

RACE, CULTURE, AND TRUST: WHY SHOULD I TAKE A SHOT IF I'M NOT SICK?

This three-part panel discussion provides information on: 1) the role religious leaders can take in influencing health care, health access, and compliance; 2) barriers to equal health care and major gaps in immunizations among Hispanics; and 3) population management strategies for public health officials and private practice physicians. Citing barriers such as mistrust of government programs, socioeconomic conditions, lack of access to preventive health-care services, cultural attitudes, and lack of education about immunizations, the speakers also offered solutions to overcome resistance to immunization. Panel members supported these strategies and provided techniques to implement the strategy: engaging faith-based organizations, improving patient-provider communication; and creating public health initiatives to be culturally competent. (*Ethn Dis.* 2005;15[suppl 3]:S3-13-S3-16)

Key Words: Culture, Hispanic, Immunization, Race, Trust

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PART 1: THE ROLE OF THE FAITH COMMUNITY IN INFLUENCING HEALTH CARE

Religious leaders can play an important role in influencing health care, health access, and compliance, but they must have the knowledge and resources to advise their members and must provide the same information that health professionals give. The faith-based community often has better ways of getting information to its constituents than any other institution for minority populations, and is an important venue for increasing immunization rates.¹ The 11 o'clock hour on Sunday morning is the most segregated hour in the United States. Regardless of their faith, members get together for much of the weekend.

Looking to Faith Leaders for Information

Traditionally, church members from all faiths have looked to their leaders (clergy or lay) for direction on economic, education, and health matters. Health professionals must enlist faith-based leaders to assist in influencing the immunization rates. For example, if a person becomes ill, one of the first calls he or she makes is to a clergyperson. The person who is sick can take care of three things in one phone call: "Should I go to the doctor or hospital? What should I do? Please pray for me."

Nurses, doctors, and other health professionals who can give direction for a congregation on all health matters are participating in "back pew medicine." Members of the congregation consult them informally for advice about their health. This places clergypersons between a rock and a hard place. They are expected to know a little bit about a lot

of things. They can not just say they do not know.

Faith and The City (www.faithandthecity.org) is helping clergymen gain the knowledge and is providing the resources they need to impart accurate information to their congregations.

Uphill Battles in Immunization

Health professionals seeking to immunize the public face three uphill battles:

- Government mistrust still exists. People remember the Tuskegee, Alabama, syphilis scandal in which as many as 100 African-American males died of syphilis in a US Public Health Service study, even though a proven cure (penicillin) became available. Incidents from military service, such as the Desert Storm illnesses, are also given as reasons for doubting the government.^{2,3} See Figure 1 for messages that convey widespread mistrust.
- After health professionals convince people to get flu shots and to lay aside their issues with immunization, the vaccine may not be available.
- When the vaccine becomes available, people may wonder if it is safe to take.

The clergy must be confident in what they tell their members and consistent with what the health professionals are saying. A clergyperson must be able to answer his or her members' questions and avoid expressing personal opinions about the safety of a vaccine. It is understandable that clergypersons are reluctant to condone something that some members perceive as harmful. Clergy and lay leaders need to be well educated about health topics and should be targeted when health professionals

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Fig 1. BOONDOCKS cartoon illustrates barriers to overcome in educating patients about immunizations. From THE BOONDOCKS © 2004 Aaron McGruder. Dist. By UNIVERSAL PRESS SYNDICATE. Reprinted with permission. All rights reserved.

educate the public about immunizations.⁴

PART 2: IMMUNIZATION BARRIERS IN HISPANIC/LATINO COMMUNITIES

Health Disparities

Hispanic individuals, the largest minority group in the United States, face major disparities in health care, not just in immunization but also in disease outcomes, access to care, and disease prevalence.

Major Gaps in Immunization

Although the Hispanic population made progress between 1989 and 2001 in the percentages of 65-year-olds receiving influenza vaccinations, there was a downturn between 2000 and 2001. The Hispanic immunization rate exceeded that of non-Hispanic Black persons, but did not reach the level of non-Hispanic Whites. Major gaps are also evident in the percentages of 65-year-old Hispanics receiving pneumococcal vaccinations between 1989 and 2001. Although the trend in the Hispanic population was upward, the percentage never reached the level of immunization of non-Hispanic Whites. (Department of Health and Human Services. *Healthy People 2010*. 2nd ed.)

Barriers to Equal Health Care

The four main barriers in eliminating health disparities are socioeconomic conditions, lack of access to preventive healthcare services, cultural attitudes, and education (lack of understanding about immunizations).

Socioeconomic factors play a large role in explaining why a gap exists between Hispanics and others in obtaining health care.

Spanish: "Doctora, lo que yo gano no me alcanza."

English: "Doctor, what I make is not enough."

The three main socioeconomic factors are: 1) salaries are insufficient to care for families in the United States and "back home" and to pay for health care; 2) absence from the job to seek immunization (when the vaccine may not be available) may lead to job loss (even with a note from the doctor); and 3) many lack health insurance or do not understand that they qualify for it.

Access to Preventive Healthcare Services

Spanish: "Mi hija tiene que venir conmigo y su unico dia libre es el Domingo."

English: "My daughter has to come with me, and her only day off is Sunday."

The access barriers include lack of transportation, limited English proficiency (LEP), lack of familiarity with the US healthcare system, administrative complexities of the health plan (not knowing the restrictions and advantages of the plan), and immigration status. Undocumented immigrants may fear exposure during registration or financial screening in a clinic setting. Legal immigrants may fear that their application for permanent residency or citizenship will be jeopardized by using publicly subsidized services.

Cultural Attitudes

Spanish: "Por que, si yo nunca me enfermo. Gracias le doy a Dios."

English: "Why should I get a flu shot if I never get sick? Thanks to God."

Differences exist in traditional vs conventional medicine, lifestyle behavior, and the cultures and languages of patients and healthcare providers. A patient is more satisfied with health care when his or her physician has the same background and speaks the same language.⁵

Education

Spanish: "Como se yo que eso no se revive en cuanto entre a mi cuerpo?"

English: "How do I know that [the vaccine] will not come alive when it enters my body?"

Hispanics may be more afraid of the vaccine than of the disease. They may think there is no need for a healthy person to take it, that it might not be effective (too much or too little), that it will weaken the immune system, and that is it being given as an experiment (which reveals lack of trust in the health system).

Eliminating Barriers

The ways to overcome resistance to immunization in the Hispanic community are to:

- Identify the barriers;
- Create culturally appropriate public health initiatives;
- Promote family and community support;
- Provide equitable access to quality health care; and
- Train healthcare providers to be more culturally competent—to know how to work with people of different backgrounds, to respect them, and to acknowledge differences in their beliefs.

PART 3: POPULATION MANAGEMENT STRATEGIES FOR IMPROVED IMMUNIZATION RATES

Toward Total Community Health

Dr. Wong spoke from the perspective of a physician involved in Kaiser Permanente's population management strategies related to treating chronic diseases in large populations and of a front-line provider in seeing patients at Asian Health Services, a federally qualified health center in Oakland (California) Chinatown. He has seen patients react to immunizations in diverse ways: gladly standing in line for flu shots, refusing to take the pneumococcal vaccine, and using the threat of "a shot" to make their children behave.

Among Medicare beneficiaries, Asian enrollees had influenza vaccination rates of 74% but only 51% rates of

immunization with the pneumococcal vaccine.⁶

Cultural Context of Immunizations

Cultural competence is important in each component of immunization: outreach, in-reach, interactions between providers and patients, obtaining consent, administering the vaccine, and following up. If the patient and the provider are not of the same background, the result can be "cultural dissonance." For the past 10 years, training has been taking place in America to prepare physicians and healthcare teams to be more culturally competent in dealing with their patients.⁷

Major Obstacles and Challenges in Patient Outreach

Providers need to overcome the perceptions of the patient, his or her family, and the community about immunizations. Some health entities have used special events such as "Bring a Loved One to the Doctor" Day to promote stronger patient and provider interactions. The outreach activities should be bilingual and should take into consideration the level of "health literacy" among patients. *Do they understand what you are telling them?*

In-reach Activities

The in-reach issues focus on patients' perceptions of immunizations. Are vaccines just for children? Are they for "sick" adults? Are many people taking the shots, not "just me"? Should I be concerned about safety?

Provider-patient Communication

Two questions are important in communicating with patients: With whom should I talk? (The matter of patient confidentiality vs the family unit.) How much does the patient understand? (Go lightly in using bio-medical jargon, use trained adults as translators, and determine how much the patient understands.)

Obtaining Consent

Getting a patient's consent to be vaccinated can be a "land mine" for providers.^{8,9} It sends a mixed message, in that the doctor is telling the patient that the shot is good for her while asking her to sign a consent form to absolve the medical facility of responsibility if she becomes ill from the shot. There is a critical need for translators and staff who are trained to be supportive. Still, patients should not feel coerced to submit to the immunization.

Tips for Administering the Vaccine

The following tips will be helpful to providers as they give the vaccine: let the patient see what is happening, remove the mystery by narrating each step in the process, forewarn patients about pain from the vaccination, be respectful and use proper precautions, and visibly dispose of the needle so that the patient will see that it will not be re-used.

Following Up

Two steps are important in follow-up: 1) explain clearly any potential side effects, and tell the patient what to expect; and 2) guard against confusion or mistrust by explaining that all vaccinations are not the same. Some are "booster" shots, some are required yearly, and others are used for diagnostic purposes.

Kleinman's Questions for Increasing Cultural Competency

Arthur Kleinman at the University of Washington suggests using the following questions as a culturally competent approach to communicating with patients.¹⁰ The questions can be useful in administering immunizations.

- What do you call the problem?
- What do you think caused the problem?
- Why do you think it started?
- What do you think about the sickness?

- What are the problems the sickness has caused?
- What do you fear about the sickness?

QUESTIONS AND ANSWERS FROM SESSION ON RACE, CULTURE, AND TRUST

Q. What other outreach programs should we consider in addition to working with the faith-based community?

A. Dr. Genao: Get to know the community. Don't stereotype. Find out what is important to the people. What do they see as problems? Be respectful of the answers—they may be different from what you expected to hear.

Dr. Burnett: Make sure the faith-based organization or any other group involved in community-based health agrees to work with all other entities in the community to “make things happen.” One organization cannot do it alone.

Q. How do we provide information to ministers in rural areas who are willing to help educate their members about immunizations?

A. Dr. Burnett: Engage the target population in helping develop the educational materials. Use the language that the people understand and obtain feedback by asking if the materials “speak” to them.

Q. Can cultural competency be taught to physicians whose backgrounds differ from those of their patients?

A. Dr. Genao: It is impossible to know everything about a culture. So many differences exist, even within families. We need to educate doctors to rec-

ognize and respect the differences. Patients are looking for providers who understand where they are coming from and respect who they are.

Dr. Wong: It is not just a matter of producing more physicians who are culturally competent. We must also hold organizations accountable for developing cultural competency. Organizations should examine their structure, their hiring practices, their policies, and their healthcare delivery so that they can address diversity.

Dr. Burnett: Spend time with a patient to understand where he or she is coming from. The patient-physician relationship is built on time.

Q. How does it affect your community when certain populations, such as young White mothers, reject vaccines outright?

A. Dr. Wong: We need to understand why those groups feel the way they do. The history of the community is important. For example, Asian immigrants were lined up and given shots in refugee camps. We need to find out what the un-immunized community has experienced and what they perceive to be important, not just in medical procedures but in the total sphere of things.

Dr. Genao: A patient's perception of pain from an immunization counts a lot in how they feel about receiving a vaccine.

Q. With people migrating to geographic areas of the nation where providers lack cultural competency and linguistic skills, what are substitute ways to protect the community?

A. Dr. Wong: Traditional medical practice has not been that successful in

terms of immunizing our most vulnerable populations. It is not inconceivable that community health workers in the future will be called on to provide immunizations.

Dr. Burnett: The physician's relationship with the community is important. In geographic areas where the people lack representation in the healthcare delivery system, the system should relate to the community so that cultural competency is potentially achievable.

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