The TB Challenge

"Partnering to Eliminate TB in African Americans"

A Newsletter from the Division of Tuberculosis Elimination, Field Services and Evaluation Branch

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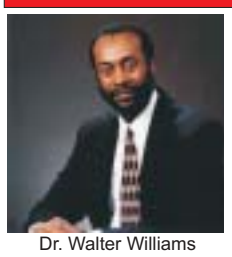
Addressing Cultural Issues in TB Prevention Programs

Walter Williams, MD, MPH, Associate Director for Minority Health, CDC



Dr. Walter Williams

Nationally, CDC data show that persons born outside the United States have high rates of tuberculosis (TB) compared to the overall population, particularly those persons born in Africa, southeast Asia, and Latin America. To effectively provide targeted testing and treatment of latent TB infection and of TB disease to persons from these populations, health departments must effectively identify those at risk in their communities and devise culturally effective communication and follow-up strategies to provide services that are tailored to community needs.

Social and cultural factors influence the successful control of TB. It is clear these factors influence health education, access to health services, accurate diagnosis and proper treatment, patient participation in treatment decisions, and adherence to treatment regimens. For example, communication and understanding are an essential part of patient-provider interaction. Communicating with patients assists the provider with diagnosis, assessment, and determination of treatment. Communicating with the provider gives the patient information needed to make decisions about his or her care. This can be difficult when there are cultural or language barriers. For example, the following situation may occur: A non-English speaking woman from Vietnam comes to a TB clinic for follow-up recommended after immigration. As the health care worker explains about TB, the woman nods her head as if in understanding, smiles, and looks down, never making eye contact. Although she appears to present "Western" nonverbal signs of understanding, she does not speak any English and does not understand what is being explained to her. The health care worker is not aware and continues to explain in English.

Culture often influences a person's initial perception and interpretation of health. This has an impact on how quickly an individual will seek health services and who he or she may choose to go to for these services. For example, Filipino parents may attribute their child's respiratory symptoms to a folk illness called "piang" rather than to TB. If the parents believe their child's illness is due to "piang," they are more likely to take the child to a traditional healer for a cure through massage to correct presumed injury to the skeletal or muscular system. This results in long delays before the child is brought to the TB clinic.

Adherence to treatment is essential to TB control. Adherence, however, requires a patient to incorporate treatment into his or her daily life, but can become interrelated with culture and be affected by the treatment beliefs of patients as well. For example, a TB clinic that kept typical clinic hours was finding that many patients of Chinese descent were missing their appointments. These patients were shopkeepers and could not come to the clinic because they could not close their shops until after 10 p.m. Culture should also be considered when choosing incentives. Say, for example, a TB program provides ham and cheese sandwiches for patients who come in for their directly observed therapy (DOT). Patients from Somalia, a predominantly Muslim country whose people do not eat pork products, would find the sandwiches to be a disincentive.

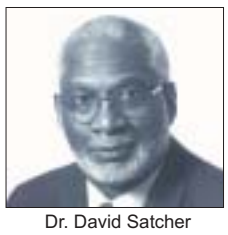
It is critical that TB programs offer culturally and linguistically appropriate services. There are several ways to address cultural and linguistic barriers in TB control. **Engage in culturally and linguistically appropriate dialogue.** Openly discuss beliefs in a non-threatening manner, taking an interest in the cultural and folk remedies the patient uses. In many cultures, healing and religion are intricately linked. Use a trained interpreter or bilingual staff member for interactions with patients who are not proficient in English. **Provide culturally and linguistically appropriate patient education.** Provide information about TB, transmission, risk, and treatment that is culturally and linguistically appropriate. Use an interpreter or bilingual staff member who is familiar with the culture of the patient and can explain and answer questions. Be conscious of literacy level and be sure to offer services to read or explain all information that is written for patients. **Collaborate with others to address cultural barriers.** By working with a team of physicians, healers, social workers, patient advocates, interpreters, and even the patient's family, you can help a patient adhere to treatment. **Tailor your services and your incentives and enablers to your patient.** Consider the patient's culture, needs, and interests in determining what types of services, incentives, and enablers will work to help your patients adhere to treatment.

Taking these and other steps can help address cultural and linguistic barriers in TB control.

To access culturally and linguistically appropriate information on TB education and training resources, please visit the TB Education and Training Resources Web Site at www.findtbresources.org.

World TB Day, Georgia Style

Gail Burns-Grant, Program Consultant, DTBE/FSEB



Dr. David Satcher

On March 24th, World TB Day is observed around the globe. This day's annual event commemorates the date in 1882 when Dr. Robert Koch announced his discovery of the tuberculosis (TB) bacillus. This year, the Georgia Department of Human Resources (DHR) TB Control Program, the Georgia Lung Association, and CDC worked collaboratively to send the message loud and clear that while strides have been made in the United States to eliminate TB, there is still work to do. With the theme, "TB Elimination: Now Is the Time!" on their minds, the Georgia team kicked off the day in grand style. The keynote address was delivered by Dr. David Satcher, former U.S. Surgeon General and former CDC Director, now serving as Director of the new National Center for Primary Care at the Morehouse School of Medicine in Atlanta. Beverly DeVoe, Georgia TB Control Program Director, DHR, presided over the occasion, and the newly elected President of the Concerned Black Clergy, Pastor Darrell Elligan, provided the inspiring invocation calling for a "divine intervention" to eliminate TB. Georgia's event demonstrated the spirit that must be ever present to win the battle against TB disease: TB elimination will demand the mobilization and maintenance of public support. Georgia's roster of invitees represented some of these supporters who have demonstrated their commitment despite the challenges that TB control programs have encountered over the past several years.

Dr. Rose Sales, State Epidemiologist, Georgia TB Control Program, presented surveillance data that showed Georgia as one of 12 states in the United States with TB case rates higher than the national average. Dr. Sales reported that in 2003, blacks (non-Hispanic) represented 59%

World TB Day *cont. on page two*

A Texas Perspective: An Interview with Phyllis Cruise

Vic Tomlinson, TB Program Consultant, DTBE/FSEB

Phyllis Cruise

Ms. Phyllis Cruise is a senior public health advisor with CDC assigned to the Texas Department of Health's TB program.

Vic Tomlinson: In the course of your career, what have you done to address the issue of health disparities among African Americans and other minorities?

Phyllis Cruise: Being African American in a primarily Caucasian-dominated environment, I can not and have not attempted to represent the experiences or the points of view of all other African Americans. I have attempted to bring attention to and place on the agenda issues I have encountered in my public health experience which I found to be beneficial to most persons regardless of race or ethnicity. Having the opportunity to work in various geographic parts of the United States, with persons from all socioeconomic levels as well as numerous racial and ethnic groups, I developed a broad-based perspective. I have found people are more similar than different racially. Most of the differences I have encountered have been defined more by socioeconomic status, geographic areas, and personal circumstance.

VT: What are the health disparities that exist in Texas?

PC: I will respond to this from the perspective of TB prevention and control. In Texas, TB morbidity is primarily in the major metropolitan areas of the state and in the areas of the state that border Mexico. These are the same areas with the highest concentration of poverty and minorities. In Texas, persons of Mexican descent are the major minority group in all areas of the state, followed by African Americans, who are in the major metropolitan areas but not a significant presence in the border areas. Along with the racial factors of TB morbidity there are also the socioeconomic issues of poverty and lack of access to quality health care. Texas has three of the poorest counties in the United States. Both Hispanics and African Americans are disproportionately affected by these issues and are disproportionately represented by the rates of TB.

VT: What are you doing currently to address health disparities in Texas?

PC: I again will respond from a TB perspective. I am not the director of the TB program and I do not have the authority or the responsibility to make policy or to directly affect change. I provide input to the director; I am an active participant in a significant number of the policy discussions and have a voice in the decision-making process. As one of the developers of the first binational TB projects in the state and the current supervisor of the three binational projects, I bring to the "agenda" statewide issues that affect the Hispanic minority population of the state; and by my work with the major metropolitan areas, I bring to the agenda issues which affect both the Hispanic and the African-American populations of the state.

VT: What do we as a country need to do to address health disparities among African Americans?

PC: The primary causes of health disparities are economics and societal/ racial inequities; there is a need for better opportunities for education and employment. We should not allow racist activities and/or discriminatory activities to be a part of public health activities or ignore such activities. Also, we must allow more African Americans and other minorities an active role in public health policy development, decision making, and implementation. In addition, CDC should have more African Americans in decision-making positions.

VT: How did you get involved in public health?

PC: I interviewed during a nationwide recruitment for the sexually transmitted disease (STD) program.

VT: What attracted you to public health?

PC: I was interested in a change, the opportunity to do something different, and the opportunity to make a difference beyond my immediate environment.

VT: Which public health programs have you worked with?

PC: All of my public health experience has been with CDC working for 10-plus years with the STD program before my assignment to the TB program.

VT: Tell me about your early days of working in TB. What was it like?

PC: It was very interesting. As I had no previous direct experience in TB as the director of the program, it was imperative for me to learn all areas of TB as soon as possible, since I had direct responsibility for all aspects of the state program. I was the direct link to the local health departments, to hospitals statewide and to private providers, and others.

VT: How has the Texas TB program changed over time?

PC: The primary change has been in the amount of state funds available for the program. Historically the program had been extremely well funded. The state is currently in a funding shortfall and in the midst of a major reorganization of all state agencies. The program was much smaller when I started; there were 9 people in the central office in Austin. Currently there are 34. In the early 90s, there was an average of 2,380 cases per year; TB morbidity reported for 2003 was 1,595 cases.

VT: Thanks for your time. Any final thoughts?

PC: I would also add that I consider myself very fortunate in the career I have with CDC. Few people have the opportunity to make a difference in the lives of a significant number of persons during the course of their own lives. Through the work I perform, I make a difference in the lives of people who I may never meet or who may never encounter me. I think the opportunity and the work I do are an important trust that I hold very seriously.

World TB Day (Cont.)

of all TB morbidity in Georgia. She added that while there have been gains in Georgia, challenges still remain; some include racial disparities, an increase in TB in foreign-born persons, and low rates of completion of preventive therapy. Dr. Satcher's stated in his keynote address, "We are trying to control and prevent disease in cultures, but the culture is not clear to us!" This will no doubt be clearer to Georgia as they enter the third and final phase of a CDC-funded demonstration project, "Intensification of TB Prevention, Control, and Elimination Activities in African-American Communities in the Southeastern United States." Georgia is working collaboratively with community leaders and TB stakeholders to close gaps and open opportunities for TB prevention and control in Fulton County, Georgia. Findings and tailored interventions from this project may be translatable to other parts of the state and throughout the nation to reduce TB rates in this population.

Dr. Zach Taylor, Chief, Field Services and Evaluation Branch, Division of Tuberculosis Elimination, CDC, gave the occasion's closing remarks, capsulizing the day's activities. He asked, "Why do we have this day?" His answer was quite startling, but true. "Because TB is a global problem; 8 million persons become ill from TB and 2 million die annually worldwide." He called for vigilance for TB elimination and turned to two former TB patients in the audience, invited by the state TB program to present personal testimonies about their experience with TB and said, "The true heroes are the patients who take their medication(s) and who defeat this disease." He concluded by stating, with conviction, that we will win the battle against TB "one patient at a time."

DTBE Partners Win CDC Award

The CDC/ATSDR Honor Award for Contributions to Minority Health (Partners to Eliminate TB in African Americans) will be presented to the community partners listed below at the CDC Roybal Campus at 10:00 a.m. on June 23, 2004. CDC staff and these recipients are commended for working collaboratively to reduce TB rates in African-American communities.

Community Partners: Chicago Department of Public Health, TB Program; Chicago Southside Community Project Task Force; Georgia Department of Human Resources; Georgia TB Advisory Group; Karen Sturdivant, Georgia Department of Human Resources; Rose Sales, M.D., Georgia Department of Human Resources; South Carolina Department of Health and Environmental Control; University of South Carolina, Institute for Families in Society; Joseph Kinney, South Carolina Department of Health and Environmental Control.

CDC Staff: Gail Burns-Grant, Chris Caudill, Dave Crowder, Beverly DeVoe, Vincent Fears, Michael Fraser, Brenda Holmes, Ann Lanner, Susan Lippold, M.D., Vivian Siler, Zachary Taylor, M.D.

Scheduled CDC/DTBE Meetings and Conferences

The Advisory Council for the Elimination of Tuberculosis (ACET), June 23-24, 2004, Atlanta, Georgia, CDC (Corporate Square Office Complex), Building 8, Conference Rooms 1A/B/C. Contact: Paulette Ford-Knights, (404) 639-8008

The Tuberculosis Education and Training Network (TB ETN) Conference, August 11-13, 2004, Atlanta, Georgia. Access website at: http://www.cdc.gov/ nchstp/ tb/TBETN/conference.htm

Conference is open to anyone interested in TB education and training activities.

Minority Health Resources:

Visit the CDC web page at www.cdc.gov, click on Health Topics and select M to view announcements, upcoming conferences, meetings, trainings, reports, publications, and other minority health-related resources.

CONTACT US ...

If you have story ideas or articles to share, or would like to provide comments, please e-mail Gail Burns-Grant at gab2@cdc.gov or call (404) 639-8126.

To add/delete someone to/from our mailing list, please contact Vivian Siler, Management & Program Analyst, DTBE/FSEB, by e-mail at vas6@cdc.gov or (404) 639-5319.