

**Bridging the Communication Gap: Provider to Patient Written Communication
Across Language and Cultural Barriers**

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for

Hablamos Juntos

October 2002

This paper was produced under contract with Hablamos Juntos, a program funded by the Robert Wood Johnson Foundation, administered by the Tomás Rivera Policy Institute (TRPI), an affiliated research unit of the University of Southern California, School of Policy, Planning and Development and of the Institute for Social and Economic Research and Policy at Columbia University. The content or opinions expressed herein are strictly those of the authors and do not necessarily reflect the views of the funder or its agents.

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Executive Summary

Linguistic and cultural barriers represent a serious threat to the quality of and access to health care services, with serious consequences to patients' health conditions and functioning of health care services.¹ These factors present special challenges when materials written for English speaking audiences are translated. The authors propose that all material originally written in English should go through a process of cultural adaptation as opposed to translation, in order to better suit the needs and characteristics of the Latino population regarding health care.

Cultural adaptation of written materials is necessary because of the role of translated materials in the communicative process and interaction between health care service providers and patients. The functions of the different types of written material (e.g. registration forms, prescriptions, signs, etc.) occur along a continuum, defined by the constant interaction among them. No form or function is more important than the rest; the effectiveness of one will depend on the effectiveness of others.

Both written and oral communication are important in patient-provider relationships. The cultural backgrounds of patients need to be considered in developing or adapting written material for non-English speaking audiences. Although the focus of this paper is on written communication, emphasis is made on the fact that written communication should be a complement of oral processes, and vice-versa.

The interaction between oral and written language is decisive to health care promotion and to enabling patients to become effective health care partners. Written material, such as leaflets and brochures or medication instructions, can enhance patient-provider encounters and are extremely useful, since they can be consulted wherever and whenever patients need to do so. To be effective and to promote adoption and use of health information, written materials must reflect an understanding of the patient's way of life. A person's beliefs, needs, interests, and norms emerge from a history of experiences and social processes or patient's "lived experiences²." Lived experiences form a way of life and result in culturally-defined ways of being ill, expressing pain, describing symptoms, explaining sickness, behaving towards health care providers, and responding to medical indications (Nguyen, n.d.).

Culture also determines the language used by individuals to communicate and also determines those factors that influence the patient-provider relationship. It affects the patient's interpretation of disease and health, and the way in which he/she interacts with health care providers, and it determines the beliefs, attitudes, intentions, and behaviors of patients toward health care. On the other hand, the health care provider's background influences the way he/she diagnoses the disease and treats the patient (Rogers, 2000).

Written communication is an essential component of human communication and is fundamental in hospitals, clinics, health care centers, drugstores, and health-related organizations. It is used to increase patients' knowledge (Meade & Smith, 1991) and to influence their behavior (Ley, 1998). Research indicates that written information offers more advantages over other methods, since it is reusable, permanent, may be read in moments of

¹ For a review of literature on health care barriers due to limited English proficiency see Appendix C.

² See Institute of Medicine (2002). *Speaking of Health, Assessing Health Communication Strategies for Diverse Populations*. Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations. Washington, D.C.: National Academies Press.

idleness, is easy to reproduce, and transmits messages in a consistent way. The unavailability and inadequacy of translated materials has been identified as the primary reason non-English speaking women do not visit their practitioners for cervical screening (Youdelman & Perkins, 2000).

Effective health care delivery and promotion largely depends on the capacity of the health system to use resources that are adequate to the needs and characteristics of specific populations, many with diverse cultural backgrounds. Characteristics such as Limited English Proficiency (LEP) and beliefs and attitudes regarding health and illness (e.g., passivity, external locus of control³, and/or family-centered values) are generally not addressed in health promotion materials developed for general American audiences. Culturally adapted materials and processes of care⁴ must be developed together to effectively enhance communication across cultural and language differences.

For all these reasons, health care settings are increasingly trusting the transmission and accumulation of information to written material, even though much of this information will be accessed by individuals who cannot understand it (Murphy, Chesson, Walker, Arnold, & Chesson 2000).

Given the costs and dangers resulting from language and cultural barriers, it is essential that written material for Latinos be adapted linguistically and culturally. There is a serious lack of available Spanish-written material that is acceptable and comprehensible for Spanish-speaking individuals. Spanish-written texts are often translated from English to Spanish with little regard or understanding of the context in which Latinos may use certain words or images. Quality of material should be evaluated on more than just reading levels and literal translation.⁵

The paper first describes in Section 1 the forms and functions of written material common to health settings in tandem with theories that deal with behavior change and effective health communication. This discussion is followed in Section 2 by a discussion of the Latino population, its social and cultural characteristics, and intra-group differences and needs that should be considered in preparing effective cross-cultural materials and communication. Finally, Section 3 outlines key considerations for cross-cultural communication, while Section 4 specifically addresses the promotion of health through written material. An overview of the processes of translation and cultural adaptation is provided in this section.

³ See "Social Cognitive Theory" in Appendix B.

⁴ "Processes of care" is a term used to describe the routines and systems used in health care settings to begin, conduct and end an encounter with patients when they seek services, these processes may include an entry or check in and registration process, administrative and clinical data gathering pre and post the patient-provider encounter as well as the actual patient-provider encounter.

⁵ Other conditions for useful written materials are discussed separately—see "Useful Written Materials: Evaluating Written Communication Across Language and Cultural Barrier" (Givaudan et al, forthcoming).

SECTION 1: WRITTEN MATERIALS AND BEHAVIOR CHANGE

*“Language access is more than a communication tool, it is a symbol of respect”.*⁶

Types of Written Communication: Functions and Forms

Written language occurs on a continuum within the health care service process and is composed of elements that interact in a permanent way. It is an essential tool for enabling the processes of care and the promotion of health and can serve to support and reinforce oral communication between patients and their providers. Written communication can take many forms and serve many purposes; thus the considerations and challenges for developing culturally adapted written materials will vary. To describe the use of written language within the health care sector, it is useful to differentiate materials and documents based on their function.

Function determines the characteristics of written material, so that describing each type according to several functions is useful in assessing effectiveness, determining whether there is room for improvement and evaluating alternatives. In the context of this paper, classification of materials according to their function would allow one to determine which elements could be culturally adapted.

Classification does not imply that one type of material is more effective than the other regarding its utility to support patient-provider communication or the processes of care. A variety of materials complement and support the processes of care, and their effectiveness depends as much on the quality and adequacy of the forms of written language as on how the materials are used and presented in health care interactions.

Through a review of health literature and references from health care providers, we have determined the classification of the forms and functions of written communication in health care settings described in Table 1 below. These examples of written material accompany patients in the whole health care process, collecting data necessary in administrative and financial processes, reinforcing oral instructions and supporting health care providers in their role as educators.

Table 1. *Classification of the forms and functions of written communication in health care settings*

Form	Function(s)	Examples
Signs and Images	To communicate messages in a synthesized way To complement and reinforce information in messages	Symbols to guide individuals inside health care centers; images in books
Administrative	To carry out procedures and transactions of medical services To carry out diverse economic and labor-related activities of health care provider or system	Admission forms, informed consent forms, invoices, insurance forms, inventories.
Treatment	To instruct the patient	Prescriptions, indications and contraindications of products and medicines; patient education pamphlets, home care instructions

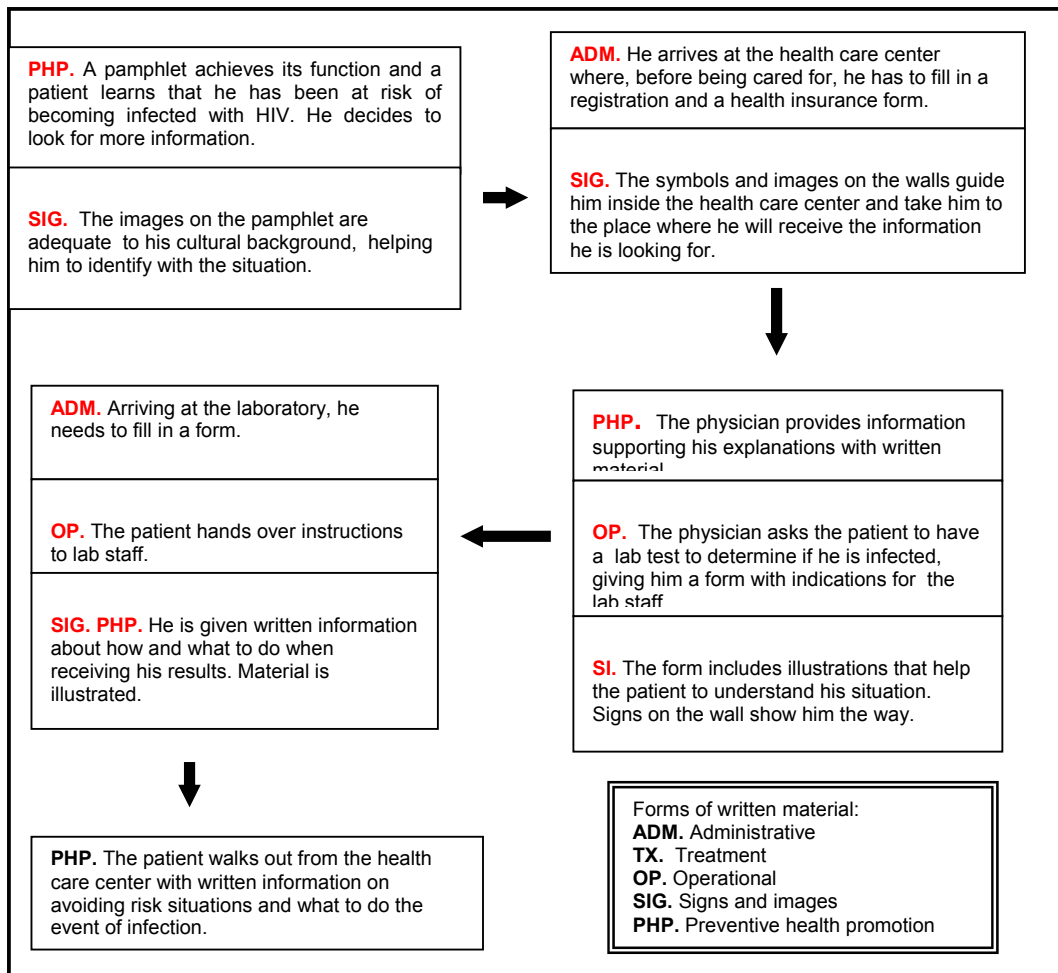
⁶ Savolaine, cited in Cardillo and Ngeo (1997).

Operational	To transmit information from one health care provider to another or to a specific area of service	Files, referral instructions, specific instructions for X-rays, laboratory, pharmacy
Preventive/ Health promotion	To inform the patient regarding health care promotion To educate patients on health care alternatives To do research	Pamphlets, leaflets, brochures, health insurance information, web sites, scales, questionnaires; magazines and articles; surveys; warning messages and safety procedure messages

Written materials support all aspects of the health care system, from administrative to clinical functions. Due to the variety of materials, the opportunity and challenge of cultural adaptation varies. The larger the potential to transfer information, educate individuals and promote change, the more essential culturally appropriate written material becomes.

The continuum along which the different forms of written material support communication follows no predetermined or hierarchical order regarding the way materials are used by the patient. Figure 1 depicts the constant interaction of written material in the process of health care and promotion, and the way this material is used by the patient to achieve the purpose of this material.

Figure 1. Patient interaction of written material in the process of receiving health care.



Patients and health care providers constantly use multiple forms of written materials to communicate, including material that provides directions to a particular facility, instructions on how to take medication, or provide information on medical procedures or disease processes and treatments. Written materials serve to guide patients through admission and discharge procedures, gather patient histories and to give and obtain informed consent for a specific procedure.

Written materials in and of themselves can lead to a variety of outcomes. Material that is not well understood by patients can result in negative outcomes due to misdiagnosis, non-compliance or care avoidance by patients. On the other hand, in the case of patients whose cultural background is different from that of the health care provider, written materials may prove useful as tools in overcoming barriers related to language and culture. If written texts include proper language and words in a culturally relevant format and presentation, they may reinforce or provide more useful images and messages than health care providers who are not bicultural and bilingual can provide. Pictorial elements are often useful to educate patients regarding processes and instructions (as is the case with condom use).

Finally, it is important to emphasize that written language cannot for substitute interpersonal relationships. Both oral and written communication between health care providers and patients are irreplaceable; they fulfill different functions and complement each other.

In the next section, theories of behavior modification are discussed to provide insights into important considerations for developing culturally adapted materials which seek to convince the target audience to adapt a particular health behavior. The authors suggest that the term "*cultural adaptation*" be used in place of the word "*translation*" when the purpose of providing written material is to motivate readers to adopt preventive measures and to promote health.

Communication Strategies Based On Behavior-Change Models

The patient-provider relationship is a partnership where the provider brings medical knowledge to diagnose and treat, and the patient contributes to his/her health and recovery by providing useful and necessary information and by acting on the recommendations and advice provided. As part of their responsibility towards the well-being of individuals, health care providers must not only alleviate patients from disease but are also obligated to educate them in a culture of prevention, promoting health-oriented behavior.

Communicating with patients about physiological processes and medical science is a challenge under any condition. Language barriers and cultural differences make this challenge increasingly difficult. Disciplines including psychology, sociology, anthropology, and marketing have developed theoretical models targeted at the design, application, and evaluation of interventions that promote behavior change towards health promotion. These theories can be incorporated in most communication strategies, modified to incorporate specific cultural and personal characteristics and applied to the development of culturally adapted materials.

Following is a summary of five of the most commonly cited⁷ behavior-change models, theories, and constructs. Without regard to culture or language, these models offer a

⁷ Adapted from Brown, Kelli McCormack. Health Behavior Change: Theories and Models. Retrieved November 11, 2002 from http://hsc.usf.edu/~kmbrown/hlth_beh_models.htm.

general overview of key variables that are part of the process of change. They help explain the dynamics of behavior, suggest ways to modify conduct, and predict the reactions of individuals. The models are applicable to interventions that contemplate health care providers and Spanish-speaking individuals, allowing better understanding of the road to change and the strategies to achieve it⁸.

Individual-centered models:

Models in this category focus on individual factors such as knowledge, attitudes, beliefs, previous experience, and personality which influence the choices of behavior. These individual factors are influenced by culturally-defined socialization processes and lived experiences. Applying these theories effectively with culturally diverse populations requires an examination of how target populations construct the concepts that are at issue.

1. The *Health Belief Model* proposes that in general, behavior depends on both how much an individual values a particular goal and on his/her judgment that a particular action will achieve that goal. The model identifies the key elements that influence decision-making processes, like the individual's perception of susceptibility (risk perception) and perceived barriers (Soto, Lacoste, Papendufuss, & Gutiérrez, 1997). Cultural concepts such as "machismo" create different patterns for risk assessment among Latinos. Understanding the cultural influences related to risks and barriers can help in developing culturally adapted materials and successful application of this model.
2. The *Theory of Reasoned Action* aims to explain the relationship between beliefs, attitudes, intentions, and behavior and is based on the assumption that human beings are rational and apply information available to them in a systematic way, weighing the costs and benefits of a particular action.

According to this theory, the most important determinant of a person's behavior is the intention to carry it out (behavior intention). An intention to perform a behavior is a combination of attitude towards performing the behavior (based on beliefs about the consequences of performing it) and subjective norms. In order to be effective, this theory suggests that written materials need to construct arguments and models of logic that make sense to the target audience.

3. The *Transtheoretical Model/States of Change* posits that intentional changes in behavior are achieved through a six-stage process involving the following steps:
 - a. Precontemplation-- an individual is aware of a need for change;
 - b. Contemplation-- an individual becomes aware of the risks and need for change;
 - c. Preparation--an individual begins to seek information and prepares to take action;
 - d. Action--an individual changes his behavior;
 - e. Maintenance--the individual makes a habit of the new behaviors;
 - f. Termination--the old behaviors are extinguished.

The model is circular, not linear, which means that the individual can move between stages and/or return to previous stages. The manner by which information is introduced needs to be based on culturally-defined patterns of communication. Successful application of this theory is based on developing messages that resonate with and are consistent with an adopted "way of life."

⁸ For more information on theories, see Appendix B.

Social-Centered Models:

Models in this category focus on the process between the individual and primary groups that provide social identity, support, and role definition. Application of these theories for material targeting Latinos must address the importance and roles of family, community life and religion in the lives of Latinos, which must be incorporated in strategies to inform and promote health.

4. *Social Cognitive Theory* focuses on the social origins of human thinking and the role of cognitive processes in human motivation and action. Two basic concepts are included to understand behavior: self-efficacy and locus of control. Self-efficacy refers to an individual's feelings regarding his/her capacity to respond to changes in the environment in an adaptive manner (Maddux, 1995, cited in Schwarzer, 1998), while the concept of locus of control refers to the belief of individuals regarding the origin of events that happen to them.
5. *Community Organization Building* emphasizes that the social milieu of a community has an important role in validating messages concerning healthy behaviors and in creating external pressures that support an individual's decision to change behaviors, through peer pressure, establishment of social norms, etc. Success in the application of the model depends on the participation of the community, but since the interpersonal factors that influence behavior are not contemplated, this theory's efficacy is limited.

Summarizing the main theoretical concepts of the individual- and social-centered behavior change models, we can say that there is a relationship between the beliefs, attitudes, intentions towards change, behaviors of people, and individual and social factors such as self-efficacy, learned helplessness, norms, social influence and infrastructure. In the case of health:

- **Beliefs** represent the information individuals have concerning health issues. A belief links health with an attribute; the set of beliefs of an individual determines his/her attitude towards health. In the case of Latinos, some of the beliefs that influence health behavior (or absence of it) are related to modesty, sexual prejudices or taboos, family-centered values, and availability of support networks.⁹ For example, a Latina who believes that God will punish her if she uses any kind of contraceptive method will have a negative attitude toward these methods.
- **Attitudes** are learned predispositions towards something. They may be favorable or unfavorable with regards to health. When the attitude is unfavorable, individuals will not have a positive disposition towards health care. For example, in the case of the Latina woman mentioned above, her disposition towards reading a leaflet with information on contraception will be negative.
- **Intentions**, like beliefs, are influenced by three components: personal attitude toward performing the behavior, perceived social pressure to perform/not perform it, and perceived behavioral control (Poss, 2001). For example, a Latina woman who does not sense that she has control over her actions may not have the intention of going to the doctor, changing unhealthy habits, etc.

⁹ Source: Intercultural Cancer Council (2001). *Hispanos/Latinos y Cancer*. Retrieved November 11, 2002 from <http://iccnetwork.org/cancerfacts/cfs4s.htm>.

These three aspects (beliefs, attitudes, and intentions) are interrelated and modify each other. At the same time they are influenced by internal (personal) and external factors. External factors are related to social and cultural aspects and refer to beliefs and norms of the individual's culture along with the effect of other people who, with their beliefs, attitudes, intentions, and behaviors influence the beliefs, attitudes, intentions and behaviors of the subject. In turn, internal factors refer to personal characteristics such as:

- *Self-efficacy*--the belief in one's ability to organize and execute the sources of action required and managing prospective situations (Bandura, 1977). Self-efficacy is linked to self-esteem and the capacity to make decisions, in this case health-oriented decisions.
- *Learned helplessness*--the assumption that individuals learn that other individuals or circumstances determine their life. Some people do not try to carry out or change certain behaviors that could lead them to achieve their goals.

Life and psychosocial skills and specific resources and abilities are also necessary to promote change. Life skills and psychosocial skills are essential for the promotion of health and wellness, concerning "those capacities that promote adequate and positive behavior, allowing individuals to efficiently face the requirements and challenges of daily life."¹⁰ But even in the presence of positive attitudes and intentions to change, individuals also require specific resources and/or abilities to make changes (Ajzen, 1985 and Ajzen & Madden, 1986 in Carpi & Breva, 2001). These attitudes may include an individual's self-perception and his/her perceived capacity to achieve his/her goals. In this sense, the perception of self-efficacy, which is directly related to self-esteem, is of utmost importance, and so is the individual's capacity to make decisions, communicate needs and feelings, negotiate with others and solve conflicts, among other psychosocial skills. The development of these skills, however, is not favored in some Latino subpopulations where humility, passivity, and obedience are highly regarded.

Information is also necessary to promote change. Individuals who lack information can be under-informed or misinformed and may not adequately consider health risks and the need for change. But awareness alone is not a sufficient condition for behavior change (Fineberg, 1998). Research indicates that a certain amount of information which personalizes risks and benefits while transmitting expectations of success is needed to initiate the process and contributes to the likelihood of behavior modification. Timing is also important. There are times when risk-related information is of no use; in fact, it may unnecessarily raise anguish. Thus, the proper use of information can promote a change in attitudes, beliefs, and knowledge, while the development of life skills will support the individual in successfully changing or adopting new behaviors.

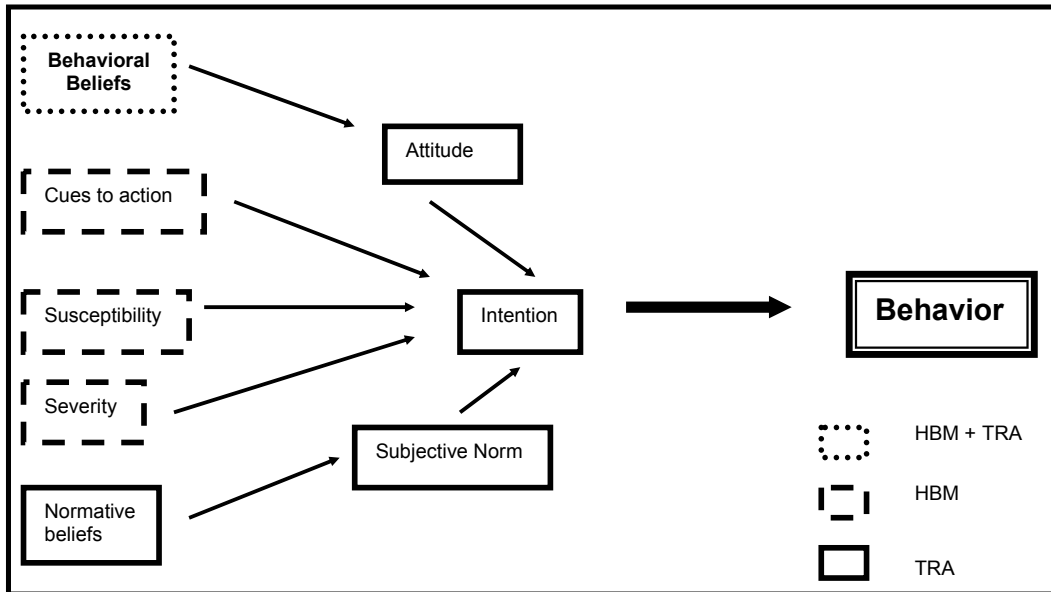
Understanding the cultural context of individuals is important in developing effective communication strategies for the Latino population. To this end, Poss (2001) developed a model for cross-cultural research that synthesizes the Health Belief Model (HBM) with the Theory of Reasoned Action (TRA)¹¹. The model was applied to the study of Mexican migrant workers (see Figure 2), considering basic cultural values attributed to Latinos, such as collectivism, personal interdependence, conformity, and susceptibility to influence by others.

¹⁰ Source: World Health Organization (1993). Enseñanza en los Colegios de las Habilidades para Vivir. División de Salud Mental (Teaching of Life Skills in Schools. Mental Health Division). Geneva: WHO.

¹¹ See page 7.

Results from the study indicated that the intention of this population toward a specific behavior (participation in tuberculosis screening) could be explained through a model containing four variables: subjective norms, attitudes, susceptibility, and cues to action. The best model to predict behavior (actual participation in the screening) required two variables: intention and susceptibility to be influenced by others.

Figure 2. Combined Health Belief Model and Theory of Reasoned Action



In summary, theoretical models can provide us with explanations on internal and external elements that may be precursors of change and which must be taken into account when dealing with patients either personally or through written material. These internal and external elements must be examined within the cultural context of the target population. In the next section, the cultural characteristics that need to be acknowledged by health care providers working with Latinos are discussed.

SECTION 2: CHARACTERISTICS OF THE LATINO POPULATION

Interaction with Health Care Services/Providers

In the past decade, the Latino¹² population has increased by 60% and is currently the most numerous minority group in the continental United States. According to the U. S. Census 2000¹³, the Latino population reached 35.3 million, approximately 13% of the total number of inhabitants on the mainland, with another 3.8 million Latinos living in Puerto Rico, a U. S. territory. Growth projection indicates that by 2035, Latinos will form the largest ethnicity, accounting for more than 40% of the U. S. population.

The growth of the Latino population is attributed to an increase in birth and migration rates from 1990. In 1998, Latina women had the highest fertility rate among all racial and nationality groups, with 84 births for every 1,000 women between 15 and 44 years, as opposed to the fertility rates of White women (57.2 births for every 1,000 women).

Although ethnically and racially diverse, a majority of Latinos who live in the U.S. share a common language (Spanish) and religion (Catholicism). In the year 2000, major sub-populations included the following groups: Mexican and Mexican-American (66.1%); Puerto Rican (9.0%); Cuban and Cuban-American (4.0%); Central and South American (14.6%), and "other Hispanics" (6.4%).

Substantial intercultural differences exist among all these groups, both ethnically and racially. Latinos can have White (mainly Spanish), African, Indigenous/Native and even Asian racial origins, the result of conquests, invasions, or historical immigration patterns that vary based on the country of origin. For example, most of the population in Mexico is Mestizo, with White and American-Indian ancestors. Cultural and racial fusion took place primarily between Spanish men and Indian women (mainly Aztec); their children became the Mestizos of today, who adopted the Spanish language and Catholic religion, while keeping many ancestral traditions. Likewise, Puerto Ricans are mostly descendant from a combination of Spaniards and American-Indians (Arawaks) who lived on the island, and Africans, whose ancestors were brought to America as slaves of the Spaniards.

The different combination of origins of these and other groups is an example of the wide cultural and racial diversity of Latinos in the U. S. These groups may also differ from each other regarding their general educational and socioeconomic background, their representation in the U.S. (the number of individuals with the same country of origin), their legal status, and their way of life. Other differences that determine Latinos' way of life and how they react to their environment include historical differences within the U.S. such as the conditions of migration, the degree of acceptance in the country, the year in which they arrived, and the place where they settled.

With so many differing characteristics among these sub-populations, intra-group diversity can pose a great challenge for health care providers serving Latinos. Additional challenges can be found in socio-cultural factors and attitudes which represent significant barriers to health for Latinos. Latinos tend to be uninsured more often and experience higher poverty

¹² In this paper, the word "Latino" will be used specifically to refer to individuals of Latin American origin who speak Spanish and live in the U. S., although this population encloses a broad ethnic and racial diversity.

¹³ U. S. Census Bureau (2001). Overview of Race and Hispanic Origin. Retrieved November 11, 2002 from <http://www.census.gov/prod/2001pubs/c2kbr01-1-1.pdf>.

rates when compared to other groups. Legal status in the country, poor education and language barriers limit employment options for many Latinos, resulting in lower rates of health insurance coverage. In addition, cultural attitudes, poverty, and poor education contribute to a way of life in which health is devalued and often contradicted by certain practices. For many Latino men, caring for their health is a sign of weakness, while Latina women tend to place higher priority on caring for children and other members of the family than on themselves. Other important factors have to do with some Latinos' lack of psychosocial skills, their ability or inability to take control of their life and myths and beliefs about external forces that "decide" their future (Venguer & Quezada, 1999). (For a discussion on the health needs of Latinos in comparison with other ethnic groups, please see Appendix A.)

Patients are individuals with particular traits and needs, and as such, they should be treated on an individual basis. Nevertheless, there are certain general considerations that may prove useful in terms of improving communication between patients and providers and health promotion across cultures and language when basic cultural characteristics are acknowledged. The following section describes cultural characteristics and health needs common among Latinos as a group.

Cultural Characteristics and Needs of Latino Patients

The characteristics of the Latino population in general derive from their socioeconomic status in the U.S., their difficulty in accessing health care services (Keppel, Percy & Wagener, 2002) and several cultural traits. Latinos have a high need for personal contact and are more likely to call toll-free numbers to talk to qualified individuals regarding health issues. Yet health is not their first priority. Their first two priorities are securing the family's economic sustainability and protecting themselves and their families from crime. Latinos give preference to the needs of the family even when doing so results in personal loss of health (Berry, Spranca, Brown et al, 2001).

Focus group findings reported by Berry et. al. (2001) show the following with respect to the Latino population:

- Latinos think they have insufficient information to make decisions concerning their health;
- It is difficult for them to find information about health care;
- They do not consider the information they find to be very useful;
- They do not trust most of the usual sources of information, such as the American Cancer Society or the American Medical Association, perhaps due to unfamiliarity;
- They express that apart from consulting with friends, relatives or health care providers, they would call a toll-free number to obtain information;
- They report that they are less exposed to information than the rest of the population;
- They prefer to obtain their health-related information through personal contact with someone who is enabled to provide it, such as a health care provider or a toll free number. Other options are pamphlets, leaflets, books, and reports; and,
- Their trust in publications like the *Consumers Report* is lower with respect to other groups, probably because these are not available in Spanish.

Regarding issues of trust and satisfaction with health care services, only 57% of Latinos and 44% of Spanish-speaking Latinos trust their doctor, compared to 72% reported by the rest of the population. Moreover, 13% of Latinos feel that they should be treated better regardless

of their race, ethnic group, or language. Finally, to an extent double that of whites (18% vs. 9%), Latinos report having felt they were treated in a disrespectful way during their last doctor's visit because of their race/ethnicity, their inability to speak English or to pay for the visit (Berry et. al., 2001).

Health Beliefs

The importance of inter-group and intra-group variability cannot be overstated. Latinos are as diverse as the panorama of multi-ethnic groups that reside in the US. Nonetheless there are common beliefs, practices and values¹⁴ that underlie these differences and which result in wide variations in how these beliefs, practices and values are expressed, if at all. Health care providers should have basic knowledge of common perceptions of sickness and health among Latinos, patterns of association within the Latino family, and the comfort of Latinos with physical touch.

The following characteristics outline some of the common beliefs, practices and values of the Latino population:

- Sickness is generally perceived as an imbalance: lack of equilibrium between internal and external forces (e.g. cold vs. warm; natural vs. supernatural).
- Folk-defined diseases like *mal de ojo* (evil eye) or *empacho* (indigestion), and diseases defined by modern medicine such as asthma, diabetes, etc., are both used as sources of explanation for disease.
- Folk healers are often the first option for treatment.
- Health problems are often believed to be caused by God or other external forces, and patients may perceive themselves as innocent victims who are supposed to be passive with respect to their ailments.
- Friendly and polite relationships are preferred over distant therapeutic ones.
- Eye contact with health care providers may be avoided as a sign of respect; for others, visual contact is related to evil spirits.
- Nodding does not necessarily mean agreement with what is being said, but rather that the patient is listening.
- Silence often indicates a lack of understanding or disagreement.

Families play an important and defining role for Latinos, influencing social and individual values. As with common beliefs, practices, and values, there are wide variations in how family relationships are expressed, if at all. Again, basic knowledge about common perception of patterns of association within the family should be used as a frame of reference to guide health care providers in their work with Latinos. A general pattern of dynamics within the Latino family would include the following practices:

- Mothers generally decide if and when a family member gets medical attention, while the male head of the family grants permission to go to the medical center.
- The head of the family, normally the eldest male, is the one who makes decisions, although important decisions involve the whole family.

¹⁴ Adapted from University of Washington Medical Center, Staff Development Workgroup (1999). *Culture Clues: Communicating with your Latino Patient*. Retrieved November 12, 2002 from <http://depts.washington.edu/pfes/pdf/culture-sp.PDF>.

- The father or eldest male is usually the spokesperson for the family, though this custom is often modified when the ability to speak English is a priority.
- It is common for Latino families to try to protect the patient regarding knowledge of his/her illness, preferring to hear bad news before the patient is informed. The family spokesperson will generally be responsible for delivering serious information.
- Families are an important source of emotional support, and patients enjoy seeing and sharing time with family members.
- Family members generally distribute the patient's daily activities among themselves so that the patient can rest.

There are also important intra-group and inter-group variations which have to do with proficiency in English and with legal status in the U.S. Regarding the latter, illegal status in the country is a frequent reason for not seeking health care services (Perry, Kannel, & Castillo, 2000).

In order to promote empathetic relationships that will facilitate trust and lead patients to health oriented behaviors, health care providers must always have in mind that human beings are unique and that factors like country of origin, education, income level, health conditions, and past experiences account for important differences when dealing with health issues. To this end, the next section discusses cross-cultural communication.

SECTION 3: CROSS-CULTURAL COMMUNICATION INVOLVING LATINOS

Patient-Provider Communication

Communication skills are important to foster trustful and useful relationships that can lead to behavior change. Communication is a form of interaction in which a message is passed from one person (transmitter) to another (receptor). The transmitter codifies a specific message that the receptor must decode in order to understand its meaning. Communicating effectively means codifying and decoding verbal and nonverbal messages so that both transmitter and receptor understand their meaning.

Cross-cultural communication occurs when a member of one culture transmits a message that must be comprehended by a member of a different culture. In cross-cultural contact, transmitters and receptors use different codes, a fact that causes misunderstandings among the participants. Misunderstandings and confusion arise from preconceptions on both sides; the transmitter has preconceptions on the way the receptor will react to what he/she says, based on his/her own experience (codification system), while the receptor has preconceived expectations and uses his/her cultural patterns of interpretation to check the meaning of the message sent by the transmitter.

All cultures develop rules for communication. These rules can be referred to according to their impact on the context (the set of stimuli surrounding communication) and the meaningful extent of these stimuli in the communication process. These factors increase the difficulties and challenges for communication and for translation of texts from one language to another.

Moreover, cultures vary in the ways they communicate. In *high context* cultures, words by themselves do not communicate a message. Most of the information imparted by a word is either physical or meaningful because of some assigned meaning within the culture. Context is very important in high-context cultures—for example, Latinos use references from others to express their feelings or needs (“I was told that...” or “Pablo told me that...” instead of saying “I want...” or “I feel...”).

Low Context cultures use language to convey a precise message; words are the message. The context is unimportant.

Figure 3 shows a brief classification of some cultures according to the importance of context along a continuum from high context to low context¹⁵.

¹⁵ Figure is adapted from McGahn, N. (n.d.) Intercultural Communication and Cultural Competence. Retrieved at http://courses.international.edu/bc680/nmcgahn/intercultural_comm/index.html. Derived from research of Porter, R.E., Samovar, L.A., (1994). An introduction to intercultural communication. In L.A. Samovar & R.E. Porter, (Eds.), Intercultural communication: a reader. Belmont, CA: International Thompson Publishing.

Figure 3 – Importance of Context in Communication

High Context
Japanese
Chinese
Mid-east
Greek
<u>Mexican</u>
<u>Latino</u>
Italian
English
French
<u>American</u>
Scandinavian
German
Low context

Verbal mannerisms provide immediate ways of communicating thoughts and ideas, but they are closely related to nonverbal mannerisms that may overshadow them. For this reason, effective communication from a member of one culture to someone from a different culture requires a consideration of nonverbal behavior, which varies from one culture to another. Gestures, facial expressions, eye contact, posture and movement, touching practices, dress, valued objects and artifacts, and the concepts of time and space are all issues to be considered. The concept of time within a culture encloses its past, present, and future philosophy, while the meaning of space within a culture refers not only to the physical distance between two individuals holding a conversation, but also physical attitudes and orientation.

Handling the diverse situations that arise from the interaction between health care providers and patients who do not share a cultural background is obstructed for several reasons that start with a lack of consensus on the definition of culture. A culture is most commonly defined by several aspects that bring its members together, including factors such as language, conventionalisms and symbols which differentiate the culture from others.

Thus, communication between health care providers and patients from different racial or ethnic groups presents many obstacles, from the use of inadequate written material to offensive or culturally inappropriate treatment. Discrepancies regarding the interpretation of information among different cultures may generate problems, delay actions, and impact interpersonal relations. Communicating effectively means codifying and decoding verbal and nonverbal messages so that both transmitter and receptor understand their meaning. Other obstacles are derived from cultural insensitivity, stereotypes¹⁶ and prejudices, presumptions of shared reference points,¹⁷ and differences in language and meanings.¹⁸

¹⁶ *Stereotyping*. Refers to the belief that those characteristics that the individual “knows” about the other’s cultural background define him/her.

¹⁷ *Presumption of common sphere of reference*. Has to do with assuming that the other person shares the same reference points and understands the meaning of what is being communicated.

¹⁸ *Language and meanings of language*. The language of one party cannot be understood by the other party and vice-versa, because linguistic codes or symbols are not the same.

Common sources of miscommunication stem from assumptions (the patient has a phone, owns a car, has health insurance) or misinterpretations of non-verbal behaviors. For example, Latino patients, especially women, may not make eye contact with the physician as a sign of respect; a physician, in turn, may misinterpret this as indifference, lack of understanding or inattention. Fear and apprehension are another source of miscommunication. Working with someone with a different cultural background may generate fears of making mistakes, inadvertently offending, or not being understood.

Because of US demographics, most physicians and health professionals routinely see patients from a wide range of ethnic and racial backgrounds who, in addition to having limited English proficiency, may experience health and disease differently. Cross-cultural communication therefore emphasizes interpersonal skills to be empathetic, warm, and to be able to convey respect. Several communication steps and techniques have been developed for providers can undertake to improve patient-provider communication across cultures and languages (Venguer & Givaudan 1999):

Placing oneself in the patient's place. The mental exercise of imagining a patient's emotional vulnerability, concerns, and likely understanding of what is happening in the patient-provider exchange may give providers insights about questions and fears that patients may leave unstated. The effort to understand the patient's point of view is seen as caring and often leads to empathetic behavior.

Exploring feelings and developing self-awareness. Taking time to explore and think about personal feelings that one may have increases self-awareness about stereotypes, prejudices, and assumptions that have been adopted over time. If unrecognized, these inner feelings and beliefs may influence a provider's capacity to listen and thus the quality of the service they provide, and/or his/her diagnoses.

Feeling less superior. The high regard and value placed on medical science, the ability to deal with life and death, and the ability to ameliorate pain and suffering may unwittingly contribute to a sense of superiority. Becoming aware of these feelings may help providers understand their attitudes and behaviors toward their patients and the manner in which they provide care. Is there an attitude of service, authoritarianism, or paternalism?

Resisting infallibility. Many individuals among the Latino population believe that health care providers are infallible, that they cannot be wrong, and that there is no point in questioning their decisions. Underlying feelings of infallibility may be reinforced by patient behavior. Special consideration must be given to Latino patients who are generally unwilling to question or protest.

Considering alternative approaches. A common prejudice for health care providers is a tendency to underestimate alternative medicine. This bias may increase the reluctance among patients such as Latinos who are accustomed to home remedies and spiritual healings to report these practices to providers during history taking, thereby increasing the chances of poor health outcomes.

Knowing the passive patient. Passivity is a common trait of some Latino subpopulations, particularly those of Mexican origin. A passive patient may easily obstruct the efforts of health care providers because he/she will be reluctant to volunteer information, express concerns, ask for clarification of doubts, or assume responsibility for his/her personal health care. Health care providers who work with Latino patients may need

to probe more deeply and specifically, offering explanation even when not asked and working to educate patients of their role and responsibilities regarding their health.

Finally, in order to encourage a positive interaction that will promote health-oriented behaviors between Latinos and the health system, health care providers should consider common health beliefs and their attitudes and values toward family discussed earlier in this paper. Latinos tend to respond to genuine concern towards their health and generally prefer personal contact that will benefit their families as much as themselves (Preloran, Browner, & Lieber, 2001).

SECTION 4: CONSIDERATIONS FOR USEFUL WRITTEN MATERIALS

The Promotion of Health Through Written Material

Patient education towards health promotion is the key strategy for maintaining and improving health. Physicians, nurses, medical aides, social workers, and other health care providers are responsible for the promotion of health, and as such, they assume important roles as educators. Health care providers must teach people to be responsible for their own health, help them to identify those factors and habits that put them at risk, and educate them to carry out actions that promote their well-being.

Several studies indicate that curricula for health care providers does not include elements to raise awareness of their role as educators, nor do programs include courses teaching them how to establish efficient patient-provider communication (Venguer & Givaudan, 1999).

In order to promote behavior change and the maintenance of health-oriented behaviors in an ever-increasing population, health care delivery must be a continuous process between health care settings, the home, and community of a patient. Health care providers need to promote health care beyond personal attention and face-to-face communication; to achieve it, they must often rely on written communication.

An increase in knowledge seems to be the most reliable effect of written information with respect to health. Nevertheless, one has to consider that information is like medication: it has the potential to improve a patient's health condition, but only when it is appropriate to the specific conditions of that patient and compatible with his/her reading level.

If the material is well-designed, however, a number of benefits can be observed. Written material can also be useful in reducing stress and anxiety associated with lack of comprehension of diagnoses, reinforcing verbally transmitted information. Treatment compliance may also be positively affected (Lawrenson & Leydon, 1998) through the use of written materials. Compliance with written advice, instruction, and appointment keeping are also related to written material. Finally, there is evidence that providing written material influences outcomes and raises the patient's level of satisfaction (Ley, 1998).

In addition, communication technology provides health care providers with new opportunities to benefit patients through non-verbal methods of communication. Such methods provide an effective platform to educate patients with respect to medication instructions, specific diseases, or new ways of preventing an illness. Finally, it should be noted that different media can achieve different objectives: television is highly effective for drawing individuals' attention, while written pamphlets might be the most effective method to help patients to make health related decisions (Beaulieu, Talbot, Jadad, & Xhingesse, 2000).

Challenges:

Although hardly effective by itself in terms of behavior modification, printed material can be useful in terms of informing and complementing health care education, provided it is suitable for the target population. Nevertheless, the challenges regarding the efficacy of written materials are numerous.

As the diversity within the U. S. population grows, health care providers struggle to break down the barriers of communication, with an increasing awareness of the risks that non-

English-speaking patients run with respect to misunderstanding or not comprehending crucial information regarding diagnosis, treatment, health insurance or payment options.

Most written material in the U.S. is written in English at a reading level of tenth grade or higher, so that paradoxically, those groups with the greatest need of health education are the least likely to benefit from this practice. Thus, written material cannot be used by 90 million people who live in the U.S; primarily African-Americans, Latinos, Native Americans, and Whites with low socioeconomic status (Foltz & Sullivan, 1999). High levels of functional illiteracy and low socioeconomic levels co-exist among ethnic minorities. 35% of English-speaking and 62% of Spanish-speaking patients who received health care services in inner city hospitals were functionally illiterate in their primary language, according to a study by Williams et al, 1998 (cited in Horner, Surratt, & Juliusson, 2000). Exacerbating this problem is the fact that when written materials are adapted from English to Spanish, bicultural professionals who could culturally adapt the texts so that contents project the right meaning for the Latino population are rarely consulted in the process.

One of the main barriers for overcoming linguistic and cultural barriers in health care settings is the lack of bilingual and bicultural health care providers.¹⁹ The forms of written language are defined by the specific culture, so that before adapting a text from English to Spanish, specialists should understand the characteristics and needs of the target population (in this case, Latinos). Often, this is best accomplished through the use of individuals who are more intimately familiar with the Spanish language and Latino culture. With this in mind, the following two sections outline two processes for developing written materials in another language: translation and cultural adaptation.

The Process of Translation

Human beings from different places communicate in a variety of different languages, and while we all have the capacity to learn languages that are not our own, it is impossible to comprehend and communicate, either through writing or speaking, in a language that we do not understand. Thus, all the information that is inaccessible to us due to language barriers would remain inaccessible were it not for translation or interpretation, i.e. processes that allow for information to be transmitted in a language that we can understand.

Nida and Taber (1974) have defined the term “translation” as “*reproducing in the receptor language, the closest natural equivalent of the source-language message, first in terms of meaning and second in terms of style*”. A good translation ensures that information is transferred across the barriers of communication and language. It is also reliable, offering an adequate representation of its source with messages remaining essentially intact. Thus, written materials are useful when they achieve these objectives.

Translations cannot be derived products, mere copies, or substitutes. They can never repeat, coincide with, or duplicate their source since languages and cultures are neither symmetric nor isomorphic. This means that there is no identical correspondence between two texts in two different languages, with respect to the number of words used to convey an idea or concept, nor will there be an equivalence between the number of ideas a word implies. Not only does a given language change with translation, so does the context, the moment and the function—in short, the entire communicative situation (Hermans, 1998).

¹⁹ *Bilingualism*: Equal ability to communicate in two languages. *Biculturalism*: Familiarity with two distinct cultures in one nation or geographic region.

Historical and social contexts present difficulties for translation. Caro and Stiles, 1998 (in Banville, Gene-Volet & Desrosiers, 2000) state that translating is difficult because it “*is not a simple mechanical matter of changing words from one language to another, but a subtle and personal task, an act of re-creation, of reconstruction*”.

Thus, any theory or translation model is not workable if it is confined to the treatment of separate words or sentences. Even though many of the basic needs of human beings do not change drastically from one culture to the other (e.g. all people need health care services), the way in which cultural situations are perceived or interpreted may differ substantially from one language to the other.

Just as there are no two words in a language that have the exact same meaning, no word has an exact equivalent in another language. Words bring with them the atmosphere and rhythm of the historical, cultural, and aesthetic tradition; they obtain their meaning through their association with other words, through the link with their cultural and historical past and through their rhythmic and sonic constructions within a given sentence.

Words by themselves have very loose boundaries. In most cases they are very general and do not reflect specific connotations. For example, those verbal expressions that express feelings in one culture have certain characteristics that cannot be reproduced in another. Thus, in the process of translation, any interpretation of words or phrases must consider the etymological, cultural, and historic associations embedded within the context.

The Minnesota Department of Health, in a guide on the translation of materials for LEP communities, states that the most frequent difficulties in the process of translation result from failure to recognize the meaning of words or phrases within a particular context in the mind of the reader.²⁰ This is why information that is transmitted from one language to the other depends on the agreement about the context in the minds of the one who translates and the one who reads or listens to what is said; for this is where most misunderstandings occur. If there is no mutual understanding of the context, there will be no mutual understanding or communication. Context is the main factor in determining meaning.

Regarding the context, several types of meaning have to be acknowledged in order to communicate a message:

Cultural. Refers to the environment in which an individual lives that structures his/her way of thinking. Characteristics of our thinking process are determined by the culture in which we live (e.g. our culture determines which foods are acceptable—beef, worms, etc.)

Idiosyncratic. Has to do with each individual’s own idiosyncratic knowledge of language. The meaning of each word is incorporated in a person’s own lexicon because each word is learned in a series of discrete contexts and stored in the memory according to that context. An example of an idiosyncratic use of language might involve words that people use as expressions, but that are also nouns, as when a Mexican says “Chihuahua”, he might be expressing surprise, anger or anxiety, though “Chihuahua” is also the name of a state in Mexico.

²⁰Minnesota Health Department (Nov 2000). Translation Protocol: A Guide to Translating Materials for Limited English-Speaking Communities. Retrieved November 12, 2002 from <http://www.health.state.mn.us/communityeng/multicultural/translation.pdf>

Physical Environment. Deals with the fact that each environment, apart from having its own very characteristic flora and fauna, conveys an image of the world in which language is codified and decoded. This determines the meaning of words with respect to experiences related to the environment. For example, when saying “it is hot”, inhabitants of a tropical island are not talking about the same temperature as inhabitants of Alaska.

It can be said that the cultural, idiosyncratic, and physical environment’s meanings constitute the situational meaning. When translating, it is necessary to include the original situational meaning in a manifest way, so that the total meaning is communicated.

Linguistics:

Linguistics, the study of human speech, includes the following elements-

Lexis. Has to do with the way each word in the vocabulary of a person is connected to other words in his/her mind. There are words whose meaning is determined by the context in which they are used. Generally, their “formal” (dictionary) meaning is different from their meaning in daily use. In order to transmit the meaning of these words from one culture to another, it is even possible for the word not to be used since its utilization could alter the message.

Sense relationships. Refers to the ways in which words can connect themselves through sharing some area of meaning. These relations are bound with language and culture.

Topical relationships. Deals with the way a word is used in an expression so that the context indicates its meaning, even though the word by itself is unknown to the reader.

Grammatical relationships. Refers to the meaning transmitted through grammatical relations. Meaning depends on the characteristics of the original language and the target language.

Referential. Refers to the vehicle through which the transmitter refers to an object to bring it into context. A word refers to a certain attribute, event or “thing” which individuals can perceive or imagine. Popular expressions provide a good example. Their meaning can be transmitted in a different language without literally translating, by using words that convey the same idea. For example, the Spanish version of the expression “No news is good news” is “*Las malas noticias viajan más rápido*” (Bad news travels fast).

In order to produce a good translation, it is necessary to discover the meaning in the language of origin and to use forms within the target language that express that meaning in a natural way.

The Process of Cultural Adaptation

Based on the considerations outlined in this paper, the authors of this paper suggest that the term “*cultural adaptation*” be used to replace the word “*translation*,” because an adequate cultural adaptation:

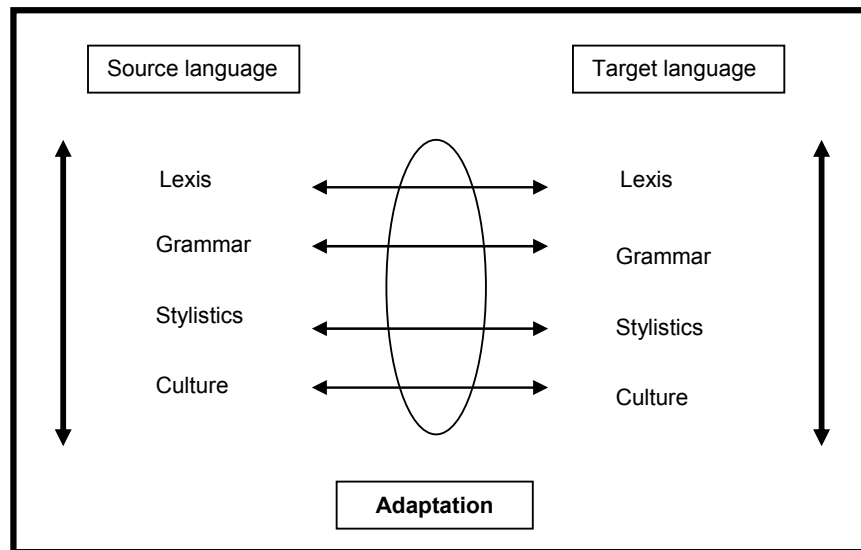
1. Uses the normal forms of the target language;
2. Communicates to speakers of the target language the message that was meant by the speakers of the original text as precisely as possible; and,

3. Maintains the dynamics of the original language of the text, so that the result is presented in such a way that it will evoke the same response that the original text meant to evoke.

The process of cultural adaptation is a process of communication and is based on the linguistic and cultural repertoires that run parallel to each other which are constantly moving to match and replace lexis, grammar, stylistics, and cultural equivalences. Culturally adapting information from one language to another necessarily implies transmitting the meaning and form of a message from one culture to another.

In the case of culturally appropriate written material for health care promotion, following this process means determining the type of contents, the target population and its characteristics, the distribution of the material, and the method for its production. The final result is intended to support, never substitute, the efforts of the health care provider and those of the patient. **Figure 4** illustrates this process:

Figure 4. Process of cultural adaptation (Darwish, 1989).



Apart from culturally adapting the information, health care providers face the difficult task of interpreting medical terms and/or hospital policies for their patients. If this is not done appropriately, the information may confuse and even harm the patient, while jeopardizing the health care provider's credibility and integrity in the eyes of the patient.

Although limited to overcoming linguistic and cultural barriers regarding mental health, the following strategy, developed by the American Psychiatric Association for the Diagnostic & Statistical Manual of Mental Disorders, is useful in terms of presenting examples of what has to be considered in written and oral cross-cultural communication in health care settings. It includes:

- Information concerning cultural variations in the clinical manifestation of disorders included in the classification;

- An appendix with the description of 25 unclassified syndromes related to culture that do not correspond or fit in any of the formal descriptions of mental diseases; and,
- A cultural formulation outline to evaluate the context of the individual (see **Table 2**).

Table 2. *Cultural formulation outline*

Cultural identity of the individual (ethnic and cultural reference groups, degree of involvement with both the host culture and the culture of origin, language abilities);
Cultural explanations of the individual's illness ("nerves", possessing spirits, somatic complaints, misfortune);
Cultural factors related to psychosocial environment and levels of functioning (social stressors, social support systems, role of religion and kin networks);
Cultural elements of the relationship between the individual and the clinician (differences in culture and social status between the clinician and the individual; difficulty communicating in the individual's first language; difficulty relating or eliciting symptoms or understanding their cultural significance), and
Overall cultural assessment for diagnosis and care (discussion on how cultural context specifically affects comprehensive diagnosis and care).

Thus, the cultural adaptation of written material is clearly intended to bridge potential gaps in cross-cultural communication by addressing the potential gaps very early in the process. In this manner, anticipating and understanding the needs of the target population (Latinos) can lead to the production of more effective written materials, since the variables of culture and language are considered at every stage in the process.

Conclusion

As a complement to oral communication between patients and providers and permeating through all the processes related to the health care system, written communication is a key factor in the education of patients towards their own health care. For written material to be effective, meaning that it provides clear and comprehensible information and influences the beliefs, attitudes and intentions of individuals so that they make health-oriented decisions, it has to acknowledge the language and culture of those individuals.

In the case of the Latino population in the U.S., the health care system must provide Spanish-language documents that are either specifically developed for Latinos or culturally adapted from English in form and content, so that they reproduce as closely and naturally as possible the original message(s) according to the needs and characteristics of this group. To achieve this, cultural adaptation must take into account the linguistics of the Spanish language and the meaning of words according to the context in which they are written. Important considerations for adequate cultural and linguistic adaptation of written material for Latino patients include the way Latino patients perceive and react to sickness/health and the health care system, the role Latino families play in health-related issues, and the literacy level of individuals.

Never a substitute for face-to-face communication between patients and providers, cultural adaptation of English-written material to Spanish, as opposed to translation, is absolutely necessary to overcome communication and language barriers among Latino patients and English-speaking health care providers. Cultural adaptation is not an option; it is a requirement if the health care system wants to educate Latino patients to act towards their own health. The process must be carried out by bilingual and bicultural individuals, preferably health care providers who are familiar with the Latino culture, language, and health care promotion.

Appendix A: Latino Health Issues in Comparison with Other Groups

Regarding health issues and in comparison to other ethnic and racial groups, the Latino population is characterized by:

- Lower rates of infant mortality;
- More health-related disorders than Whites;
- Higher rates of hypertension and obesity than Whites;
- Having twice the tendency to die of diabetes than Whites (10% of Latinos suffer from diabetes);
- Together with diabetes, HIV/AIDS is one of its major health problems, with Latinos representing 18% of the total number of reported cases of HIV/AIDS and 23% of children's AIDS;
- Lower use of alcohol, tobacco and drugs; and,
- Significantly less susceptibility to reporting chronic diseases.

The following table shows the leading causes of death among Latinos and Whites²¹.

Table 1. *Leading causes of death among Latinos and Whites*

Hispanic Deaths, 1998	White non-Hispanic Deaths, 1998
<ul style="list-style-type: none"> • Heart disease • Cancer • Unintentional injuries • Stroke • Diabetes • Homicide & legal intervention • Liver disease & cirrhosis • Pneumonia and influenza • COPD • HIV/AIDS • Suicide • Infant mortality 	<ul style="list-style-type: none"> • Heart disease • Cancer • Stroke • COPD • Unintentional injuries • Pneumonia & influenza • Diabetes • Suicide • Kidney disease • Liver disease

The main causes of death for Latino children include low birth weight, birth defects and unintentional injuries. Motor vehicle injuries, injuries by fire arms and teen-age pregnancies are the most common cause of death among Hispanic youth (Keppel, Pearcy and Wagner, 2002).

The major health issues facing Latina women in the U.S. are²²:

- 1) Health care access. More Latina women are uninsured (30%) to an extent higher than any other race/ethnic group, even though many of them are employed or live with

²¹ Adapted from a PowerPoint presentation by Blanca Torres for the Center for Disease Control, Office of the Director, Office of Minority Health (May, 2001). Hispanic/Latino Socio-Economic Status and Health Profile. Retrieved November 11, 2002 from <http://www.cdc.gov/od/admh/ses.ppt>.

²² National Women's Health Information Center, U.S. Department of Health and Human Services, Office on Women's Health (1998). Latina Women's Health. Retrieved November 11, 2002 from <http://www.4woman.gov/faq/latina.htm>.

someone who is employed. Difficulties with language, transportation, childcare, immigration status, or cultural differences act as further barriers to health care services.

- 2) Diabetes
- 3) Obesity
- 4) HIV/AIDS
- 5) Prenatal care. Many Latina women do not receive timely prenatal care in the first three months of pregnancy.

With respect to health information of Latino men in the U.S., precise and reliable data is hard to find, potentially because men access health care services to a lesser extent than women.

Disparities in health care service utilization also affect Latinos. Research data indicates that the average number of medical visits by Latinos is lower than the average number for any other ethnic group (Trevino, Moyer, Valdez & Stroup-Benham, 1991). This could be explained by the fact that Latinos have the lowest percentage of insured individuals in the U.S, -in 1998, 35.3% of Latinos lacked medical coverage, in contrast with 15% for Whites and 22% for Afro-Americans (Collins, Hughes, Doty, Ives, Edwards and Tenney, 2002). Moreover, poor interaction between Latinos and health care services is also due to their difficulty in communicating with and understanding health care providers. Finally, results of an analysis carried out by *Healthy People 2010*²³ indicate that 40% of the population-based, final and interim objectives did not include Latinos in their baseline data. Ironically, one goal of *HP 2010* is to eliminate health inequalities, yet because data is not available for many of these objectives, health disparities among Latinos are likely to persist.

²³ Document published by the U. S. Department of Health and Human Services (DHHS), referring to U.S. health goals to be achieved by the year 2010. Available at <http://www.healthypeople.gov/>.

Appendix B: Models of Health Promotion

Health Belief Model (HBM). Developed in the 1950's by Godfrey Hochbaum, Stephen Kegels and Irwin Rosenstock with the intention of explaining the reasons for the failure of people to participate in health-oriented behaviors such as screening and immunization programs, this model provides a method to explain and predict preventive behavior. The model was based in psychosocial theory, particularly the work of Kurt Lewin, which itself is rooted in phenomenological orientation, describing positive and negative influences that impact the subject's world, affecting his/her behavior. This model is considered to be pioneering work, having spawned systematic and theory-based research in behavioral conduct.

The model proposes that in general, behavior depends on how much an individual values a particular goal and on his/ her judgment that a particular action will achieve that goal. It is based on three premises: 1) the belief or perception that a certain problem is serious or important enough to give it some consideration; 2) the belief or perception that one is vulnerable to that problem, and 3) the belief or perception that the action will result in a benefit, at an acceptable personal cost. If the goal is to prevent a specific health problem, the individual must feel personally vulnerable (perceived susceptibility) to a situation that he/she has previously classified as serious (perceived severity) and must believe that the benefit of an action undertaken to reduce a health threat (perceived benefit) will be more significant than any obstacles to that action (perceived barriers).²⁴

With respect to Latinos, LEP individuals generally perceive their ability to communicate as a barrier to health care access, feeling great frustration at not being understood by health care providers and not understanding medical instructions. Often, Latinos generally do not perceive themselves as susceptible to illness and they are not sensitized with respect to behaviors that present health risks. According to this model, therefore, a program in health promotion for Latinos must address these feelings of reduced susceptibility and increased perception of barriers to action among Latinos.

HBM has been widely used during more than 30 years; critiques to the model refer to its limitations, including a lack of uniformity in the testing model, variable operation and evaluation instruments. An important objection to this theory is that it does not include normative or cultural factors such as socioeconomic status or previous experiences that are important in explaining health-oriented behavior.

Theory of Reasoned Action (TRA) Human behavior theory, developed and tested by Fishbein and Ajzen (1975), aims at explaining the relationship between beliefs, attitudes, intentions and behavior and is based on the assumption that human beings are rational and apply information available to them in a systematic way, weighing the costs and benefits of a particular action. The objective of TRA is to predict motivational influences on behavior and to identify how and where to direct behavior modification strategies.

According to this theory, the most important determinant of a person's behavior is the intention to carry it out (behavior intention). The intention to perform a behavior is a combination of attitude towards performing the behavior (based on beliefs about the consequences of performing it) and subjective norms. In this way, individuals will have the intention of performing a behavior not only when they have a positive attitude towards it but

²⁴ See Soto, Lacoste, Papendufuss and Gutierrez, 1997.

also when they believe that other significant individuals think they should do so (Fishbein, 1990).

Regarding health care, if an individual has the intention of going to the clinic for a check-up, and his/her partner and children think that this is an important action, the individual will go not only because it is important for him/her, but also because it is important to people who have a special place in his/her life. In like manner, Latinos often place the needs and desires of their families above their own individual needs.

One of the main objections against TRA is that it focuses more on explaining intentions than behaviors, while the goal of researchers (and health care providers) is to understand and modify behavior. The main advantage of the model, however, is that it includes a culture-based perspective of behavior. This perspective is vital to promote health-oriented behaviors, since it deals with culturally-dependent variables such as popular beliefs, social norms and gender roles that have to be considered when working with patients from different ethnic and racial backgrounds.

Transtheoretical Model/States of Change. This model results from the work of Prochaska and DiClemente (1984) which compared the experiences of individuals who quit smoking on their own to smokers under professional treatment, determining the states of change that individuals go through to modify their behavior. The model posits that intentional changes in behavior are achieved through a six-stage process that: 1) begins before an individual is aware of a need for change (*precontemplation*); 2) increases awareness of the risks and need for change (*contemplation*); 3) involves the seeking of information and preparation to take action (*preparation*); 4) leads to an action or behavior change (*action*) to 5) institutes a habit of new behaviors (*maintenance*); and 6) extinguishes the old behavior (*termination*).

The model is circular, not linear, which means that the individual can go in and out of a stage. It also contemplates the possibility of individuals returning to previous stages. A more complete description of the stages is presented here:

1. Precontemplation. This is the stage in which individuals are not thinking of the need to change and there is no awareness of possible reasons to modify a specific behavior. In this phase, subjects might not know that certain behaviors put their health at risk or that they have a health problem; alternatively, individuals are aware of the problem or risk but do not want to change their behavior. For example, Latinos generally eat foods rich in fat and, although most of them know that eating large amounts of fat is unhealthy, they are not likely to change their eating habits.
2. Contemplation. The individual realizes that certain behaviors are risky or that he/she has a health problem. A problem is identified and recognized and the intention of change is already present. (The subject realizes that the excess of fat is causing weight gain and heart problems). He/she has the disposition to do something about it in the next six months but does not yet act. (Subject decides that the best thing to do would be to eliminate food rich in fat, but he/she will not do it just yet.)
3. Preparation. The subject intends to act within the next 30 days and takes some behavioral steps in this direction. He/she is willing to give it a try. (Subject starts compiling fat-free diets and has the will to try to eat differently, though he/she will not start dieting just yet.)

4. Action. The individual carries out active work toward modification of behavior. (Subject starts eliminating foods rich in fat from his/her daily diet, although sometimes he/she still eats them.)
5. Maintenance. The subject makes a habit of adopted behaviors. He/she must practice them continuously. The habit is consolidated at this stage, and the individual is able to maintain the new practice. (Less and less greasy foods are included in the diet and relapses are rare.)
6. Termination. Previous overt behavior will never return, and there is complete confidence that it is possible to cope with the change without fear of relapse. (Greasy foods are completely eliminated from the daily diet.)

The most important contributions of this model have to do with its consideration of the common problem of relapses in behavior modification processes, while taking into account the potential ineffectiveness of any health-oriented program if the targeted subject or population has not identified the health problem.

Identification of the problem is extremely important for Latinos since they tend to blame external forces (luck, God, fate) for what happens to them, with less awareness that personal health care is each person's responsibility than may be true for other ethnic groups. This feeling of diminished personal responsibility may account for constant relapses; if individuals do not understand the relationship between their health habits and their health, they will not follow through with lengthy treatments or changes in behavior.

According to Ockene (1992), during the precontemplation stage, information must be provided in a manner that personalizes risks and benefits while transmitting expectations of success. However, during the contemplation stage, as the individual is progressively more aware of risks and the need for change, risk-related information is of no use and may in fact raise anguish unnecessarily. In this stage, the proper use of information can promote a change in attitudes, beliefs and knowledge, but it is important to promote the development of life skills that will assist the individual in developing a behavior modification plan and sticking to it.

Regarding the provision of health-related information, and in relation to the stages in this model, Carpi and Breva (2002) mention that individuals in the precontemplation phase could lack information, be misinformed, feel incapable of making changes or even be unaware of the possibility of change. They are generally defensive with respect to their habits and are extremely resistant to external pressure.

Social Cognitive Theory. Proposed by Bandura (1977), this theory "embraces an interactional model of causation in which environmental events, personal factors and behavior all operate as interacting determinants for each other". The model focuses on the social origins of human thinking and on the role of thinking processes in human motivation and action.

An individual learns through direct experience and the observation of other people's behaviors and their consequences. In this "Modeling" process, he/she develops rules to generate and regulate his/her behavior without needing to go through trial and error. Behavior is strongly influenced by self-regulation (evaluation of one's own actions in terms of personal standards) and self-reflection (analysis of personal experience to alter thinking).

Latinos, especially those who grow up in poor socioeconomic conditions, live in a culture in which health care is not always a priority, and role models (parents, grandparents, teachers, etc.) may perpetuate unhealthy behavior (e.g. poor eating and hygienic habits and careless sexual behavior). At the same time, health-related actions are hardly self-evaluated due to the already mentioned cultural tendency of Latinos to detach from personal responsibility (Venguer & Quezada, 1999).

Bandura includes two basic concepts to understand behavior: self-efficacy and locus of control. Self-efficacy refers to individuals' feelings regarding their capacity to respond to changes in the environment in an adaptive manner (Maddux, 1995 in Schwarzer, 1998); while the concept of "locus of control" refers to the belief of individuals regarding the origin of things that happen to them.

According to the author, individuals can be classified in two categories: those who have an internal locus of control and those who have an external one. The first group believes that individuals can control events, and that outcomes are the result of their behavior. This being the case, it is easier for them to engage in behaviors that they will control and for which they will be responsible. On the contrary, individuals who feel that they have little control over their life and the consequences of their actions, find it difficult to even think of changing their behaviors.

Behavior modification regarding health is generally difficult to achieve among Latinos because their culture dictates that they should have a passive attitude towards life, leading them, in general, to believe that they cannot control events.

Community Organization Building (COB). This theory emphasizes that the social milieu of a community has an important role in validating messages concerning good health behaviors, while creating external pressures (e.g. peer pressure, social norms) that support an individual's decision to change behaviors.

This model centers on the prioritization of problems by the community, so that its members develop a sense of belonging and responsibility and work jointly to solve their health problems. The success of this theory's application depends on the participation of the community, but since the intra-personal factors that influence behavior are not contemplated, COB's efficacy is limited.

Appendix C: Review of Literature on Language Barriers

The preference of Latinos in using the Spanish language has been associated with poor knowledge, decreased use of preventive services and lower health status, even after controlling for variables such as education and medical insurance coverage (Polednak, 1996 in Derose & Baker, 2000). The Department's Agency for Health care Research and Quality (AHRQ) has found that 1/2 to 1/3 of the barriers of Latinos to health care services are associated with limited English proficiency (LEP) to a greater extent than factors including income and health insurance.

According to the results of a survey released in March 2002 by the Commonwealth Fund, a private New York-based health research foundation, Latinos generally cite communication problems, such a failure to understand the doctor or a feeling that the doctor does not listen to them. According to a recent study, limited English proficiency (LEP) is as important a predictor as lack of health insurance in dissuading Spanish-speaking Latinos from seeking health care.²⁵

Derose and Baker (2000) found that limited English proficiency is a barrier between many Latinos and their use of health services, and as such, is an important determinant of health care service utilization. Results indicate that LEP Latinos report significantly fewer visits to health care services than English-speaking non-Latinos. Moreover, LEP patients are less likely to be referred for follow-up appointments due to communication barriers, frustration, or because physicians do not fully understand the nature of their problems. Also, because of communication barriers, patients with LEP may not understand the need or the specifics for follow-up care and may not return for follow-up visits.

LEP Latinos are also susceptible to medical errors if they lack assistance including interpreters and written, audiovisual or interactive material in Spanish. Their limited or non-existent capacity to deal with linguistic barriers (and consequently, cultural barriers) obstructs communication, generating inaccurate information that may lead to serious consequences, such as the creation of erroneous medical files or irreparable health damage. Racial and ethnic disparities have also been found to exist for children who do not speak English or whose parents have difficulty with English (Weinick and Krauss 2000).

Another example of the impact of language barriers is found in a study prepared by the Access Project,²⁶ in which more than 4,100 patients were surveyed, of whom 15% needed the assistance of an interpreter, Spanish being the language of origin in 95% of cases. Results from this study show that 45% of those individuals who required but did not have access to an interpreter perceived low helpfulness of health care providers and services. More than 25% did not understand prescriptions, while almost one third of the individuals stated that they would not use the health service again. The study provides persuasive, consistent evidence of the importance of communication across language and cultural barriers.

²⁵ California Pan-Ethnic Health Network (March, 2001). *Diverse Patients, Disparate Experiences*. Retrieved November 11, 2002 from http://www.cpehn.org/pdfs/diverse_patients.pdf.

²⁶ Andrulis, D., Goodman, N., and Pryor, C. (April, 2002). *What a Difference an Interpreter Can Make*. Boston: The Access Project. Retrieved November 11, 2002 from http://www.accessproject.org/downloads/c_LEPreportENG.pdf.

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