



The importance of addressing linguistic ethno-cultural diversity in the delivery of public health services: a literature review.

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Key Take Home Messages

1. Effective communication is central to providing culturally competent public health services to ethnic minorities. Such communication needs to address both different levels of English language proficiency and the need for culturally appropriate health messages. Better communication with ethno-cultural groups means improved involvement in preventive public health interventions and eventually better health outcomes.

2. The main ways of achieving effective communication (existent in the literature at fair and good levels of evidence) are:

1. Timely and appropriate use of professional interpreters in services with direct interaction with the clients. The use of 'informal interpreters' in health care settings is dangerous and must be actively discouraged⁶ (Grade B (IIb, III))
2. Provision of high quality culturally appropriate translated material (medico-legal documents or health promotion material) directed to specific ethno-cultural groups¹². (Grade B (IIb, III; B)).
3. Active engagement of the ethno-cultural community and reliance on bilingual community health educators in the process of actively delivering a public health service (health messages through community health promotion).^{5,18,25}(Grade B- IIb).

3. Health promotion initiatives created for the general population often do not work for ethno cultural communities due to⁵:

- Differences in English proficiency levels
- Different cultural norms and beliefs
- Differences in communication styles
- Perceived stigmatizing attitudes, racism and discrimination

preventing members of ethno-cultural communities from getting involved in health promotion activities and benefiting from the educational resources^{5,28,29}.

4. People in ethno-cultural communities are the best sources of information on the barriers they face in accessing any of the health care system levels. The process of working together and involving community members in a health promotion project also can help achieve the main goal

of health promotion: enabling people to increase the control they have over their health^{18,19,22}. (fair evidence)

5. Ethnic monitoring requires the identification of individuals as belonging to groups defined in terms of their culture and origin - this should include language (and possibly religion). In addition, an ethno-cultural analysis of the main cultural norms and barriers related to health behaviours and beliefs in different ethnic groups can provide further insight in specific health promotion strategies³⁰⁻³². (grade C)

6. Developing culturally appropriate language support policies and practices might require the involvement of other regional governmental levels and organizations for a better use of existent resources and better ethnic monitoring³²

Executive Summary

Background:

Census data from 2001 and 2006 show that nearly half of Peel's population were immigrants (48.6% according to the 2006 Census) up from 43.1% in 2001, the proportion of population with neither English nor French as mother tongue dropping from 63% in 2001 to 56% in 2006, and over a third of Peel's population speaking a non-official language at home. In fact, there are over 70 different languages spoken at home in Peel, and 3.74% of Peel residents compared to 2.22% for all of Ontario report to be unable to speak English or French.

Peel Public Health's 10-year Strategic Plan has committed through the infrastructure priority on ethno-cultural diversity to understand the concepts of health and wellness as they are understood and experienced by the range of diverse populations in Peel Region and, as a result, to create programs and services that remove any barriers, facilitate access and promote participation/utilization.

Objective:

The aim of the present literature review is to identify and critically appraise the available evidence on the importance and effectiveness of addressing the ethno-culturally appropriate language needs of multicultural communities targeted by core public health services, within the broader concept of providing ethno- culturally competent public health programs.

The review was conducted to provide a succinct, evidence –based list of key recommendations to inform policy and practice related to program planning and evaluation in Peel, addressing the ethno- cultural diversity infrastructure priority outlined in the 10- year Strategic plan.

The specific research question used for this literature review was whether the delivery of public health programs in multiple languages improves access to and use of primary health care services, especially public health services offered in the community, increases client satisfaction and/or results in improved perceived health or health status indicators in a multi- ethnic multicultural population when compared with the delivery of the same program using only the mainstream official language(s).

Methods:

We conducted an extensive literature search, limited to the English language, in Ovid (Medline), PubMed, CINAHL, EMBASE and PsycINFO for publications between 1996 and October 2009. We also searched the Cochrane Library and healthvidence.ca, as well as reference lists of articles of interest. In addition, we did a web-based search looking at websites such as: NHS-ethnicity and health, Canadian Best Practice Portal, Community Guide, BMC, Campbell Collaboration. The search strategies and the number of references generated are illustrated in Appendix 1. We selected systematic reviews or high quality primary studies comparing the delivery of multi-lingual programs with programs using only the mainstream official language. The inclusion/exclusion criteria for the selected articles are illustrated in Appendix 2.

Results:

The key findings are organized under the following 3 specific headings which can be related to practice areas and policy directions:

1. Meeting the direct language needs during program delivery (interpreter services for the client-provider interaction and translation of the medical or medico-legal documents):

There is substantial, recent evidence in favour of providing proper language support, with demonstration of adverse effects linked to its absence.^{6,7} Published studies report positive benefits linked to the use of professional interpreters in clinical encounters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care.⁶ (Grade B evidence (IIb, III)). Moreover, the interpreter's competence and the style of interpreting seems to have an important role in the clinical encounter's immediate or long-term outcomes, such as compliance with the recommendations and treatment, patient satisfaction and trust in medical services and provider¹¹ (Grade B evidence (III)). However, there is still little research on the cost-effectiveness of implementing adequate translation services (involving both interpreters and translation of medical documents).¹⁰ More needs assessments may be required, but they should be tied to guaranteed resourcing and evaluation. Furthermore, adequate time and resources should be allocated to ensure that initiatives are fully worked through. Training in overcoming language barriers is needed for both users and providers of health care services.

II. Health promotion materials and interventions: In health promotion there are various ‘models that work’ and an array of approaches and procedures for successful health promotion at the very local level¹⁴⁻²⁰. (Grade B-IIa-III, Grade A) The language barrier is influencing accessibility and uptake of the cancer screening programs independently of other several important factors, such as income, level of education, insurance status, and self-related health status. (Grade B-level III, cross-sectional) A common theme of all studies has been an assertion of the need to move away from printed materials and passive dissemination, and towards audio-visual presentation and active engagement with minority communities.¹⁴⁻¹⁷ Combinations of verbal, written and multimedia messages prove more effective.¹⁸⁻²¹ More study is needed to ascertain the effectiveness of the use of existing media, new media and an expanding arsenal of technological advancements for the dissemination of health information, particularly at the interface between information dissemination and minority ethnic groups. (Grade C-IV)

III. Procedures for managing and planning for linguistic diversity: The provision of language and cultural support services is still in a developmental phase and there is still a lack of systematic evaluation to explore how such services might relate to the stakeholders and structures specific to the existent health care system. A degree of consensus exists around the importance of working with communities locally, needs analysis being seen as an essential element, integrating cultural awareness and training for staff, and understanding the roles and abilities of different levels of language intermediary²⁶⁻³². (IIa-III; C)

Conclusions:

Effective communication is central to maintaining the quality of health care, especially in respect of the needs of members of all ethno-cultural and linguistic minorities. Improved language access has a positive impact on behavioural changes targeted through preventive interventions (i.e. diabetes management or cancer screening uptake), proven in the Asian immigrant community.

Translating material into other languages can send out an important signal to minority communities about intentions to be inclusive. Messages must be specifically tailored to their audience, taking religious and other beliefs and practices into account.

Outreach work by members of the minority ethnic community, the use of video projects to gather views, and the use of bilingual, volunteer ‘community inter-actors’ or ‘link-leader’ as an educator seem to have the best results. In addition, involving the community in planning, design and delivery of interventions empowers and engages the minority groups in the public health intervention as true partners.

Despite that there are several promising strategies to increase involvement of ethnic groups in preventive interventions, studies specifically targeting disease areas and processes of care are still needed.

Full Report

Background

In Ontario, the 2006 Census shows that 28.3% of Ontario's total population identify themselves as immigrants. Peel had the second highest percentage of immigrants in the GTA behind Toronto. Census data from 2001 and 2006 as well as information from internal Region of Peel planning documents show that nearly half of Peel's population were immigrants (48.6% according to the 2006 Census) up from 43.1% in 2001¹.

Since the 2001 Census, Canada has seen an 18.2% increase in individuals who speak neither of the two official languages (Statistics Canada, 2007a). In Peel, the proportion of the population with English or French as a mother tongue dropped from 63% in 2001 to 56% in 2006, and over a third of Peel's population reported speaking a non-official language at home. In fact, there are over 70 different languages spoken at home in Peel. The percentage of Peel residents reportedly unable to speak English or French is somewhat higher than the provincial average; 3.74% compared to 2.22% for all of Ontario¹. In addition, Peel had the highest percentage of visible minorities within the GTA; this percentage increased from 38% in 2001 to 50% in 2006 (2006 Census). Brampton has the second highest percentage of visible minorities in the GTA with 57% of its residents reporting belonging to a visible minority. Mississauga is third highest in the GTA with 49%. Furthermore, one in four people living in Peel in 2006 identified themselves as South Asian.²

Research shows that not speaking the culture's predominant language is a key barrier to receiving culturally sensitive health care services³. Evidence further shows that members of ethno-cultural communities have a much lower rate of participation in health promotion, prevention and treatment programs, and are less likely to receive needed care than the general population due to systemic and service barriers which include language and cultural factors, discrimination, stigmatizing attitudes and mistrust of mainstream service providers.^{4,5}

The concept of 'ethnicity' recognises that people identify themselves with a social grouping on cultural grounds including not only language, but also lifestyle, religion, food and origins. Furthermore, in a world of migration and mixing, it is essential to recognise that these cultures and societies are dynamic

rather than fixed. A definition of “cultural competence” as it relates to the health care setting in general entails: “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.”³

Peel Public Health’s 10-year Strategic Plan has pledged through the ethno-cultural diversity infrastructure priority to understand the concepts of health and wellness as they are understood and experienced by the range of diverse populations in Peel Region and, as a result, to create programs and services that remove any barriers, facilitate access and promote participation/utilization.

Objectives:

The aim of the present literature review is to identify and critically appraise the available evidence on the importance and effectiveness of addressing the ethno-culturally appropriate language needs of multicultural communities targeted by core public health services, within the broader concept of providing ethno- culturally competent public health programs.

The review was conducted to provide a succinct, evidence –based list of key recommendations to inform policy and practice related to program planning and evaluation in Peel, addressing the ethno- cultural diversity infrastructure priority outlined in the 10- year Strategic plan. More specifically, the relevant literature findings would suggest ways to address specific language needs involved in providing public health programs that are barrier –free and accessible to all ethno-cultural groups living in Peel.

The specific research question used for this literature review was whether the delivery of public health programs in multiple languages improves access to and use of primary health care services, especially public health services offered in the community, increases client satisfaction and/or results in improved perceived health or health status indicators in a multi- ethnic multicultural population when compared with the delivery of the same program using only the mainstream official language(s).

Methods

We conducted an extensive literature search, limited to the English language, in Ovid (Medline), PubMed, CINAHL, EMBASE, PsycINF, as well as the Cochrane Library and healthvidence.ca for publications between 1996 and October 2009. In addition, we did a web-based search looking at relevant websites such as: NHS- ethnicity and health, Canadian Best Practice Portal, Community Guide, BMC, Campbell Collaboration and a hand-search of the following public health core journals: Canadian Journal of Public Health, Health Promotion International, Health Education and Behaviour, American Journal of Prevention Medicine. Additional articles were added after looking at the reference lists of the initially retrieved articles.

The search strategies, developed in collaboration with two librarians working with Peel Public Health, and used for the electronic data bases, together with the number of references generated are illustrated in Appendix 1. The final articles selection was done based on the type of intervention relevant to public health programming in Canadian settings, or in communities with a similar ethno-cultural composition, as well as on the quality of the study (using the EIDM framework and CASP critical appraisal tools). The inclusion/exclusion criteria for this review are in the Appendix 2. Selected articles are listed in Appendix 3. The evidence grading system can be found in Appendix 4.

Results:

The review is based on 21 studies emerging from countries and regions that experience population diversity similar to Canada (including USA, United Kingdom and Australia) and that are committed to improve their health care systems cultural competency specifically addressing the linguistic needs of their population.

The literature review's main findings are organized under the following 3 main areas of providing culturally appropriate language services in public health interventions, which can more easily related to practice areas and policy directions:

- 1. Meeting the direct language needs during program delivery (interpreter services for the client-provider interaction and translation of the medical or medico-legal documents)**

The selected studies are from clinical care settings, as no appropriate studies were found to refer specifically to the impact of professional translators in public health clinical or non-clinical encounters. However, the results seen in primary care and emergency services settings can be easily applicable to the public health programs involved in clinical care (specialized primary care clinics, i.e sexual health, TB, vaccination, dental care clinics).

There is substantial, recent evidence in favour of providing proper language support, and demonstration of adverse effects linked to its absence.^{6,7} Published studies report positive benefits linked to the use of professional interpreters in clinical encounters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care.⁶ (Grade B evidence (IIb, III)). Moreover, the interpreter's competence and the style of interpreting seems to have an important role in the clinical encounter's immediate or long-term outcomes, such as compliance with the recommendations and treatment, patient satisfaction and trust in medical services and provider¹¹ (Grade B evidence (III)). In addition, without quality translations of medical documents in the language of their patients, clinical providers cannot provide best quality care, and patients are at risk of receiving inferior care. (Grade B (IIb, III; B)). However, there is still little research on the cost-effectiveness of implementing adequate translation services (involving both interpreters and translation of medical documents).¹⁰ More needs assessments may be required, but they should be tied to guaranteed resourcing and evaluation. Furthermore, adequate time and resources should be allocated to ensure that initiatives are fully worked through. Training in overcoming language barriers is needed for both users and providers of health care services.

The literature reviewed for this area can be divided in 2 subcategories: one category dealing with interpreter services needed during the direct client-provider interaction and the second category dealing with the actual translation of the medical or medico-legal documents used as part of the client-provider written communication.

a. Provision of interpreter services for client-provider interactions

One systematic review (based on 28 studies)⁶ and 2 primary studies^{8,9} were selected to look at the impact of professional interpreters on the quality of the encounter, defined by

different outcome measures most likely to either impact or reflect disparities in health and health care.

Recent evidence supports the claim that the use of professional interpreters to provide proper language support during the client-provider interaction results in positive benefits in all four outcome measures. In addition, the evidence demonstrates adverse effects linked to the lack of appropriate interpreter services support. There is little research into cost-effectiveness, or into the direct clinical implications of introducing adequate interpreter services and how the interpreter's competence and the style of interpreting are impacting on any of the above mentioned outcomes.

The systematic review by Karliner et al.⁶ (2007) rated as fair evidence (Grade B- levels IIb and III) and based on 28 peer-reviewed studies comparing at least two language groups, as well as containing data about professional medical interpreters, reports positive benefits of professional interpreters vs. ad-hoc interpreters or no interpreters on communication, service utilization, clinical outcomes and satisfaction with care. In all four areas examined, the use of professional interpreters was associated with improved clinical care more so than the use of ad hoc interpreters, and professional interpreters appeared to raise the quality of clinical care for low English proficiency patients to approaching or equal that for patients without any language barriers. The studies included in the review were mainly from the US (71%) and were peer-reviewed, retrospective cohort or case series studies, ranging in evidence from levels IIb to III.

One of the primary studies (Sarver et al⁹, 2000) taken into consideration comes from a more comprehensive review on culturally competent healthcare systems (Anderson et al⁸. 2003) also posted on the US Guide to Community Preventive Services⁸ (www.thecommunityguide.org/social/interpreterservices.html). Last updated: 26/10/2009. Accessed Nov. 20, 2009). This review looked at five interventions aimed at improving cultural competence in healthcare system, the use of interpreter services or bilingual providers for clients with limited English proficiency being one of them (the other 4 interventions were: programs to recruit and retain staff members who reflect the cultural diversity of the community served, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings), and concludes

that because only one comparative study with fair quality of execution was available there was insufficient evidence to determine the effectiveness of using interpreter services or bilingual providers for clients with limited English proficiency, regardless of the fact that this individual study (Sarver et al, 2000) concluded that clients who reported that an interpreter was needed but not used were more likely to be discharged without a follow-up appointment than clients with language-concordant physicians (OR=1.79, 95% confidence interval =1.00, 3.23).

The second primary study¹⁰ (Bernstein , 2002) was a retrospective cohort study done in an US emergency department (ED) set up to investigate the impact of an Interpreter Service on the intensity of ED services, utilization, and charges, by describing the effects of language barriers on health care service delivery for the index ED visit and a subsequent 90-day period. The sample was limited to four languages— English and the three other most commonly spoken languages in the examined patient population: Spanish, Haitian Creole, and Portuguese Creole, in order to reach a sufficient number of subjects for analysis. The study brought fair evidence that the use of trained interpreters was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without any simultaneous increase in length of stay (LOS) or cost of visit.

The paper by Wallin et al.¹¹ (Cross-cultural interview studies using interpreters: systematic literature review; 2006) was included in this sub-category as it raised important issues related to the interpreter's role/involvement in the research process involving multi-ethnic groups. Even though the paper refers to the research settings, the conclusions can be extrapolated to the clinical settings as well: the interpreter's competence and style can have an impact on the clinical encounter immediate or long-term outcomes, such as compliance with the recommendations and treatment, patient satisfaction and trust in medical services and provider.

b. The translation of the medical or medico-legal documents

Despite a growing number of patients who do not speak English fluently in countries with English as an official language, little literature attends to issues of accurate translation of medical documents from English to different other languages. The review by Garcia-Castillo et al.¹² (2007) analyzed the quality of medical translations in 44 relevant articles, in terms of factors that

affect the quality of translated medical documents or clinical instruments, types of errors that occur during the translation process and potential consequences, and solutions to problems arising during medical documents translation. Two major themes were revealed: 1) mechanics/practicalities of translating medical documents, and 2) extrinsic factors influencing medical translations.

Balancing mechanics of translation and practicalities influences translation quality. Most translators agree that the meaning of the text should take priority over syntax, grammar, and sentence structure. Fifteen articles in this review stressed the importance of striving for cultural equivalence and considering socio-demographic issues when translating. Since the quality of translation depends mainly on the knowledge and judgment of the translator, a translated text may have errors. Therefore, it is important to consider potential errors and possible consequences of mistranslation. Back-translation was considered a good way to improve the accuracy of translated text by highlighting different possibilities and challenging the translator's choices. Of extrinsic factors affecting medical translation, legal issues and socioeconomic factors were discussed most frequently in these articles. Six articles discuss the relevance of and need for appropriate public health policies on medical translation. This review concludes that medical translation is a complex process involving far more than mechanically converting one language to another, and that attention to translation procedures can improve the quality of care for patients with limited English proficiency. Offering all patients culturally equivalent written information is one mechanism to fight health disparities and discrimination. From both legal and ethical perspectives, availability of medical forms in the patient's language is imperative. (Grade C evidence- III, IV).

II. Health promotion materials translation and multilingual intervention

Nine papers (6 of them from Canada) were selected for this area: 3 systematic reviews, one cross-sectional study and 5 qualitative studies, all supporting the idea that the various 'models that work' in health promotion use an array of approaches and procedures at the very local level addressing specific needs of ethno-cultural groups. (Grade B-IIa-III) It seems that the language barrier is influencing accessibility and uptake of the cancer screening programs independently of other several important factors, such as income, level of education, insurance

status, and self-related health status. (Grade B-level III, cross-sectional) A common theme of all studies has been an assertion of the need to move away from printed materials and passive dissemination, and towards audio-visual presentation and active engagement with minority communities.¹⁴⁻¹⁷ Combinations of verbal, written and multimedia messages prove more effective.¹⁸⁻²¹ More study is needed to ascertain the effectiveness of the use of existing media, new media and an expanding arsenal of technological advancements for the dissemination of health information, particularly at the interface between information dissemination and minority ethnic groups. (Grade C-IV)

The Cochrane review by Hawthorne et al.¹⁸ (2008) looked at culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups and selected 11 randomized controlled studies meeting the inclusion criteria, 10 of which were included in a meta-analysis. In this review, 'culturally appropriate' health education was defined as any type of diabetes health education which has been specifically tailored to the cultural needs of a target minority group. Based on the outcome measures analysis, culturally appropriate health education improved blood sugar control in participants (HbA1c levels), compared with those receiving 'usual' care, at three and six months post-intervention, which could be of potential clinical importance if sustained. Knowledge about diabetes, and healthy lifestyles also improved. (Grade A evidence – level Ib). One important limitation of these studies was that none of them were long-term, and so clinically important long-term outcomes such as weight and BP, could not be sufficiently concluded on. None of the other clinical outcome measures such as cholesterol, blood pressure or weight showed any improvement. No studies included an economic analysis, and the heterogeneity of studies made subgroup comparisons difficult to interpret with confidence. Nevertheless, there are still important findings regarding the relationship between patient knowledge related to diabetes care and a sense of self-effectiveness in managing the diet and the anti-diabetic treatment. The review on the use of linguistically and culturally appropriate health education materials found on the Guide to Community Preventive Services¹³ website (www.thecommunityguide.org/social/educationmaterials.html. Last updated: 26/09/2009. Accessed Nov. 20, 2009) and included in the paper by Anderson et al.⁷ (Culturally competent health care systems; 2003), concluded that there was insufficient evidence to determine the effectiveness of interventions to provide linguistically and culturally appropriate health education

materials, due to the small number of comparative studies assessing outcomes relevant to this systematic review, as well as limitations in their execution (Grade B-III, insufficient evidence). When looking at the individual studies in this review, the four of them examined the effectiveness of culturally sensitive health education videos¹⁴⁻¹⁷, but only one of these studies reported a change in health behaviours¹⁷. The remaining studies included measures of patient satisfaction with the cultural relevance of the public health intervention. Three of the studies were looking at culturally sensitive AIDS educational videos for African American audiences including adults, women and teenagers, and targeting increase in risk sensitization and knowledge. The fourth study looked at the impact of brief smoking prevention videotapes on smoking cessation among African-American adolescents, and showed positive results. (Grade B- IIc-III)

The cross-sectional analysis¹⁸ of the 3-year Pap test use among US women ages 18 to 64, (Ponce et al. 2006), had as its the objective to determine whether primary language use, measured by language of interview, is associated with disparities in cervical cancer screening. This study was chosen for its analysis of possible confounders (ie. race/ethnicity, marital status, income, educational attainment, years lived in the United States, insurance status, usual source of care, smoking status, area of residence, and self-rated health status) that might interfere with the language role as a barrier to the accessibility and uptake of cancer screening interventions. Compared with the referent English interview group, women who interviewed in Vietnamese had a significantly reduced probability of screening (OR= 0.67; 95% CI: 0.48–0.93), with similar results found for women who interviewed in Cantonese (OR 0.44; 95% CI 0.30–0.66), Mandarin (OR 0.48; 95% CI 0.33– 0.72), and Korean (OR 0.62; 0.40–0.98), even when important factors were controlled for in the statistical analysis. The authors concluded that improved language access could reduce cancer screening disparities, especially in the Asian immigrant community. (Grade B- III)

The systematic review by Black et al.²² (2002) looked at the effectiveness of the community –based strategies available to public health staff to increase cervical cancer screening, especially in the hard-to-reach minority groups. Of 42 relevant studies, 1 was rated ‘strong’, 18 ‘moderate’ and 23 ‘weak’.

Among the strong/moderate studies, 10 were aimed at disadvantaged women. The most frequently used intervention was mass media campaigns, alone or combined with individual strategies; followed by individual education using lay health educators; and last, letters of invitation. Thirteen of the moderate/strong studies evaluated strategies that reported statistically significant increases in Pap smear rates and other outcomes. The authors concluded that strategies that combined mass media campaigns with direct tailored education to women and/or health care providers seemed most successful. Minority groups may indeed be more responsive to small culturally sensitive education methods, often relying on lay health educators, rather than community-based broad strategies. (Grade B- level IIb).

In the same category of cancer screening uptake, but this time in a qualitative research paper, by Black et. al.²⁵ (2006) the authors involved the community at different steps in the program development with the aim of improving the detection of breast and cervical cancer in Chinese and Vietnamese immigrant women in Ontario, doing an ethno-graphic analysis of culturally appropriate public health interventions. The project had not only increased cancer screening among immigrant women but had also transformed PHNs' work with underserved women in the city, as the authors concluded. Public health practitioners learned about the importance of listening as immigrant women tell their stories and therefore understand more fully the barriers they face in accessing health care, including early detection of cancer.

In a similarly qualitative, but more process oriented type of study, Howlet et. Al.²³ (2009) outlines the consultation/development process and evaluation strategy for promoting cancer screening among Chinese women with limited English language skills in Ontario communities. Acknowledging that there are inherent challenges in reaching newcomers to Canada in cancer screening interventions, the paper looked at how culturally appropriate materials and multi-pronged strategies for effective outreach in the Chinese community can be obtained as a process. Through coordinated facilitation of material development with active stakeholder engagement, enhanced interactions among CCO's screening and prevention programs and partners have been noted, including Canadian Cancer Society, public health units and other community agencies/organizations. This was a striking example of the power of collaboration with community partners and stakeholders to meet the needs of a vulnerable

population. Strong partnerships were found to be essential in developing customized interventions that are meaningful for specific target populations. Collaboration was essential for project success and to ensure that the best materials are available to meet the unique needs of specific communities and ethno/cultural groups. The authors present this multi-year project as a template that can be further adapted and used in other ethno-cultural groups within and outside Ontario. Further impact assessment of the materials created through this process is expected to be done in 2009.

When looking at specific disease risk factors in South Asian population, the qualitative research paper by Iftexhar Mian et al.²⁰ (2009) is tackling the issue of dietary education tools targeting specifically South Asians with diabetes. Their perceived needs and preferences for diet counselling resources were examined based on the newly revised Canadian Diabetes Association meal planning guide. The study provides a useful model for developing culturally relevant diet counselling teaching tools, useful in tackling challenges in resource development caused by the diversity of South Asian languages, religions, holidays, and dietary customs, as well as the potentially differing degrees of acculturation. The approach used in this study included detailed exploration of cultural dietary practices and evaluation of major dietary counselling tools and concepts, both with diet counselors and members of the relevant cultural community. The study used 5 focus groups from different regions of South Asia (n=53), which discussed portion size estimating methods, cultural values and holidays, food group classifications, and common South Asian foods. A focus panel with dieticians (n=8) provided insight on current diabetes education methods and resources for teaching South Asian clients. The dietician panel members reported a need for resources targeted at differing client skill levels. They also noted preferences for individual counselling, and common barriers to education including finances, access, South Asian diets, and cultural views on health. Resources in South Asian languages, inclusion of pictures, as well as the inclusion of food groups for legumes, sweets, and snacks were preferred. This study's findings can be very well used when developing new counselling tools for the South Asian community.

The qualitative study done by CAMH⁵ on best practices in community education in mental health and addiction, specifically addressing alcohol use and low risk drinking levels (Agic B et al. 2005) concluded that language was identified by the focus group participants as one of the greatest barriers in access to health programs for people of non-English speaking background. What is considered mental illness and substance use problem is largely shaped by cultural norms, attitudes, and beliefs. No single definition of “normal” drinking, problem drinking, or alcohol dependence can apply equally to all cultures. Concepts that reflect the dominant culture are often not directly transferable to communities with different cultural background. Original material, including both text and the graphical elements, needs to be culturally adapted to reflect cultural values and social norms of the intended community. Direct translation, which does not take cultural concepts into account, limits the usefulness of health information. Evidence-based practice demonstrates that working in partnership with community groups and community-based agencies helps reach the intended audience, identifies culturally competent strategies, and gives more credibility to the message. Effective adaptation and translation require extensive testing with the intended audience during all phases of message development. Program effectiveness also depends on the mode of delivery, which is often culturally specific. Working in partnership with community groups and/or community-based organizations is the best strategy to ensure effectiveness of health education initiatives.

In a field as sensitive as sexual health, especially for immigrants from countries where sex education is not delivered to youth, the paper by Maticka-Tyndale et al.²⁴ (2007) explores in a series of qualitative interviews the needs and experiences of Iranian immigrants in Canada. The results are specific to this ethnic group’s experiences related to barriers accessing and using sexual health services, but language barriers, cultural misunderstandings, embarrassment, long waits, and limited time that physicians spend with patients can be applicable to other ethnic groups as well. The authors concluded that more attention needs to be paid to developing public health and medical services related to sexual health that take account of the cultural diversity represented in the Canadian population.

III. Procedures for managing and planning for linguistic diversity

The provision of language and cultural support services is still in a developmental phase with a lack of systematic evaluation of the existent international experience in the field (i.e. UK

and Australia) to explore how such services might relate to the stakeholders and structures existent in Canada, and more specifically in Peel.

A review of health promotion theories and strategies for new immigrant women, done by Hyman et al.²⁸ (2002) and conducted for the Ontario Women's Health Council looked at effective theoretical models and health promotion strategies for women. It is acknowledged that new immigrant women represent a diverse group, which often face multiple cultural, linguistic, and systemic barriers to adopting and maintaining healthy behaviours. The review made recommendations focused on reducing informational, cultural, linguistic, economic and systemic barriers to care, and on involving the community in planning, design, and delivery of interventions by using the community "link leaders".

Health promotion activities for all women should address theoretical variables as well as broader determinants of women's health. Many theoretical constructs of potential importance to recent immigrant women have not been adequately researched. More research is also needed on the relevance and the applicability of commonly used health promotion approaches for this group.

The systematic literature review by Beach et al.²⁹ (2006) that analyzed and synthesized the findings of 27 controlled studies (RCT and other controlled studies) evaluated interventions targeted at health care providers to improve health care quality or reduce disparities in care for racial/ethnic minorities. Almost all (n = 26) took place in the primary care setting, and most (n = 19) focused on improving provision of preventive services. Only two studies were designed specifically to meet the needs of racial/ethnic minority patients. All 10 studies that used a provider reminder system for provision of standardized services (mostly preventive) reported favourable outcomes. The following quality improvement strategies demonstrated favourable results but were used in a small number of studies: bypassing the physician to offer preventive services directly to patients (2 of 2 studies favourable), provider education alone (2 of 2 studies favourable), use of a structured questionnaire to assess adolescent health behaviours (1 of 1 study favourable), and use of remote simultaneous translation (1 of 1 study favourable).

Interventions employing more than one main strategy were used in 9 studies; however no consistent results were recorded. There were limited data on the costs of these strategies, as only one study reported cost data. Several promising strategies were proposed, that may improve

health care quality for racial/ ethnic minorities especially in the field of preventive care services, but the fact that the studies reporting them were not specifically targeting disease areas or processes, makes the evidence only fair, and draws the attention for a need for further research.

A degree of consensus exists among the papers selected with regards to the importance of working with communities locally, needs analysis being seen as an essential element, integrating cultural awareness and training for staff, and understanding the roles and abilities of different levels of language intermediary²³⁻²⁵. (B-IIa to C - IV)

The report done by the Commission for Healthcare Audit and Inspection³⁰ (2009) summarizes a range of work undertaken by the Healthcare Commission and looks at the extent to which the NHS in England is meeting the basic legal building blocks in promoting race equality. The report summarizes the available data on the ethnic make-up of the national population and NHS workforce, and examines some of the health needs of different ethnic groups, and some of the different experiences of health services.

It also highlights some of the legal obligations of the NHS in meeting its race equality duties and in this view reviews the progress on the performance by NHS trusts in promoting race equality. The recommendations made are specific to the Department of Health, commissioners and providers of services in the UK. The value of the report resides in further evaluation of how such international experience might be applicable to the Canadian current situation.

The international experience is valuable, but some of it relies on ethnic monitoring/data collection done at a more consistent level across the health care system than in Canada, as the needs of minority ethnic groups are more often recognized as important to be addressed in health equity audits and health impact assessments experience.

Conclusions

Effective communication is central to maintaining the quality of health care, including public health services, especially with respect to addressing the needs of all ethno-cultural and linguistic minorities. Improved communication addressing both English language proficiency and the need for culturally appropriate health messages and medical documents has been proven

to contribute to improved participation of the minority groups in preventive interventions in related their specific risk factors to certain diseases.(i.e. diabetes, hypercholesterolemia, obesity, cardio-vascular diseases, cancer screening)^{5,18-20}. The lack of proper translation and interpreter services can have a negative impact on the clinical encounter and eventually on the health status of the ethnic minority groups.

Translating material into other languages can send out an important signal to minority communities about intentions to be inclusive. Messages must be specifically tailored to their intended audience, taking religious and other beliefs and practices into account²¹⁻²³.

Outreach work by members of the minority ethnic community, the use of video projects to gather views, and the use of bilingual, volunteer ‘community inter-actors’ or ‘link-leader’ as educators seem to have the best results^{25,28,29}. In addition, involving the community in planning, design and delivery of interventions empowers and engages the minority groups in the public health intervention as true partners.

Despite the fact that there are several promising strategies to increase involvement of ethnic groups in preventive interventions, studies specifically targeting disease areas and processes of care are still needed.

Health promotion initiatives created for the general population often do not work for ethno - cultural communities. Several factors, such as differences in English proficiency levels, different cultural norms and beliefs, differences in communication styles prevent members of ethno-cultural communities from getting involved in health promotion activities and benefiting from all existent educational resources.

People from ethno-cultural communities are the best sources of information regarding the barriers they face in accessing any of the health care system levels. The process of working together and involving community members in a health promotion project also can help achieve the main goal of health promotion: enabling people to increase the control they have over their health.

The main recommendations for achieving effective communication based on fair and good evidence in the literature are:

-
4. Timely and appropriate use of professional interpreters in services with direct interaction with the clients. The use of 'informal interpreters' in health care settings is dangerous and must be actively discouraged
 5. Provision of high quality culturally appropriate translated material (medico-legal documents or health promotion material) directed to specific ethno-cultural groups.
 6. Active engagement of the ethno-cultural community and reliance on bilingual community health educators in the process of actively delivering a public health service (health messages through community health promotion).

Developing culturally appropriate language support policies and practices will require organizational infrastructure change and the involvement of other regional governmental levels and organizations for a better use of existent resources and better ethnic monitoring.

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Appendices

Appendix 1: Search Strategies

Database: Ovid MEDLINE(R) <1996 to November Week 3 2009>

Search Strategy # 1:

- 1 (cultural diversit* or multiculturalism* or multi-culturalism*).tw. (705)
- 2 exp Ethnic Groups/ (47658)
- 3 exp Culture/ (48432)
- 4 or/1-3 (89438) - P
- 5 public health.mp. (71262)
- 6 program.mp. (145155)
- 7 Community Health Services/ (7675)
- 8 public health.mp or community health services/ (78029)
- 9 (program and (public health or community health services)).mp. [mp=title, original title, abstract, name of substance word, subject heading word, unique identifier] (8362)- (public health program as intervention)
- 10 4 and 9 (540)- P (ethnic group) and I (public health program)
- 11 Language/ or language.mp. (46847)
- 12 (multi-language or multilanguage).tw. (19)
- 13 (multi-lingual or multilingual).tw. (318)
- 14 Language/ or language.mp. or (multi-language or multilanguage).tw. or (multi-lingual or multilingual).tw. (47000)- I (language related)
- 15 10 and 14 (32)- P(cultural) & I (multi-language & public health programming)
- 16 4 and 14 (4428) – P(cultural) &I (language related intervention not limited to public health)
- 17 4 and 5 and 6 and 14 (22) - P&I (language & related to public health/ community health services programs)
- 18 8 and 16 (156) P&I (language & related to public health/ community health services not limited to programs)
- 19 limit 18 to "review articles" (16)
- 20 Health Status/ (32856) Outcome
- 21 18 and 20 (8) P&I (language & related to public health/ community health services not limited to programs) & O (health status)
- 22 16 and 20 (188) P(cultural) &I (language related intervention not limited to public health)&O(health status)
- 23 limit 22 to "review articles" (11)
- 24 Health Status Disparities/ (1616) O
- 25 18 and 24 (3) P&I (language & related to public health/ community health services not limited to programs)& O (Health Status Disparities)
- 26 10 and 24 (9) P (ethnic group) and I (public health/community health services program) & O (health status disparities)

- 27 9 and 24 (25) I (public health/community health services program) & O (health status disparities)
- 28 Translating (1325) I
- 29 Language/ or language.mp. or (multi-language or multilanguage).tw. or (multi-lingual or multilingual).tw. and Translating/ (584)
- 30 18 and 29 (7) P&I (language and translating & related to public health/ community health services not limited to programs)
- 31 4 and 5 and 28 (10) P & I (public health and translating)
- 32 Patient Education as Topic/ (36250) I
- 33 Language/ or language.mp. or (multi-language or multilanguage).tw. or (multi-lingual or multilingual).tw. and Translating/ and Patient Education as Topic/ (18) I (language & translating& patient education)
- 34 18 and 32 (10) P&I (language & related to public health/ community health services not limited to programs and patient education)
- 35 Health Promotion/ (25977) I
- 36 16 and 35 (95) P(cultural) &I (language related intervention not limited to public health and Health Promotion)
- 37 limit 36 to "review articles" (13)
- 38 6 and 36 (25) P(cultural) &I (language related intervention not limited to public health and Health Promotion and program)
- 39 15 and 35 (7) P(cultural) & I (multi-language & public health programming& Health promotion)
- 40 Communication barriers/ (2646) O
- 41 16 and 40 (450) P(cultural) &I (language related intervention not limited to public health)& O (Communication barriers)
- 42 8 and 41 (25) P(cultural) &I (language related intervention limited to public health/ community health services)& O (communication barriers)
- 43 15 or 17 or 19 or 21 or 23 or 25 or 26 or 27 or 30 or 31 or 33 or 34 or 37 or 38 or 39 or 42 or 43 (153)
- 44 from 43 keep 3, 5-9, 15-16, 25, 31, 38... (47)

PubMed

Search #1 (((("cultural diversity"[MeSH Terms]) AND "language"[MeSH Terms]) AND "delivery of health care"[MeSH Terms]) AND "communication barriers"[MeSH Terms]) AND "outcome and process assessment health care"[MeSH Terms] Limits: Humans

Appendix 2: Inclusion/Exclusion Criteria

- Systematic reviews, or high quality primary studies (quantitative or qualitative) that looked at specific public health programs delivered using multiple languages vs. programs using only the mainstream official language
- The studies' quality was assessed using CASP or HealthEvidence.ca tools
- The intervention done in the healthcare system, preferably in a public health setting
- Canadian settings, or similar multicultural communities (similar population composition, similar political situation)
- Aim to cover studies in all 3 main areas in which language could have an important impact in service uptake and different types of outcomes, such as health status and patient satisfaction :
 1. *Meeting the direct language needs during program delivery (interpreter services for the client-provider interaction and translation of the medical or medico-legal documents)*
 2. *Health promotion materials translation and multilingual interventions*
 3. *Procedures for managing and planning for linguistic diversity*

Limits:

- English only.
- Available electronic full text.

Appendix 3:

I. Meeting the direct language needs during program delivery

i. Interpreter services

1. Karliner L S, Jacobs EA, Chen AH, Mutha S.

Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. Health Research and Educational Trust 42:2; 2007.

Abstract

Objective: To determine if professional medical interpreters have a positive impact on clinical care for limited English proficiency (LEP) patients.

Data Sources: A systematic literature search, limited to the English language, in Pub- Med and PsycINFO for publications between 1966 and September 2005, and a search of the Cochrane Library. Study Design. Any peer-reviewed article which compared at least two language groups, and contained data about professional medical interpreters and addressed communication (errors and comprehension), utilization, clinical outcomes, or satisfaction were included. Of 3,698 references, 28 were found by multiple reviewers to meet inclusion criteria and, of these, 21 assessed professional interpreters separately from ad hoc interpreters. Data were abstracted from each article by two reviewers. Data were collected on the study design, size, comparison groups, analytic technique, interpreter training, and method of determining the participants' need for an interpreter. Each study was evaluated for the effect of interpreter use on four clinical topics that were most likely to either impact or reflect disparities in health and health care.

Principal Findings. In all four areas examined, use of professional interpreters is associated with improved clinical care more than is use of ad hoc interpreters, and professional interpreters appear to raise the quality of clinical care for LEP patients to approach or equal that for patients without language barriers.

Conclusions. *Published studies report positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care.(evidence*

2. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, and the Task Force on Community Preventive Services.

Culturally Competent Healthcare Systems. A Systematic Review. Am J Prev Med 2003; 24(3S):68–79

Abstract:

Culturally competent healthcare systems—those that provide culturally and linguistically appropriate services—have the potential to reduce racial and ethnic health disparities. When clients do not understand what their healthcare providers are telling them, and providers either do not speak the client's language or are insensitive to cultural differences, the quality of health care can be compromised. We reviewed five interventions to improve cultural competence in healthcare systems—programs to recruit and retain staff members who reflect the cultural

diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings.

Conclusion: According to Community Guide rules of evidence, available studies provide insufficient evidence to determine the effectiveness of using interpreter services or bilingual providers for clients with limited English proficiency. Evidence was insufficient because only one comparative study, with fair quality of execution, assessed outcomes relevant to this systematic review.

Note: For the use of interpreter services or bilingual providers for clients with limited English proficiency intervention, conclusions are based on only one study with the greatest suitability, and with a fair execution (same study is cited by the Community guide, see below 2.a.).

2. a. Guide to Community Preventive Services. Culturally competent health care: use of interpreter services or bilingual providers. (The [Task Force on Community Preventive Services](http://www.thecommunityguide.org/social/interpreterservices.html)) www.thecommunityguide.org/social/interpreterservices.html. Last updated: 09/02/2009. Accessed Nov. 20, 2009

2.a Sarver J, Baker D. Effect of language barriers on follow up appointments after an emergency department visit. J Intern Med 2000;15:256–64.

Study was conducted in an urban hospital emergency department serving predominantly Latino clients.

- Clients who reported that an interpreter was needed but not used were more likely to be discharged without a follow-up appointment than clients with language-concordant physicians (OR=1.79, 95% confidence interval =1.00, 3.23).
- Clients who communicated through an interpreter were also more likely to be discharged without a follow-up appointment than clients with language-concordant physicians (OR=1.92, 95% confidence interval =1.11, 3.33).
- People in the intervention groups were no more likely to adhere to appointments than were controls.

3. Bernstein J., Bernstein E., Dave A., Hardt E., James T., Linden J., Mitchell P., Oishi T., Safi C.

Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up. Journal of Immigrant Health. 4(4): 171-176. 2002.

Abstract

The study was conducted to investigate the impact of an Interpreter Service on intensity of Emergency Department (ED) services, utilization, and charges. This study describes the effects of language barriers on health care service delivery for the index ED visit and a subsequent 90-day period. In all 26,573 ED records from July to November, 1999, resulted in a data set of 500

patients with similar demographic characteristics, chief complaint, acuity, and admission rate. Non-interpreted patients (NIPs) who did not speak English had the shortest ED stay (LOS) and the fewest tests, IVs and medications; English-speaking patients had the most ED services, LOS, and charges. Subsequent clinic utilization was lowest for NIPs. Among discharged patients, return ED visit and ED visit charges were lowest for interpreted patients (IPs).

Use of trained interpreters was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without any simultaneous increase in LOS or cost of visit.

4. Wallin AM. Ahlstrom G.

Cross-cultural interview studies using interpreters: systematic literature review.
Journal of Advanced Nursing. 55(6):723-35, 2006

Abstract

Aim: This paper reviews how the interpreter's role is described in empirically based, qualitative cross-cultural interview studies and how trustworthiness is determined.

Background: Increased immigration during the past decades has created a multiethnic society in many countries. This development poses a challenge to healthcare staff, in that they need to understand how people from different cultures experience health and illness. One way to assess immigrants' experiences is through cross-cultural interview studies, involving an interpreter. Thorough knowledge of the interpreter's role is needed in order to increase the trustworthiness of this kind of nursing research.

Method: Literature searches were conducted from October to November 2004 using PubMed, CINAHL, Psycinfo, Sociological abstract, Your Journals@ovid, and Eric databases. Qualitative interview studies written in English and performed with an interpreter were included. The Matrix Method was used to review the literature.

Findings: In almost all of the 13 relevant papers found, the role of the interpreter(s) in the research process was only sparsely described. In addition, all studies except one employed different techniques to established trustworthiness. The most common techniques were prolonged engagement, member check or triangulation, the latter performed either on the data, investigators or methods.

Conclusion: *Methodological issues with respect to interpreters have received only limited attention in cross-cultural interview studies. Researchers in the field of nursing need to consider (1) the interpreter's role/involvement in the research process; (2) the interpreter's competence and the style of interpreting; (3) the interpreter's impact on the findings. This information is a prerequisite when trying to determine the trustworthiness of a cross-cultural study.*

ii. Medical documents translation (administrative, medico-legal documents)

5. Garcia- Castillo D, Fetters MD.

Quality in Medical Translations: A Review.

Journal of Health Care for the Poor and Underserved 18 (2007): 74–84.

Abstract: Despite a growing number of U.S. citizens who do not speak English fluently, little literature attends to issues of accurate translation of medical documents. We conducted

a systematic review of the World Wide Web and electronic library resources to identify sources on translating clinical and medical research documents. The explicit purpose of the search was to identify resources with information about: 1) factors that affect the quality of translated research or clinical instruments; 2) types of errors that occur during the translation process and potential consequences; and 3) solutions to problems arising during translation. We identified and carefully examined 44 relevant articles. Each article was coded with 5 to 10 key words that were used as a guide when we searched the articles for issues salient to assuring quality in medical translations. We divided these into two major categories, mechanics/practicalities of translating medical documents and extrinsic factors influencing medical translations.

The results of this review confirm that medical translation is a complex process involving far more than mechanically converting one language to another. Attention to translation procedures can improve the quality of care for limited English proficient patients.

II. Health promotion materials and interventions:

6. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, and the Task Force on Community Preventive Services. Culturally Competent Healthcare Systems. A Systematic Review. Am J Prev Med 2003;24(3S):68–79

Conclusion: According to Community Guide rules of evidence, available studies provide insufficient evidence to determine the effectiveness of interventions to provide linguistically and culturally appropriate health education materials because only a small number of comparative studies, with limitations in execution, assessed outcomes relevant to this systematic review (see below at 1.a. the Community Guide studies references).

6. a. Guide to Community Preventive Services. Culturally competent health care: use of linguistically and culturally appropriate health education materials.
www.thecommunityguide.org/social/educationmaterials.html. Last updated: 09/02/2009.
Accessed Nov. 20, 2009

Four studies qualified for the review and all studies examined the effectiveness of culturally sensitive health education videos. However, only one of these studies reported a change in health behaviors. The remaining studies included measures of satisfaction with the cultural relevance of the videos.

Included Studies

6.1 Herek GM, Gillis JR, Glunt EK, Lewis J, Welton D, Capitanio JP. Culturally sensitive AIDS educational videos for African American audiences: effects of source, message, receiver, and context. Am J Community Psychol 1998;26:705–43.

6.2 Kalichman SC, Kelly JA, Hunter TL, Murphy DA, Tyler R. Culturally tailored HIV-AIDS risk-reduction messages targeted to African American urban women: impact on risk sensitization and risk reduction. *J Consult Clin Psychol* 1993;61:291–5.

6.3 Stevenson HC, Gay KM, Josar L. Culturally sensitive AIDS education and perceived AIDS risk knowledge: reaching the “know-it-all” teenager. *AIDS Educ Prev* 1995;7:134–44.

6.4 Sussman S, Parker VC, Lopes C, Crippens DL, Elder P, Scholl D. Empirical development of brief smoking prevention videotapes which target African-American adolescents. *Int J Addict* 1995;30:1141–64.

7. Agic B, Kobus-Matthews M. Culture Counts: Best Practices in Community Education in Mental Health and Addiction with Ethnoracial/Ethnocultural Communities. CAMH. 2005

Conclusions:

- *Language is identified as one of the greatest barriers in access to health programs for people of non-English speaking background.*
- *The Report on Language Barriers in Access to Health Services (2001) states that, at least, 1 in 50 Canadians requires an interpreter for health care, but it is believed that this number is actually much higher. Language barriers, if not addressed, create a risk of individuals misinterpreting key concepts and misunderstanding health information.*
- *Concepts that reflect the dominant culture are often not directly transferable to communities with different cultural background.*
- *Original material, both text and the graphical elements, need to be culturally adapted to reflect cultural values and social norms of the intended community.*
- *Direct translation, which does not take cultural concepts into account, limits the usefulness of health information.*
- *Effective adaptation and translation require extensive testing with the intended audience during all phases of message development.*
- *Program effectiveness also depends on the mode of delivery, which is often culturally specific.*
- *Working in partnership with community groups and/or community-based organizations is the best strategy to ensure effectiveness of health education initiatives*

8. Hawthorne K, Robles Y, Cannings-John R, Edwards AGK. Culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups. *Cochrane Database of Systematic Reviews* 2008, Issue 3.

PLAIN LANGUAGE SUMMARY

Culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups

In upper-middle income and high income countries, minority ethnic groups often suffer a higher prevalence of type 2 diabetes mellitus than the local population. They also tend to come from lower socio-economic backgrounds, with attendant difficulties in accessing good quality health care. In some cases, cultural and communication barriers increase the problems minority ethnic

communities experience in accessing good quality diabetes health education, a vital aspect contributing towards patient understanding, use of services, empowerment and behaviour change towards healthier lifestyles. In this review, 'culturally appropriate' health education is taken to mean any type of diabetes health education which has been specifically tailored to the cultural needs of a target minority group.

The review found eleven randomized controlled trials (RCTs) of culturally appropriate diabetes health education in the world literature that met the selection criteria (participants from a defined ethnic minority group living in a middle income or high income country, over 16 years in age, with type 2 diabetes mellitus, and receiving a culturally tailored health education intervention). Culturally appropriate health education improved blood sugar control in participants, compared with those receiving 'usual' care, at three and six months post-intervention, to be of potential clinical importance if sustained. Knowledge about diabetes, and healthy lifestyles also improved. None of the other clinical outcome measures such as cholesterol, blood pressure or weight showed any improvement, nor were there any improvements in quality of life outcomes for patients. Studies tended to be of short duration, so longer term outcomes could not be measured. In addition, some outcomes selected by the review were not measured, such as the development of diabetic complications, death rates, or costs of the education programmes. The variation between studies, in terms of the cultural aspects of the populations being studied, the types and duration of the health education being offered to participants, the variety of different outcomes being measured and differences in the timings of these measurements after the health education intervention make interpretation of the findings limited. Although it appears that culturally appropriate health education is potentially more effective than 'usual care' in improving blood sugar control and knowledge of diabetes, with probable attendant benefits to patients, standardised RCTs of longer duration (using the same outcome measures and timings of these measures), are needed with full evaluation of costs.

Conclusions:

Culturally appropriate diabetes health education appears to have short term effects on glycaemic control and knowledge of diabetes and healthy lifestyles. None of the studies were long-term, and so clinically important long-term outcomes could not be studied. No studies included an economic analysis. The heterogeneity of studies made subgroup comparisons difficult to interpret with confidence. There is a need for long-term, standardized multi-centre RCTs that compare different types and intensities of culturally appropriate health education within defined ethnic minority groups.

**8.1. Brown SA, Garcia SA, Kouzekanani K, Hanis G.
Culturally Competent Diabetes Self-Management Education for Mexican Americans.
Diabetes Care 25:259–268, 2002**

Abstract:

OBJECTIVE— To determine the effects of a culturally competent diabetes self-management intervention in Mexican Americans with type 2 diabetes.

RESEARCH DESIGN AND METHODS— A prospective, randomized, repeated measures study was conducted on the Texas-Mexico border in Starr County. A total of 256 randomly selected individuals with type 2 diabetes between 35 and 70 years of age, diagnosed with type 2 diabetes

after 35 years of age, and accompanied by a family member or friend were included. The intervention consisted of 52 contact hours over 12 months and was provided by bilingual Mexican American nurses, dietitians, and community workers. The intervention involved 3 months of weekly instructional sessions on nutrition, self-monitoring of blood glucose, exercise, and other self-care topics and 6 months of biweekly support group sessions to promote behaviour changes. The approach was culturally competent in terms of language, diet, social emphasis, family participation, and incorporation of cultural health beliefs. Outcomes included indicators of metabolic control (HbA1c and fasting blood glucose), diabetes knowledge, and diabetes related health beliefs.

RESULTS— Experimental groups showed significantly lower levels of HbA1c and fasting blood glucose at 6 and 12 months and higher diabetes knowledge scores. At 6 months, the mean HbA1c of the experimental subjects was 1.4% below the mean of the control group; however, the mean level of the experimental subjects was still high (>10%).

CONCLUSIONS— *This study confirms the effectiveness of culturally competent diabetes self-management education on improving health outcomes of Mexican Americans, particularly for those individuals with HbA1c levels >10%.*

9. Iftekhhar Mian S, Brauer P.

Dietary Education Tools for South Asians with Diabetes

Can J Diet Prac Res 2009; 70:28-35

Abstract

Purpose: South Asian immigrants to Canada are at high risk for developing diabetes, and culturally relevant diet counselling tools are needed. We examined perceived needs and preferences for diet counselling resources based on the newly revised Canadian Diabetes Association meal planning guide.

Methods: Five focus groups of individuals from different regions of South Asia (n=53) discussed portion size estimating methods, cultural values and holidays, food group classifications, and common South Asian foods. A focus panel with dietitians (n=8) provided insight on current diabetes education methods and resources for teaching South Asian clients.

Results: The dietitian panel members reported a need for resources targeted at differing client skill levels. They also noted preferences for individual counselling, and common barriers to education including finances, access, South Asian diets, and cultural views on health.

Community focus groups reported larger portions but fewer daily meals in Canada. Ingredients and portions were not measured. Fasting was an important value, and sweets were a crucial component of holidays. Resources in South Asian languages, inclusion of pictures, and separate legumes, sweets, and snacks food groups were preferred.

Conclusions: *Findings can be used when developing new counselling tools for the South Asian community.*

10. Ponce NI, Chawla N, Babey SH, Gatchell S, Etzioni D, Spencer BA, Brown R, Breen N **Is there a Language Divide in Pap Test Use?**

Med Care; 44: 998–1004. 2006.

Abstract:

Objective: We sought to determine whether primary language use, measured by language of interview, is associated with disparities in cervical cancer screening.

Data sources: We undertook a secondary data analysis of a pooled sample of the 2001 and 2003 California Health Interview Surveys. The surveys were conducted in English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese.

Study Design: The study was a cross-sectional analysis of 3-year Pap test use among women ages 18 to 64, with no reported cervical cancer diagnosis or hysterectomy (n = 38,931). In addition to language of interview, other factors studied included race/ethnicity, marital status, income, educational attainment, years lived in the United States, insurance status, usual source of care, smoking status, area of residence, and self-rated health status.

Data Collection/Extraction Methods: We fit weighted multivariate logit models predicting 3 year Pap test use as a function of language of interview, adjusting for the effects of specified covariates.

Principal Findings: Compared with the referent English interview group, women who interviewed in Spanish were 1.65 times more likely to receive a Pap test in the past 3 years. In contrast, we observed a significantly reduced risk of screening among women who interviewed in Vietnamese (odds ratio OR 0.67; confidence interval CI 0.48–0.93), Cantonese (OR 0.44; 95% CI 0.30–0.66), Mandarin (OR 0.48; 95% CI 0.33–0.72), and Korean (OR 0.62; 0.40–0.98).

Conclusions: *Improved language access could reduce cancer screening disparities, especially in the Asian immigrant community.*

11. Black, M.E., Yamada, J., & Mann, V.

A systematic literature review of the effectiveness of community-based strategies to increase cervical cancer screening.

Canadian Journal of Public Health, 93, 386–393; 2002

Abstract:

Objective: To evaluate and summarize evidence of the effectiveness of interventions available to public health staff that could be used to increase cervical cancer screening to women.

Method: A thorough literature review was conducted, articles screened for relevance and assessed for quality.

Results: Of 42 relevant studies, 1 was rated ‘strong’, 18 ‘moderate’ and 23 ‘weak’. Among the strong/moderate studies, 10 were aimed at disadvantaged women. The most frequently used intervention was mass media campaigns, alone or combined with individual strategies; followed by individual education using lay health educators; and last, letters of invitation. Thirteen of the moderate/strong studies evaluated strategies that reported statistically significant increases in Pap smears rates and other outcomes.

Conclusions: *Strategies that combined mass media campaigns with direct tailored education to women and/or health care providers seemed most successful. The importance of accurate centralized cytology databases for recall is underscored.*

12. Howlett RI, Larsh S, Dobi L, Mai V;

Promoting Cancer Screening among Ontario Chinese Women
Can J Public Health 2009;100 (4):315-19.

Abstract

Objectives: Cancer screening participation is typically low among newcomers to Canada. Consequently, mortality and morbidity rates are higher in ethno/cultural populations. There are inherent challenges in reaching these population groups to increase awareness and participation in cancer screening. Many reports have cited the need for culturally appropriate materials and multi-pronged strategies for effective outreach in the Chinese community. This paper outlines the consultation/development process and evaluation strategy for promoting cancer screening among Chinese women with limited English language skills.

Participants: As Chinese is the third most commonly spoken language in Canada, this community education project focused on health promoters providing services to Chinese women 50 years and older.

Setting: Ontario communities.

Intervention: Partners and stakeholders were consulted and engaged to define the best approach to develop and distribute culturally sensitive public education resources to assist communities in realizing greater awareness of and participation in cancer screening.

Outcomes: Customized resource kits were developed and distributed to the target population over the course of two phases of this project. An evaluation strategy was designed and implemented to assess the impact of the project.

Conclusion: The process to develop culturally sensitive and evidence-based materials for Chinese is detailed in this article. This multi-year project designed and distributed customized resource kits, through consultation with partners and stakeholders. Project outcomes will be further assessed one year after distribution of the kits.

13. Eleanor Maticka-Tyndale, Khosro Refaie Shirpak, & Maryam Chinichian. (2007). Providing for the Sexual Health Needs of Canadian Immigrants: The Experience of Immigrants from Iran. Canadian Journal of Public Health, 98(3), 183-6.

Abstract

Sexual health is increasingly understood as an integral part of health. In Canada, education for sexual health is delivered predominantly in middle and secondary school. What of adults who immigrate to Canada from countries where sex education is not delivered to youth? This paper explores the needs and experiences of one such group of Canadian immigrants: those from Iran. Ten married male and 10 married female immigrants from Iran living in a mid-sized Canadian city were recruited using snowball sampling and participated in qualitative interviews. The sample varied in age, education level, duration of marriage, and stay in Canada. Participants addressed three themes: experiences accessing information and health services, necessary content of information, and preferred ways of providing sexual health information and services. *Key barriers to accessing and using sexual health services, experienced by all interviewees, regardless of the length of time they were in Canada, included language, cultural misunderstandings, embarrassment, long waits, and limited time that physicians spent with patients. Examples were provided of misunderstandings and inappropriate or even offensive questions or suggestions made by health practitioners who were unfamiliar with patients'*

cultural norms related to sexuality. Participants believed their needs and questions were different from their Canadian counterparts and wanted a confidential, linguistically and culturally friendly source of information such as a website in the Farsi language. More attention needs to be paid to developing public health and medical services related to sexual health that take account of the cultural diversities represented in the Canadian population.

**14. Black ME, Angela Frisina A, Hack T, Carpio B,
Improving Early Detection of Breast and Cervical Cancer in Chinese and Vietnamese
Immigrant Women
ONCOLOGY NURSING FORUM – VOL 33, NO 5, 2006**

Conclusion

The project not only has increased cancer screening among immigrant women but also has transformed PHNs' work with underserved women in the city. Public funding will enable us to extend screening to other communities and to develop screening strategies in a chronic disease perspective. We have learned the importance of listening as immigrant women tell their stories, and we understand more fully the barriers they face in accessing health care, including early detection of cancer. We must direct future efforts toward building healthy public policy that will address inequalities and develop sustainable programs.

**15. Talbot, Y., Fuller-Thomson, E., Tudiver, F., Habib,
Y., & McIsaac, W.J. (2001).
Canadians without regular medical doctors. Who are they?
Canadian Family Physician, 47, 58–64.**

Abstract

OBJECTIVE: Because having a regular medical doctor is associated with positive outcomes, this study attempted to determine the characteristics of Canadians without regular doctors so that alternative methods of delivering care to people with those characteristics can be studied. **DESIGN:** Secondary data analysis of the National Population Health Survey using bivariate analyses and logistic regression. **PARTICIPANTS:** A total of 15,777 respondents older than 20 years. **MAIN OUTCOME MEASURES:** Responses to the question "Do you have a regular medical doctor?" and analysis of 11 variables covering demographics, health status, and lifestyle factors. **RESULTS:** One in seven respondents did not have a regular doctor. Younger respondents, men, single people, poorer respondents, respondents who perceived themselves in better health, recent immigrants, those without confidants, and smokers were more likely not to have regular doctors. Comparing provinces, participants from Quebec were least likely to have regular doctors. **CONCLUSION:** Primary care reform might need to consider alternative ways of providing care to certain people. Future primary care programs could be targeted to improve coverage of relatively underserved people, particularly men, people on low incomes, those without confidants, and recent immigrants.

III. Strategies for managing and planning for linguistic diversity

16. Tackling the challenge. Promoting race equality in the NHS in England. Commission for Healthcare Audit and Inspection 2009. Accessed Nov , 2009

http://www.cqc.org.uk/db/documents/Tackling_the_challenge_Promoting_race_equality_in_the_NHS_in_England.pdf

This report summarizes a range of work undertaken by the Healthcare Commission and looks at the extent to which the NHS in England is meeting the legal basic building blocks in promoting race equality.

The report:

- Highlights some of the legal obligations of the NHS in meeting its race equality duties.
- Summarizes the available data on the ethnic make-up of the national population and NHS workforce, and examines some of the health needs of different ethnic groups, and some of the different experiences of health services.
- Reviews progress on the performance by NHS trusts in promoting race equality, through assessment of performance against parts of relevant core standards that address some of the key requirements of the race relations legislation.
- Sets out some recommendations for the Department of Health, commissioners and providers of services, and the Care Quality Commission.

17. Hyman I, Guruge S.

A review of theory and health promotion strategies for new immigrant women. *Canadian Journal of Public Health*, 93, 183–187; 2002.

Abstract:

Background: There has been little empirical research on the best ways to influence women's health behaviour, particularly among women who are recent immigrants to Canada.

Methods: literature review conducted for the Ontario Women's Health Council on effective theoretical models and health promotion strategies for women.

Findings: Health promotion activities for all women should address theoretical variables as well as broader determinants of women's health. New immigrant women represent a diverse group who often face multiple cultural, linguistic, and systemic barriers to adopting and maintaining healthy behaviour.

Summary of Recommendations:

- *Use behaviourally-focused strategies, recognizing that many cultural concepts with potential relevance to health practices (e.g. collectivism, ethnic identity) have not been adequately researched.*
- *Focus on reducing informational, cultural, linguistic, economic and systemic barriers to care.*
- *Use an empowerment philosophy.*
- *Use community "link leaders", leadership and the media.*
- *Involve the community in planning, design, and delivery of interventions.*

- *Be dynamic, as immigrants' attitudes, beliefs and behaviours change as part of an acculturation process.*

Interpretation: Many theoretical constructs of potential importance to recent immigrant women have not been adequately researched. More research is also needed on the relevance and the applicability of commonly used health promotion approaches for this group.

18. Beach, M.C., T.L. Gary, E.G. Price, K. Robinson, A. Gozu, A. Palacio, C. Smarth, et al. Improving Health Care Quality for Racial/Ethnic Minorities: A Systematic Review of the Best Evidence Regarding Provider and Organization Interventions. *BMC Public Health* 6:104. 2006.

Abstract

Background: Despite awareness of inequities in health care quality, little is known about strategies that could improve the quality of healthcare for ethnic minority populations. We conducted a systematic literature review and analysis to synthesize the findings of controlled studies evaluating interventions targeted at health care providers to improve health care quality or reduce disparities in care for racial/ethnic minorities.

Methods: We performed electronic and hand searches from 1980 through June 2003 to identify randomized controlled trials or concurrent controlled trials. Reviewers abstracted data from studies to determine study characteristics, results, and quality. We graded the strength of the evidence as excellent, good, fair or poor using predetermined criteria. The main outcome measures were evidence of effectiveness and cost of strategies to improve health care quality or reduce disparities in care for racial/ethnic minorities.

Results: Twenty-seven studies met criteria for review. Almost all (n = 26) took place in the primary care setting, and most (n = 19) focused on improving provision of preventive services. Only two studies were designed specifically to meet the needs of racial/ethnic minority patients. All 10 studies that used a provider reminder system for provision of standardized services (mostly preventive) reported favorable outcomes. The following quality improvement strategies demonstrated favorable results but were used in a small number of studies: bypassing the physician to offer preventive services directly to patients (2 of 2 studies favorable), provider education alone (2 of 2 studies favorable), use of a structured questionnaire to assess adolescent health behaviors (1 of 1 study favorable), and use of remote simultaneous translation (1 of 1 study favorable).

Interventions employing more than one main strategy were used in 9 studies with inconsistent results. There were limited data on the costs of these strategies, as only one study reported cost data.

Conclusion: There are several promising strategies that may improve health care quality for racial/ ethnic minorities, but a lack of studies specifically targeting disease areas and processes of care for which disparities have been previously documented. Further research and funding is needed to evaluate strategies designed to reduce disparities in health care quality for racial/ethnic minorities.

19. Szczepura A et al. An overview of the research evidence on ethnicity and communication in healthcare. Centre for Evidence in Ethnicity, Health & Diversity ; 2005. <http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/research/communicationreview.pdf>. Accessed Nov, 2009.

Overall Key Recommendations:

- Effective communication is central to safeguarding the quality of health care, especially in respect of the needs of members of cultural and linguistic or migrant minorities. Use of 'informal interpreters' in health care settings is dangerous and must be actively discouraged
- In the longer term, consideration needs to be given to moving from an approach based on the model of interpretation, translation, advocacy or language support service (ITALS), towards delivery of 'Culturally and Linguistically Appropriate Services' (CLASS).
- Ethnic monitoring requires the identification of individuals as belonging to groups defined in terms of their culture and origin - this should include language (and religion) and should be enforced.
- Health should develop language support policy and practice with other Government departments, perhaps through an inter-departmental working group: good practice already exists in legal services
- Organizations should have in place policies, structures, practices, procedures, and dedicated resources to support linguistic competence (e.g. those defined by the US National Center for Cultural Competence)

20. Pasick, R.J., Hiatt, R.A., & Paskett, E.D

Lessons learned from community-based cancer screening intervention research. *Cancer*, 101(5, Suppl.), 1146–1164; 2004.

Behaviors associated with cancer screening have been the focus of intensive research over the past 2 decades, primarily in the form of intervention trials to improve screening based in both clinical and community settings. Meta-analyses and literature reviews have synthesized and organized the resulting literature. From the accumulated work, this review distilled lessons learned from cancer screening intervention research in community settings. The authors posed the question, “What do we know about the development of effective community-based interventions (the level of good over harm achieved in real-world conditions)?”

Framed around the concept of focal points (the simultaneous combination of target population, behavioral objective, and setting for an intervention), 13 lessons were derived. One lesson was cross-cutting, and the other lessons addressed the three focal-point components and the major intervention categories (access-enhancing strategies, mass media, small media, one-on-one and small-group education, and combinations of these categories). To build more systematically on existing research, recommendations are made for new directions in basic behavioral and intervention research.

21. Aspinall P.

Health ASERT Programme Wales Report Series

Enhancing the Health Promotion Evidence Base on Minority Ethnic Groups, Asylum Seekers/Refugees and Gypsy Travellers. A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Minority Ethnic Group Population, and of appropriate Health Care Interventions.

Centre for Health Services Studies. University of Kent . www.kent.ac.uk/chss. Accessed Nov. 2009

Based on this review of the literature on the health beliefs, health status, and use of services in the minority ethnic group population, and of appropriate health care interventions, a number of recommendations for policy and practice are put forward:

- Ethnic monitoring/data collection should be mainstreamed across all services and the needs of minority ethnic groups should be routinely addressed in health equity audits and health impact assessments.
- With respect to interventions to improve the uptake of cervical screening, the strongest evidence suggests that minority ethnic women may be more responsive to small, culturally sensitive group education rather than broad-based community strategies. The use of lay health educators, in particular, may be promising although resource intensive.
- Small informal discussion classes emphasizing the benefits – and giving practical advice – may be particularly effective in helping to increase the number of women from minority ethnic groups who breastfeed.
- The development of integrated, multi-professional services, the use of community-based diabetes specialist nurses to support primary health care teams, the employment of ethnic link-workers, and the provision of accredited training for Asian diabetes support workers are identified as elements of good practice.
- Outreach work by members of the minority ethnic community, the use of video projects to gather views, and the use of bilingual, volunteer ‘community inter-actors’ to teach drug education to families may all be effective in reducing drug misuse.

Appendix 4: Evidence Grading of Interventions

Levels of evidence and grading of recommendations

Level	Type of evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well designed controlled study without randomization
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case controlled studies
IV	Evidence obtained from expert committee reports of opinions and/or experiences of respected authorities

Grade	Type of recommendation
A (levels Ia, Ib)	Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation
B (levels IIa, IIb, III)	Requires availability of well conducted clinical (health services) studies but no randomized clinical trials on the topic of recommendation
C (level IV)	Requires evidence from expert committee reports or opinions and/or clinical (health services) experience of respected authorities. Indicates absence of directly applicable studies of good quality