
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Matikovski Vita	Meir Medical Center
Matz Eran	Leumit Health Fund
Morse Diane	Hebrew University School of Medicine
Nissim Sara	Zfat Nursing school
Ofer Gur	Israel National Institute for Health Policy Research
Oren Meir	Hillel Yaffe Medical Center
Peres Hagit	Ben-Gurion University of the Negev
Porter Boaz	Maccabi Healthcare Services
Revital Ben-David	Israel Medical Association
Rom Miriam	Hadassah Medical Organization
Rosen Bruce	Myers JDC Brookdale Institute
Rosenberg Eli	Ministry Of Health
Schuster Michal	Bar Ilan University
Seffefe Ayecheh	Ministry Of Immigration
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Sofer Tsipporah	Ben-Gurion University of the Negev
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Stern Zvi	Hadassah Medical Organization
Tabenkin Hava	Haemek Medical Center
Toren Orly	Sheba Medical Center
Valinsky Liora	Maccabi Healthcare Services
Wagner Nurith	Nurses Association
Weinstein Ruth	Ministry Of Health

Weiss Dorit	Clalit Health Services
Werber Giora	Clalit Health Services
Yisraeli Avi	Ministry Of Health
Ziv Amitai	Sheba Medical Center

GUEST SPEAKERS FROM ABROAD

Bancroft Marjory	Cross-Cultural Communications, LLC, USA
Betancourt Joseph R.	Harvard Medical School, USA
Kelly Nataly	Senior Analyst, Common Sense Advisory, USA
Kreps Gary L.	George Mason University, USA
Like Robert C.	Robert Wood Johnson Medical School, USA
Pelikan Jürgen M.	University of Vienna, Austria

LIST OF TRAINING DAY PARTICIPANTS

Adler Dorit	Hadassah Ein-Karem Hospital
Agmon-Snir Hagai	The Jerusalem Inter Cultural Center
Arieli Daniela	Hadassah- Hebrew University Medical Center
Balik Chaya	Sheonbrun Academic Nursing
Dayan Nivi	JDC-ISRAEL
Dreiher Jacob	Clalit Healthcare Services
Ecker Noa	Myers - JDC-Brookdale Institute
Ehrenfeld Mally	Tel Aviv University
Elroy Irit	Myers - JDC-Brookdale Institute
Endevelt Ronit	Maccabi Healthcare Services
Kaplan Giora	Gertner Institute
Levin Diane	Clalit Healthcare Services
Lison Lilach	Hadassah Ein-Karem Hospital
Man Michal	Emek Yezreel College
Noble Anita	Hadassah- Hebrew University Medical Center
Ohana Hanan	The Jerusalem Inter Cultural Center
Peres Hagit	Ben Gurion University of the Negev
Ramot Adi	Yoseftal Hospital
Rom Miriam	Hadassah- Hebrew University Medical Center
Schuster Michal	Bar Ilan University

Shaham Dorith	Hadassah- Hebrew University Medical Center
Shapira Ziva	Israel College
Shlesinger Miriam	Bar Ilan University
Shtarkshall Ronny	Braun School of Public Health, Hebrew University of Jerusalem
Vaknin Ofra	Hadassah Nursing Division
Valinsky Liora	Maccabi Healthcare Services
Ziv Amitai	Sheba medical center
Seffefe Ayecheh	Ministry Of Immigration
Vahab Hazel	Hadassah- Hebrew University Medical Center
Matz Eran	Leumit Health Fund
Herman Rivka	Hadassah- Hebrew University Medical Center
Wagner Nurit	Israel Nursing Association
Ulman Anne-Marie	Beer Yaakov Mental Health Center
Saado Inbal	Medical Simulation Center, Tel Hashomer