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Health Promotion Activities in the Israeli Arab Population:

To What Extent Are They Culturally Appropriate and What Can Be Done to Make Them More So?

Executive Summary

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RESEARCH REPORT

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Executive Summary

Background: There is growing emphasis in Israel on cultural appropriateness of health promotion programs as a way to facilitate health-enhancing behavioral change. The professional literature indicates that culturally appropriate programs take into account a wide range of factors, including differences in language, knowledge, values, customs, health beliefs, religion and religiosity, family roles, the relative emphases placed on the collective and the individual, lifestyles (e.g., eating patterns and hospitality), self-efficacy, and the sense of trust in the health system.

A significant number of large-scale health promotion programs are implemented in Israel every year. Some target the general population, while others target specific sub-populations. It is important that any program involving the Arab population be culturally appropriate for that group, which constitutes approximately 20% of Israel's population. This large minority group has unique health needs as well as unique social, ethnic, and cultural characteristics.

Overall goals of the study: To develop criteria for assessing the cultural appropriateness of health promotion programs for the Arab population; to assess the cultural appropriateness of these health promotion programs; and to identify ways to enhance the cultural appropriateness of future programs.

The study examined programs developed in five areas of particular importance to the Arab population: smoking, home accidents, physical activity, nutrition, and diabetes control. In addition, the study examined "healthy lifestyle" programs that address several of these areas simultaneously. These areas are particularly important to the Arab population in light of the high rate of smoking among Arab males, the high rates of obesity and diabetes among Arab women, and the high rate of accidents among Arab children.

Study design: The study had three major components: (1) Development of criteria of cultural appropriateness for the Arab population; (2) An extensive mapping of existing health promotion programs and the extent of their implementation in the Arab population; (3) An in-depth analysis of the extent of leading, culturally-appropriate organizations and programs. For each of these components of the study, we shall present the specific objectives, the study methodology, and the key findings. The study did not seek to assess the extent to which the programs have actually succeeded in changing health behaviors in the Arab population.

Component 1: Criteria Development

Objective: To develop criteria for assessing cultural appropriateness for the Arab population; the resulting criteria lists can also be used as guides for program development in the future.

Methods: Criteria were developed at three levels: (1) The organizations' cultural competence as expressed in organizational infrastructure and policies; (2) The program development processes; and (3) Program design, substance and implementation.
The process for developing the criteria comprised several stages. We conducted an extensive, international literature review of criteria for cultural competence, based on which we developed an integrated and coherent list of universal criteria. In consultation with numerous experts from the fields of health promotion and Arab health care in Israel, this list was adapted for the specific needs of health promotion, Israeli health care, and the Arab population. As an important step in this process, local experts identified the unique cultural characteristics of the Israeli Arab population that affect health and health promotion. The effort also benefited from published studies on the cultural needs of Arabs in Israel and other countries. In addition to developing criteria for health promotion in the Israeli Arab population in general, the study team, in consultation with the experts, developed specific criteria lists for each of the five areas studied (i.e., smoking, accident prevention, etc.).

Findings: The Arab population has numerous unique characteristics that should be taken into account when developing and implementing health promotion programs. These need to be addressed at three levels: overall organizational policies and infrastructure; processes for developing specific programs; and the substance of those programs (referred to below as "product" characteristics and criteria).

Component 2: The Mapping

Objectives: To assess the extent to which health promotion programs in the five key areas are implemented in the Arab population and have undergone at least some form of cultural adaptation.

Methods: A postal survey was sent to the 14 main organizations active in health promotion, in which they were asked to provide information on each program that they had implemented between 2001 and 2005. All 14 organizations responded to the survey.

Findings: Information was received regarding 221 programs, of which approximately 60% were national in scope. Of the national programs, 25% were implemented by the Ministry of Health, 40% by Clalit Health Services, and 35% by a variety of other organizations. We found that the Arab population was included in approximately 80% of all the national programs. The main reason given for not including the Arab population was budget constraints. Eighty percent of the national programs (and virtually all those implemented in the Arab population) benefited from translation into Arabic. Approximately 60% of all national programs involved cultural adaptation efforts that extended beyond translation. Thus, while there is significant penetration of the programs among the Arab population, there is still a need to intensify the effort to address cultural appropriateness. Among the large, universal organizations, Clalit Health Services was exceptional in that all the programs it fielded were implemented in the Arab population and involved cultural adaptation beyond translation.

Component 3: In-depth Analysis of Selected Organizations and Programs

Objectives:

1. To explore the relevance and applicability of the analytic framework and the criteria developed in the earlier component of the study
2. To examine the adequacy of the organizational infrastructure for promoting cultural appropriateness
3. To examine the processes undertaken to promote cultural appropriateness of particular programs
4. To examine the extent to which a set of leading programs are culturally responsive
5. To analyze the factors hindering cultural appropriateness
6. To identify ways to promote cultural appropriateness
7. To identify which dimensions of cultural appropriateness tend to be addressed and to assess whether the extent of cultural appropriateness varies by organization and/or by health promotion topic
8. To assess the extent to which specific characteristics of the Arab population were addressed in the leading programs
9. To assess the extent to which written materials produced by the organizations were culturally appropriate

Methods: 21 programs and 9 organizations were analyzed in depth. In choosing the programs, an effort was made to include examples from a range of organizations and substantive areas (smoking, nutrition, etc.). The programs were selected in consultation with the organizations, which were asked to identify their most significant program in each of the relevant substantive areas. Generally, the organizations chose those that were characterized by the greatest cultural responsiveness efforts.

Thus, collectively, the case studies illustrate the "current best practice" in Israel. While they are not representative of all of the country's health promotion programs, they can provide an indication of the extent of cultural adaptation among the **leading** programs of key organizations. They are also a valuable source of ideas of how to adapt programs culturally to the Arab population.

The examination of both the organizations and the programs was based primarily on in-depth interviews with managers and program implementers. Managers and program implementers also filled out detailed forms in which they rated the extent that each of the specific characteristics of the Arab population (that were identified by the experts as part of the first component of this study) were taken into account in the development and implementation of each specific program. In addition, relevant printed materials were analyzed.

Findings at the level of the organizations: Among the 9 organizations studied, there was substantial variation in the extent to which they met the various organizational criteria. Five of the organizations scored well on all, or almost all, the criteria and overall do a good job of

meeting the international standards of cultural competence. The more culturally competent organizations include relatively small organizations that serve the Arab population exclusively and are staffed solely by Arab professionals, as well as mid- to large-size organizations that serve the entire population.

We found a great deal of inter-organizational cooperation; more than half of the programs we studied were implemented cooperatively by 2 or 3 of the organizations. The main objectives of the cooperation were to facilitate cultural responsiveness by sharing expenses, build on each organization's relative strengths, and take advantage of opportunities for synergy.

We also found that we could usefully summarize the information collected about the organizations by categorizing them according to three dimensions: (1) the extent of awareness of the need for cultural appropriateness; (2) the extent of effort invested in creating the necessary infrastructure to promote cultural appropriateness; and (3) the extent to which the organization took initiative in this regard. Eight of the 9 organizations showed a high degree of awareness and 6 of them invest heavily in promoting cultural appropriateness. Six of the organizations serve as initiators while the remaining 3 primarily join or facilitate the initiatives of other organizations.

Findings at the level of the programs: Approximately two-thirds of the 21 programs we studied received high scores on almost all the process criteria and about half received high scores on most of the product criteria. Relatively few programs received high scores for staff training for cultural competence (a key process criterion).

We also found that we could distinguish three types of programs:

- ***Targeted programs*** that were planned and developed specifically for the Arab population in light of its unique needs (and the social, political, and cultural contexts);
- ***Differentiated universal programs*** that are implemented in the general population, but at the developmental stage already identify the Arab population as a unique sub-group and adapt existing programs and tools to address their needs;
- ***General universal programs*** that are implemented in the general population and, while open to Arab participants, take only minimal steps to address their unique needs – and these are often taken only at the implementation stage in response to problems that arise.

Of the 21 programs studied, 7 were targeted, 11 were differentiated, and 3 were general. We found that all the targeted programs received high scores on all the process and product criteria (aside from staff training). In contrast, none of the 3 general programs received a high score on any of the criteria. As expected, the differentiated programs fell in the middle, with the scores closer to the targeted programs for some of the criteria (such as awareness and adaptation of program content) and closer to the general programs on others (such as use of appropriate dissemination channels).

In general, the programs implemented with a high degree of cultural appropriateness were those run by organizations with strong infrastructures to promote this. There were also instances where organizations that lacked strong infrastructures nonetheless fielded programs that achieved high levels of cultural appropriateness. They did so by partnering other organizations with more developed infrastructures and, as we saw, cooperation was quite common.

Findings on specific characteristics: The study identified a number of specific characteristics of the Arab population that apparently did not receive sufficient attention in many of the programs. For example, with regard to smoking, these included the high levels of stress in the lives of many Arab males and the limited enforcement of anti-smoking legislation in Arab areas. In the case of nutrition, these included the widespread belief that it is important to eat a lot during pregnancy and limited recognition of the potential contribution of dieticians.

Findings on written materials: The study found most of the printed materials to be of generally high quality. However, in some of the materials that had been translated from Hebrew, the Arabic was not sufficiently clear or precise. In addition, some of the materials required a level of health literacy beyond that which characterizes the general Arab population. In some cases, the pictures and illustrations included only people with clearly Western visages and/or settings and situations that are rare in the Arab sector (such as traffic crossing guards or public parks). Finally, in some instances the content itself was not culturally appropriate, reflecting both problems of omission (e.g., not making use of relevant sayings from the Koran when these could play a helpful role) and commission (e.g., encouraging participation in smoking cessation groups when these are almost non-existent in the Arab sector).

Findings on obstacles and facilitative strategies: The study identified several obstacles to cultural appropriateness (such as tensions among various Arab community organizations and budget constraints) and several general strategies used widely to facilitate cultural appropriateness (such as system-wide efforts, involvement of key community figures, and the creation of inter-cultural steering committees). The report also identifies various tactics employed to address specific obstacles (such as promoting women's walking groups to circumvent the stigma associated with women walking alone).

Conclusions: The criteria lists developed in the earlier part of the study are relevant and useful. Using them, we were able to pinpoint which cultural responsiveness criteria tend to be addressed less well and which organizations tend to neglect them. This more detailed analysis underscores the finding from the mapping that there is a need to create the necessary infrastructure to promote cultural appropriateness in several key Israeli health care organizations, and highlights the specific areas where they need to invest more. Other Israeli organizations have realized significant achievements in this regard and can serve as models or partners; particular programs and specific innovative measures for addressing unique cultural needs can also serve as useful models. Moreover, based on the practices of various Israeli organizations and this study, a

coherent body of knowledge about culturally responsive practices has been developed and documented; it will be important to disseminate this body of knowledge.

Unique Aspects of the Study

The study makes several important contributions to the growing field of cultural responsiveness research.

1. This is the first study to systematically assess the extent of cultural competence in health across a wide range of organizations and programs
2. The study developed the first organized framework for evaluating cultural responsiveness in health promotion
3. The study makes use of both general criteria developed internationally and local expertise regarding the needs of the specific target population
4. The study brings together criteria at the level of the organization, the program development process, and the substance of the programs.
5. The study develops criteria related to the general cultural characteristics of the target population (and hence relevant to a wide range of health promotion efforts) as well as criteria that are particularly relevant to specific areas of health promotion.
6. The study presents numerous illustrations of how programs can be made more culturally responsive as well as documenting key barriers to cultural responsiveness

This is also the first systematic study of the cultural responsiveness of an Israeli human-service system to the Arab population in Israel. As such, it can serve as a model for similar studies in additional areas of healthcare as well as in other fields such as education and social services.

Future Directions

The findings point to a number of possible directions, such as:

1. Encourage all organizations to adopt a multi-dimensional cultural appropriateness strategy, with special targeting of the Arab population.
2. Increase and intensify the investment in cultural appropriateness infrastructure and processes; the investment needs to be made both at field and headquarters levels, with special attention to staff training
3, Initiate the cultural adaptation effort at the earliest phases of program development
4. Facilitate inter-organizational learning and partnering. For example, study successful programs and what made them successful.
5. Carry out a more in-depth examination of which mass media and other distribution tools are most appropriate for transferring health promotion messages to the Arab population.
6. Carry out a more in-depth examination of the relevant cultural health-promotion characteristic of sub-populations within the Arab population.
7. Continue to document and disseminate knowledge about culturally responsive practices
8. Assess the impact of culturally responsive practices on the extent to which health promotion interventions bring about change in health behaviors.