

# Concept Paper: Importance of Cultural Competency in Disaster Management

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**Purpose:** To provide input to the National Project Advisory Committee (NPAC), for the design and definition of curriculum modules on culturally competent care for disaster preparedness and crisis response based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards.

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## **Introduction**

In any society there are individuals for whom, from time to time or always, alteration of routine, adaptation of informational messages, or modification of technology use is necessary to effectively perform everyday functions that to the majority in their community may seem ordinary. This is particularly true in minority communities where the culture of asking for and receiving care are frequently different from those in majority communities. It should come as no surprise that in emergency situations or times of disaster, these individuals may require special attention, too, including preparation of risk reduction and warning messages, adaptation of assistive technologies to receive warnings, help in responding to warnings once they know the appropriate action required, and special assistance in the aftermath of a disaster event.

## **OMH Mission (Objectives for Paper)**

Increasingly, national experts, including the Office of Minority Health (OMH) at the United States Department of Health and Human Services, have been looking to cultural competency training as a means to reduce disparities in health care.

In December 2000, OMH launched the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare (OMH, 2001). These standards offer comprehensive guidance designed to address the patchwork of definitions, guidelines, and overlap about what constitutes culturally competent service delivery. The CLAS Standards consist of 14 guidelines and recommendations that serve to inform, guide, and facilitate implementation of culturally and linguistically appropriate services in health care. The CLAS Standards are organized by three themes: Culturally Competent Care, Language Access Services, and Organizational Supports. Crossover

and similarity of objectives – and motivated by lessons learned during Hurricane Katrina – has prompted OMH to consider the value of CLAS Standards in the field of disaster management and their value and relevance to disaster professionals.

OMH is currently engaged in an initiative that will result in the development of an online cultural competency curriculum for emergency responders and other disaster management professionals. This course will provide cultural competency education for emergency medical services personnel, disaster mental health professionals, and professional disaster relief organizations, such as the Red Cross and Commissioned Corps. The aim of this paper, therefore, is to highlight the importance of cultural competency in the various disaster phases and disciplines of disaster management and to provide input to the eventual development of priorities and focus areas for the OMH curriculum.

This information should be useful to disaster professionals as they seek to increase their awareness of the communities within which they work. It should also be useful to health professionals and cultural competency experts as they explore how best to work with and give guidance to their colleagues in the field of disaster management.

## **Definition of “Culture” and “Competency”**

The Office of Minority Health defines cultural competency a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function

effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross, Bazron, Dennis, & Issacs, 1989).

Cultural competency in health care aims to ensure that services are respectful of and responsive to health beliefs and practices. Meeting cultural and linguistic needs of diverse patient populations will improve the health and health care of the individual as well as the community.

Culture and language may influence:

- Health, healing, and wellness belief systems;
- How illness, disease, and their causes are perceived;
- The behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; and
- The delivery of services by the provider who looks at the world through his or her limited set of values.

The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. The principles that have guided OMH in this mission are parallel to those under which disaster managers and first responders operate. The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles (and often different from those thought of as traditional or commonplace in American society), presents a challenge to disaster management and the health care delivery service industry in this country. Disaster professionals, health care providers and persons affected and impacted by

disasters all bring individual learned patterns of language and culture to any experience. These unique patterns must be transcended in order to achieve equal access, reduce loss of lives and property, and improve the quality of health care provided.

Disaster professionals do not have to be students of sociology or anthropology in order to understand and appreciate cultural differences and better relate to the varied neighborhoods within which they work. A simple way of thinking about why individuals and communities act and react as they do is to consider that they are, more often than not, acting on common sense. In this context, culture can be seen as common sense, or the shared understanding or “sense” of what should be done in any particular situation, which is most commonly held within a society. The challenge of disaster professionals is to become familiar with the common sense of the communities for which they are responsible. Alternatively, they can learn techniques that will help them rapidly assess this community common sense during an emergent event. The first option is the most desirable.

The cultures of local racial and ethnic communities may or may not be similar to the respective cultures of their countries of origin, or even in keeping with what might be understood as the larger, national racial or ethnic character. Due to issues of acculturation, there may even be differences between adjoining communities. Increasing cultural competence in the field of disaster management is a process. To be achieved and effective, it will take time and sustained effort. Because both culture and the nature of disasters are dynamic, to be effective, the process of change must include ongoing efforts to ensure that the needs of those vulnerable to and affected by disasters are met.

The following key issues set forth in *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations* (DHHS, 2003) can be helpful in understanding the process and should have a broader constituency than the mental health professions community alone:

- Cultural competence requires system-wide change. It must be manifested at every level of an organization, including policy-making, administration, and direct service provision.
- Cultural competence requires an understanding of the historical, social, and political events that affect the physical and mental health of culturally diverse groups. Issues such as racism, discrimination, war, trauma, immigration patterns, and poverty—which reinforce cultural differences and distinguish one cultural group from another—must be considered
- Precise definitions of the terms “race,” “ethnicity,” and “culture” are elusive. As social concepts, these terms have many meanings, and those meanings evolve over time. The definition of culture should be broad and include race and ethnicity, but also gender, age, language, socioeconomic status, sexual orientation, disability, literacy level, spiritual and religious practices, individual values and experiences, and other factors.

There are many similarities in the fields of health care and disaster management. For example, disaster professionals, like health professionals, understand and promote the value of prevention. It is not an oversimplification to say that the more one prevents, the less one needs to respond. Another similarity is the need to communicate messages, some of life-saving gravity, to individuals of different lifestyles, cultures and languages.

In this context, the OMH CLAS Standards initiative to promote culturally and linguistically appropriate health services is not only a concept that is appropriate, but also one that deserves more consideration than it currently receives in the disaster management community. The national standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare are intended to inform, guide, and facilitate both required and recommended practices related to culturally and linguistically appropriate health services.

## **Disasters: Different Phases, Different Actors, Different Needs**

The field of disaster management has become broad and defined and has grown rapidly over the course of the past 15-20 years. Many disaster professionals see the phases of disaster as a continuum that goes from prevention, mitigation and preparedness through relief, recovery and reconstruction. Theoretically -- and *ideally* -- reconstruction would include mitigation and preparedness measures that would reduce the risk of subsequent similar disasters. And the cycle would continue, with lessons learned and future risk reduced.

In the parlance of disaster management, there are several “phases” of disaster events. Different organizations refer to them by various terms. Essentially, they are (UN/ISDR, 2004):

- **Preparedness** -- Activities which ensure that the systems, procedures and resources required to confront a natural disaster are available in order to provide timely assistance to those affected, using existing mechanisms wherever possible (e.g., training, awareness raising, establishment of disaster plans, evacuation plans, pre-positioning of stocks, early warning mechanisms, and strengthening

indigenous knowledge).

- **Mitigation** -- Measures taken before emergency events that intend to reduce or eliminate their impact on society and environment. These measures reduce the physical vulnerability of existing infrastructures or of vulnerable sites that endanger directly the populations (e.g., retrofitting of buildings, reinforcing "lifeline" infrastructure).
- **Prevention** -- Activities conceived to ensure a permanent protection against a disaster. These include engineering, physical protection measures, and legislative measures for the control of land use and codes of construction. These activities reduce the physical vulnerability and/or exposure to risks through infrastructures (e.g., dams, flood barriers) and sustainable development practices (e.g., reduction in deforestation in upstream areas).
- **Relief/Response (onset/acute)** -- The provision of assistance or intervention during or immediately following an event to meet the life-preservation and basic subsistence needs of those people affected. It can be of an immediate, short-term or protracted duration.
- **Recovery/Reconstruction** -- Actions taken to re-establish a community after a period of rehabilitation following a disaster. Actions include construction of permanent housing, full restoration of services and complete resumption of the pre-disaster state.

The following three additional terms in the disaster lexicon, and their relation to each other, are also important.

- **Hazard** -- A potentially damaging physical event, phenomenon or human activity that may cause the loss of life or injury, property damage, social and economic disruption or environmental degradation. Hazards can include latent conditions that may represent future threats and can have different origins, including natural (geological, hydro-meteorological and biological) or man-made (environmental degradation and technological hazards). Hazards can be single, sequential or combined in their origin and effects. Each hazard is characterized by its location, intensity, frequency and probability.
- **Vulnerability** -- A condition wherein human settlements or buildings are threatened by virtue of their proximity to a hazard, the quality of their construction, or both. Vulnerability is often discussed in terms of the degree of loss (from 0 percent to 100 percent) resulting from a potential damaging phenomenon.
- **Risk** -- The relative degree of probability that a hazardous event will occur; the probability of harmful consequences or expected losses (deaths, injuries, property, livelihoods, disruption of economic activity or environmental damage) resulting from interactions between natural or human-induced hazards and vulnerable conditions. Based on mathematical calculations, risk is the product of hazard and vulnerability. Conventionally, risk is expressed by the notation  $\text{Risk} = \text{Hazards} \times \text{Vulnerability}$ . Some disciplines also include the concept of exposure to refer particularly to the physical aspects of vulnerability.

***It is important to distinguish between a hazard and a disaster***

*“Strictly speaking, there is no such thing as a natural disaster, but there are natural hazards, such as cyclones and earthquakes. The difference between a hazard and a disaster is an important one. A disaster takes place when a community is affected by a hazard (usually defined as an event that overwhelms that community’s capacity to cope). In other words, the impact of the disaster is determined by the extent of a community’s vulnerability to the hazard. This vulnerability is not natural. It is the human dimension of disasters, the result of the whole range of economic, social, cultural, institutional, political and even psychological factors that shape people’s lives and create the environment that they live in” (Twigg, 2001).*

## **Roles and Goals of Disaster Professionals and the Importance of Cultural Competency**

The ultimate objective of a disaster professional’s interaction with a vulnerable community is to provide information so individuals can make informed decisions and take action in order to avoid, or at a minimum reduce, the risk to their health and their property. The process of effective warning of disasters includes: identifying the risk or event (e.g., hurricane, volcanic eruption, wildfire, etc.); identifying individuals vulnerable to that risk; and communicating the warning to those individuals so that they understand it, are sufficiently impressed by it, and as a result, take effective action to minimize their risk before and during the anticipated event.

Most policymakers and academics acknowledge that poor planning, poverty and a range of other underlying factors create vulnerability, resulting in insufficient capacity or measures to reduce the potential negative consequences of risk. Certainly ignorance of the cultural make-up of vulnerable communities is among these factors. This vulnerability may contribute as much to the magnitude of disaster as do the natural hazards themselves. Thus, hazards only result in disasters if high-risk conditions are present (see definitions of “hazard”, “risk” and other relevant terms presented earlier in this paper).

Providing for varying reading skill levels and translating disaster messages into multiple languages are important steps to improve access to information, and are a vast improvement over English-only parochialism. Unfortunately, literacy and language are not the only elements of the risk reduction formula; otherwise the task would be relatively easy and straightforward. Understanding various cultural beliefs, or ways of life, within the community within which one lives and works is the broader necessity, though, and is the key to success for disaster professionals (and a trait no less desirable in a good neighbor). With respect to disaster preparedness, mitigation and prevention, and longer-term risk reduction objectives, disaster managers may have an opportunity to change cultural beliefs or the common sense of the community. Ideally, this change would take place in collaboration with respected community leaders. It may be possible to convince residents that certain behaviors might be modified to reduce vulnerability. In contrast, relief during a disaster, by its very nature, is more immediate, and the principal responsibility of a first responder is to take action, not change beliefs. In either case, it is important to know the culture of the community affected, for you cannot change long-held beliefs if you do not understand those beliefs, and you cannot expect people to take action contrary to their common sense if you do not understand what motivates them.

Since local responders (experienced and inexperienced) are usually first on the scene, attention must be paid to pre-disaster planning and training with these responders in mind. Local responders, whether professionals or not, may be culturally competent by virtue of their being “of the community,” but this characteristic should not be left to chance. Additionally, characteristically, major disasters create situations where existing local facilities and personnel are overwhelmed by the nature and scope of the emergency.

In these cases, it is more likely that relief (and, later, recovery) workers will come from outside the community. More often than not, they will be professionals, or at least will likely have had experience working in past disasters. These workers may well be from the state of the affected area or from Federal agencies, such as the Office of Homeland Security, the Federal Emergency Management Agency, Department of Health and Human Services or the Department of Defense. They may also be from one of the larger, more established disaster organizations, such as the American Red Cross. Though likely skilled in their tasks, they will not be “of the community,” nor is it likely that they will have had much of an opportunity to learn about the culture of the distant communities in which they may be temporarily stationed.

Effective relief management thus depends on anticipating needs, identifying problems as they arise, and delivering specific materials and services at the precise times and points required. The ability to transport maximum supplies and personnel to a disaster area is much less essential (PAHO, 1981). Initially, information gathering, triage, and stabilization of the situation are the most important needs and deserve the greater focus of attention.

Sudden major natural disasters often cause widespread death. They are also often believed to cause massive social disruption and outbreaks of epidemic disease and famine that leave survivors entirely dependent on outside relief. Such possibilities were occasionally reported in the Gulf Coast in the wake of Hurricane Katrina. Systematic observation of the effects of disasters on human health, however, has led to different conclusions, both about the effects of disaster on health and about the most effective ways of providing relief. Although every disaster is unique (in that each affects areas

with differing social, economic, and health conditions), there are still similarities between disasters. If recognized, these similarities can help optimize the management of health relief and use of resources. The following points may be noted (Scott, 1998):

- There is a relationship between the type of disaster and its influence on health. This is particularly true for the immediate impact on the cause of injury. Earthquakes, for example, regularly cause many injuries requiring medical care; whereas floods and tsunamis, though they may result in death, cause relatively fewer such injuries.
- Some influences are a potential, rather than an inevitable, threat to health. For example, human migration and environmental changes may lead to an increased risk of disease transmission (although epidemics generally do not result from disasters).
- The actual and potential physical and mental health risks after disasters do not all occur simultaneously. Instead, they tend to arise at different times and to vary in importance within a disaster-affected area. Physical casualties occur mainly at the time and place of impact and require immediate medical care. On the other hand, risks of increased disease transmission take longer to develop and are greatest where there is crowding or a decline in sanitation. Mental health impacts often may not become evident until months or years after the actual event.
- Needs for food, shelter, and primary health care caused by disasters are usually not total. Even displaced persons often salvage some of the basic necessities of life. Further, people generally recover quickly from their immediate shock and

spontaneously engage in search and rescue, transport of the injured and other relief activities.

As the acute disaster relief phase transitions into the longer-term recovery phase, different considerations must be taken. For example, disease control assumes a different dimension after disasters. During severe disasters, it is possible that a breakdown of public health measures may occur, including lack of sanitation and limited access to clean water. Though disasters do not tend to result in the appearance of new diseases, those diseases endemic to the region may spread. Baseline surveillance data on endemic disease distribution in an area -- diseases with which the community may already be familiar -- can be used to assess the nature of disease threats to displaced people. These data can enable public health action, such as immunization, to be taken to protect groups at risk. Local health professionals and volunteers often handle this action, and it is their knowledge of the culture and up-to-date understanding of the community's health status that can be particularly important here. It is often important to rely on the knowledge of local community members and their social groups to even understand "who" is in the community. For example, a recent assessment of African communities in Clackamas, Multnomah and Washington counties in Oregon by the Immigrant and Refugee Community Organization found that many "African" community members are experiencing difficulty in balancing their perceptions of who they are ethnically and culturally with American racial stereotyping and perceptions (IRCO & ACCO, 2006). "African community leaders/influentials agree that the census under represents the general African and specific African population size as there is no ethnic, country of

origin and/or tribal category for “Africans” to specifically mark when completing the Census questions” (IRCO & ACCO, 2006).

Another example of the importance of understanding community culture, either from being of the community or having shared similar experience to which vulnerable community members can identify, was during the aftermath of the terrorist attack on the World Trade Center, September 11, 2001. In *An Evaluation of Peer-Delivered Mental Health Disaster Relief Services in New York City*, Hardiman, Carpenter, Jafee and Gourdine discuss Project Liberty Peer Initiative (PLPI), a peer-delivered program in New York City designed to provide mental health supports in the wake of the “9/11” public disaster (Hardiman, Carpenter, Jaffee, & Gourdine, 2005). The report’s findings included the value of common identity, noting that for many participants, the voice of a peer or mental health consumer was taken more seriously and ultimately given more weight, than that of a traditional non-peer provider. The differential response and greater perceived authenticity experienced by many recipients was simply “because they’re talking from their own life experiences, instead of a book” (Hardiman, Carpenter, Jaffee, & Gourdine, 2005).

Under ordinary circumstances, local physicians and other health professions with cross cultural experience would provide medical care to refugees and other recently resettled families<sup>1</sup>. During disasters, however, it is often the case that normal methods of

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<sup>1</sup> Individuals and families arriving in the United States can be divided into three categories: legal immigrants, official refugees and undocumented residents. Legal immigrants include children placed for adoption, persons granted asylum and permanent residents. An official refugee, as defined in the 1951 United Nations Convention Relating to the Status of Refugees, is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..." Undocumented residents are those who enter the country illegally (OHCHM, 1951).

receiving care are interrupted. Medically capable, but culturally unenlightened responders and health personnel have to learn “on the job” the numerous and varied ways that refugees and immigrants have of expressing their needs and relating to unaccustomed bureaucracy. The learning curve, for all involved will be challenging, but particularly steep without cultural competence training. It would not be uncommon, for example, that in addition to the medical health problems of racial and ethnic minorities, disaster victims may also suffer from anxiety, depression, adjustment reactions, trauma and other personal or family considerations. For example, survivors of torture frequently have specific physical and psychological effects, including post-traumatic stress disorder. The particular presentation of medical problems depends on numerous factors, including the trauma experienced, the patient's area of origin and their ability to adapt to new and sometimes strange environments. If such information is not already known about the individual, health sector professionals would have to consider screening refugees in a number of ways, including for traumatic experiences, nutritional status, or infectious diseases.

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Both refugees and asylees are eligible to apply for lawful permanent resident (LPR) status after one year of continuous presence in the United States in their respective status of refugee or asylee. Once granted lawful permanent resident status former refugees join the ranks of immigrant residents. Lawful permanent status does not necessarily reduce the need of these new residents to require special assistance during disasters.

# Considerations of Cultural Competency for Disaster Managers in Racially and Ethnically Diverse Communities

## ***A note about poverty***

In most cases, developing messages about risk and vulnerability that are culturally and linguistically appropriate (and selecting suitable modes to communicate those messages) can accommodate information needs that reflect the racial and ethnic make-up within a community. Most individuals, whether they are of the majority or the minority, are quite capable of taking action on warning messages or evacuation orders if they understand them. Nevertheless, there will be cases where individuals affected by disasters will not have planned properly or cannot access their traditional support systems. When poverty is added to the equation, the challenges become even greater. Because a disproportionate number of individuals and families on the lower socioeconomic scale are minority and poor and, largely because of their socioeconomic status, often live in physically isolated and vulnerable areas with poor access to communications, transportation and other public infrastructure, crafting and delivering life-saving information is more difficult.

Disaster relief after Hurricane Katrina hit the Gulf Coast presented several examples of the negative consequences of race and poverty on disaster relief. In the Russell Sage Foundation publication, *In the Wake of the Storm: Environment, Disaster and Race After Katrina*, authors reported that, “Many people were stranded in the city even after the call for evacuation. But issues of transit inequality were evident before the storm: public transit use by blacks was four times that of whites (19.2% versus 5.1%). Reliance on public transit must be taken into account in disaster planning and evacuation

procedures. Otherwise, the disparity in transportation access will, as occurred in New Orleans, translate into many who get ‘left behind’ in a time of crisis” (Pastor, Bullard, Boyce, Fothergill, Morello-Frosch, & Wright, 2006). As part of the Social Science Research Council’s series *Understanding Katrina: Perspectives from the Social Sciences*, Elizabeth Fussell writes in her article, *Leaving New Orleans: Social Stratification, Networks, and Hurricane Evacuation*, that research on labor migration shows migrants rarely come from the poorest sectors of society, since they simply have too few economic resources to migrate. Instead, migrants tend to possess at least modest economic resources and the social networks that can offer assistance in migration (Fussell, 2006).

This report does not focus on poverty but acknowledges that it is often a contributing factor, negatively affecting adequacy of disaster information and services available to racial and ethnic minorities.

### ***A note about stereotyping***

Often, the approaches that are used to train disaster professionals about how members of racial and ethnic communities act run the risk of stereotyping. In the Institute of Medicine’s *Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare*, stereotyping is defined as the process by which people use social categories (e.g., race, sex) in acquiring, processing, and recalling information about others (Smedley, Stith, & Nelson, 2003). The beliefs (stereotypes) and general orientations (attitudes) that people bring to their interactions help organize and simplify complex or uncertain situations. These components of an interaction give perceivers greater confidence in their ability to understand a situation and respond in efficient and effective ways.

The ability to simplify complex situations and respond in efficient ways is important, particularly to first responders. However, care must be taken that these characterizations do not negatively affect interaction with vulnerable community members or disaster victims. As the IOM report suggests, stereotypes can also produce self-fulfilling prophecies in social interaction, meaning the stereotypes of the perceiver influence the interaction with others in ways that conform to stereotypical expectations. One way to avoid inaccurate or negative stereotypes, while at the same time creating helpful tools for working within communities of varying cultural beliefs, is to rely on those communities to develop appropriate characterizations and communication content in times of an emergency.

### ***Working with Trusted Intermediaries: The Preferred Approach***

There is a world of difference between working with groups and working with individuals. Certainly there are times (for example, at the onset or during the immediate response phase of an event), where relief workers will have little choice but to work with individuals affected by the event who have been cut off from extended family, neighbors and other traditional sources of community support. But, if a relief worker is not *of the culture*, working with intermediaries is desirable, particularly individuals influential within the community whenever possible. Pre-disaster, risk reduction preparedness and training are ideal times to work with groups, or communities of like-culture.

During recent extreme flooding in Fargo, North Dakota, the disaster authorities found that refugee populations in areas of high damage, did not, by and large, seek assistance from the city government, FEMA or Red Cross, which were trying to make the availability of help known to the affected communities. Personal correspondence with Dr.

Mary Alice Gillespie, former Fargo, North Dakota, Cass [County] Public Health Officer, indicated that the reason for this was suspected to be a combination of cultural considerations (i.e., preference of looking to family and friends in the community rather than turning to an unknown bureaucracies), trust (i.e., refugee experience is frequently that the national and local governments in their countries of origin were often the source of harm not help), and the fact that many of the refugee populations are small and not members of formal community groups. Emergency managers found that there was a need to make significant and laborious outreach efforts, including sending teams of environmental public health workers, FEMA personnel, and interpreters into neighborhoods where they knew there had been significant flood impact, but from where they were not hearing from refugee residents. During their outreach efforts, emergency managers found that assistance was mixed within locales. For example, Somali clan members in one neighborhood had gathered to pump water and dry the home of an elder. Unfortunately, these clan members had either neglected or simply weren't aware that there were other families in the area, many with children, who were not receiving any assistance and were living in potentially severe hazardous situations. The interpreter in the outreach team served not only as the language link but also as the cultural connector. The lesson learned by the Fargo authorities was that in disasters, it is necessary to devote significant attention to targeted outreach in vulnerable communities. Otherwise, often they will not or cannot access the traditional disaster assistance resources that have been established to meet the emergency needs of the majority populations. The level-of-effort and the potential for improved success in preparedness and relief efforts may be

improved if ways can be found to develop trusted partner relationships with refugee communities (M. A. Gillespie, personal communication, October, 2007).

Partnering with community organizations is a good practice. Mutual Assistance Associations (MAAs), Community-Based Organizations (CBOs) as well as churches and Faith-Based Organizations are examples of community groups with whom disaster managers should work and through which messages can be most effectively delivered in appropriate cultural and linguistic contexts. MAAs, CBOs and Faith-Based Organizations are rooted in the community, typically operating at the neighborhood level (as distinct from national organizations which may be valuable partners, but often not as well connected on the community/neighborhood level). The mission of MAAs and CBOs often includes promoting and preserving traditional cultural practices. They also frequently serve as community councils and take on responsibilities for health promotion and advocacy. Thus, they would be natural partners for risk reduction and are ideally situated to help craft effective culturally and linguistically appropriate strategies for communicating with community residents. Historically, religious organizations have been important as providers of social and educational services, as well as spiritual functions. This is particularly true of many African American communities<sup>2</sup> and within communities of resettled refugees<sup>3</sup> (AAHC, 2006; SEARC, n.d.).

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<sup>2</sup> For example, data from a survey conducted by the African American Health Coalition in Portland, Oregon, suggests that the church, friends and family may play a vital role in the African American community's response to a public emergency. The majority of community members responding to the survey (96 of 140) indicated that they would gather at a church (AAHC, 2006).

<sup>3</sup> For example, when they first arrived in the U.S., many Southeast Asian refugee groups dedicated a surprisingly high proportion of their limited resources to establishing temples and churches, and many of their temples and churches remain enthusiastically supported and at the center of community life (SEARC, n.d.).

An example of a CBO is the Ethiopian Community Development Council, Inc. (ECDC), which is a nonprofit, community-based organization established in 1983 to respond to the needs of a growing Ethiopian community in the Washington, D.C. metropolitan area. ECDC serves immigrants and refugees from diverse cultural backgrounds while maintaining a focus on the African community. ECDC's mission is "to resettle refugees; promote cultural, educational and socio-economic development programs in the immigrant and refugee community in the United States; and conduct humanitarian and socio-economic development programs in the Horn of Africa." ECDC provides a wide range of programs at the local, regional and national levels, including economic development, public education and advocacy, refugee resettlement, and culturally and linguistically appropriate social services (ECDC, n.d.).

*Boat People SOS* is an example of an MAA which has its broad goal "to assist Vietnamese refugees and immigrants in their search for a life in liberty and dignity; by empowering, equipping and organizing Vietnamese American communities in their progress toward self-sufficiency." Before hurricanes Katrina and Rita, in 2005, the Gulf Coast was home to more than 55,000 Asians, many of whom earned a living in the fishing industries. This vulnerable population was devastated by the storms, as their livelihoods and tight knit communities were destroyed. In addition, many lacked the language proficiency to access services, and because they relied on cash savings, they were left with little or no resources. *Boat People SOS* assisted families and provided interpreting services to Asians who could not communicate with FEMA workers to access emergency services (Boat People SOS, n.d.).

*Providence House*, Shreveport, Louisiana, is an example of a faith-based organization. In non-disaster times, Providence House typically provides long-term solutions to homeless people. However, their knowledge of the community enabled them to step in after Hurricane Katrina and to provide apartments and emergency packs with basic food, personal items, and household items for the families who would temporarily live in them (Providence House, n.d.). Without sufficient staff to provide support services for the many new arrivals, they created a family advocates program, training volunteers from the local community to mentor families one-on-one. Support for these activities came from local funding networks and donors. Many of the families that found sanctuary with Providence House hailed from the lower 9th Ward in New Orleans (Providence House, n.d.).

Though working with trusted intermediaries is helpful, disaster professionals should understand that each participating organization has its own distinct mandate and methods for engaging the community. Although the overall objectives of many of these organizations are similar, planning should take into consideration that for varying reasons, information about residents in racial and ethnic communities is highly protected by the MAAs, CBOs and Faith-Based Organizations to which they belong. It should be further understood and respected that much of this information is proprietary to the organization and the community and is not, except under special circumstances, available for public access.

Reasons for this vary. In many African communities, for example, there is an acknowledged bias against giving out personal contact information even if there is agreement that it is for a good cause, such as creating an emergency contact list.

According to a 2006 African community assessment in Oregon, residents of the assessed communities listed the following as their principal reasons for reluctance in giving out contact information (IRCO & ACCO, 2006):

1. Past experiences where such information led to family/spouse/friend death and/or refugee status
2. No relationship with area community health departments and thus no trust that the departments would use information wisely and correctly
3. Belief that the list would be used to “found up” community members as terrorists or other unwanted group if the community did not “perform well” for the Western health agencies
4. Belief that the contact would be held responsible by County Health Departments for any and all actions/activities during an emergency and thus could be deported
5. Contact list antithetical to culturally prescribed ways of communicating.

Some community leaders and influentials understood the “Western” reasoning behind wanting contact information; however, many stated that if they had been brought into the planning phase of the project, they would have suggested better methods or alternatives to the contact list request.

Whatever the challenges, there is a wealth of understanding of community needs and behaviors that can be tapped into if disaster professionals respect the missions of community organizations and work through their leadership and with their guidance.

## ***Working with the Media (Newspaper, Radio, and Television) to Develop Culturally Appropriate Disaster Preparedness and Response Messages***

The role of media in disaster management has expanded significantly in recent years. This expansion reflects new advances in technology, recognition of the potential for new ethnic markets, and that listening and viewing audiences are interested in disaster events.

Early warning, preparation, onset coverage, and post disaster response are areas where broadcast media, in particular, plays a vital role in disaster management operations for all rapid-onset hazards including earthquakes, floods, landslides, tsunamis, hurricanes, tornadoes, volcanic eruptions, and wildfires. Reporting of accurate prediction and warning information can dramatically reduce the consequences of natural disasters. Relief operations also benefit from information disseminated via the media. Accurate warning depends not only on an understanding of where and when an event will happen, but also on if and how the public responds and whether they take appropriate action. Broadcast and print media can be effective in providing information about risk reduction, slower onset disasters, and health hazards such as heat waves and drought. In these circumstances, there is an opportunity to develop a story over time.

In cases where events can be predicted and warning is possible, the public reads, listens to, and/or watches information that is presented through various media outlets. Before people respond, they process and interpret the information they receive through their own filters. The action they take (or do not take) depends upon the relationship of the warning to them personally, their perception of the veracity of the message, and the immediacy of the need to take action. Understanding the culture of the intended audience here is crucial.

By design or not, television and radio broadcasters play a crucial role in shaping the messages upon which lives and property depend. They also inform the greater public about the extent of damage caused (and to whom), what support is required for the disaster's victims and how the public can appropriately respond to the needs of the victims. Thus, they have an enormous responsibility. Efforts should be made to work with the media to ensure they are aware of the cultural diversity of the community and are able to serve a more helpful function than focusing on politics and personal interest stories of survivors.

The enormity of the potential impact of ethnic media on disaster preparedness and risk reduction can be seen in the 2005 study, *Ethnic Media in America: The Giant Hidden in Plain Sight* (New California Media, 2005). This New American Media study revealed that 29 million African American, Hispanic, Asian American, Native American and Arab American adults prefer ethnic television, radio or newspapers to their mainstream counterparts. This amounts to 45% of the 64 million ethnic adults studied, and 13 percent of the entire adult population of the United States. More than half of all Hispanic adults are primary consumers of ethnic media. Approximately two-fifths of African Americans and Arab Americans each prefer ethnic media to mainstream media. Approximately one quarter of Asian Americans and Native Americans each prefer ethnic media to mainstream media. In addition, ethnic media reaches another 22 million ethnic adults on a regular basis. These adults prefer mainstream media, but they also access ethnic television, radio or newspapers on a regular basis. Therefore, the study indicates that the overwhelming majority (80%) of the ethnic populations studied are reached by ethnic

media on a regular basis. The 51 million Americans reached by ethnic media represent about a quarter of the entire U.S. adult population.

As another example, the Ecumenical Ministries of Oregon and Russian Oregon Social Services conducted a 2006 assessment of the Russian-speaking population in Portland, Oregon. The results indicated that television was the leading source of local news for the community, followed by newspapers, pastors, family members and friends for the church-affiliated group, and by family members, friends, newspapers and the internet for the non-church affiliated group (EMO, & ROSS, 2006). The assessment reported that the Russian speaking population watches local TV channels more frequently than the Russian channel. However, if channels are compared separately, then as a single channel, the Russian channel is the most popular.

The Russian channel in Portland, like many ethnically programmed services, is not necessarily local-specific. The assessment reported that the channel is frequently translated from New York or California and does not deliver local (Portland) news in full or in a timely manner. As such, it can be used for educational and preventive programs, but has limited potential when it is necessary to quickly inform Portland's Russian speaking population about a dangerous situation or to provide instructions in the case of a public health emergency (EMO, & ROSS, 2006).

In summary, working with the media and experts in the broader fields of telecommunications and information technology can help mitigate the public health impact of disasters by enabling public health officials to obtain the earliest information about the occurrence and extent of the disaster, as well as to mobilize and coordinate appropriate and adequate resources quickly. Early communication of the nature of

potential problems is critical to ensure the rapid location of supplies, such as vaccines, treatment drugs, and other specialized supplies that might prevent the development of a public health emergency. Strong surveillance systems serve as proactive measures, providing immediate reports of disease outbreaks permitting timely response. Use of these technologies is typically between scientists, disaster managers, and politicians who make informed decisions about emergency warning and response. It is nevertheless important to be concerned with the cultural context of the messages that are derived from surveillance technologies. The ability to document and explain the reasoning behind decisions made will work to the advantage of disaster professionals who hope to build a relationship based on trust with the community.

## **Beyond Race and Ethnicity**

In the United States it is estimated that there are more than twenty-six million Americans who are hard of hearing. Many of these individuals identify with a “deaf culture” in which communication, including disaster warnings, takes different forms than in the majority community. There is also a rapidly growing aging population, for whom complying with evacuation or other preparedness directives may be increasingly difficult, and whose culture and mode of communications may require special attention when it comes to receiving and understanding disaster messages. Even though the numbers of disabled persons who may need assistance because of their disability might seem significant, they are not inclusive of individuals who have no physical or mental disability, but are in need of special assistance nevertheless. These persons include transients, tourists, and others who may not be familiar with the local surroundings,

culture or language of the vulnerable area. In aggregate, these individuals may comprise a significant percentage of many communities (Scott, 2003).

## **Reducing Reliance on Overtaxed “Public” Services**

To reduce the reliance on an overtaxed public sector, and recognizing the need to generate local capacity to prevent and prepare for disasters, more attention is being given to drawing community groups and institutions outside the government structure into prevention, mitigation, and preparedness planning. These include local businesses, trade groups, voluntary organizations, labor organizations, and community leaders. In general, the local business community (and ethnic businesses, in particular) should be viewed as a valuable and virtually untapped resource with financial, technological, and logistical capabilities that should not be ignored.

More importantly, disaster risk reduction starts with the attitude of individuals towards daily risk. Actions or inactions of individuals towards protecting their livelihood, family, or community, bear significance on how society approaches mitigation and vulnerability reduction. In large urban areas, both day-to-day needs and societal pressures further reduce awareness towards self-protection and individual involvement in disaster preparedness. Lack of personal sensitivity to risk impairs societal effort in vulnerability reduction. Thus, risk mitigation starts with the development of a culture of prevention that installs primary ownership of societal protection with the individual (The World Bank, 2003).

## Relevance of CLAS Standards to Disaster Management

As noted previously, although the CLAS Standards were designed for health care services, there are many parallels to the field of disaster management. In particular, Standards 8-14 address organizational structures, policies and processes that support the implementation of the first seven standards (which focus on culturally competent health care and language access services). Standards 8-14 help organizations and providers respond to the cultural and linguistic issues presented by diverse populations.

The codification of strategic goals, policies and operational plans, and the management accountability/oversight mechanisms to provide culturally and linguistically appropriate services, should be considered as standard operating procedures (SOP) of government agencies and private sector organizations with disaster responsibilities. These SOP should include cultural and linguistic competence-related measures that will be integrated into internal audits, performance improvement programs, consumer/community satisfaction assessments, and outcomes-based evaluations. They should also be subjected to periodic organizational self-assessments of CLAS-related activities. These are, essentially, the objectives of CLAS Standards 8 and 9, which are listed below:

- **Standard 8:** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability to provide culturally and linguistically appropriate services.

- **Standard 9:** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate these into overall activities.

CLAS Standard 10 calls on health care organizations to ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated. The purpose for doing this is to:

- Adequately identify population groups within a service area;
- Ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- Prioritize allocation of organizational resources;
- Improve service planning to enhance access and coordination of care; and
- Assure that health care services are provided equitably.

While these data are desirable and would help develop and implement disaster plans, there is no mechanism to collect individual patient/consumer data in disaster situations. Further, in many cases negative personal experience and stories of legend (both accurate and inaccurate) have had negative affects on the willingness of many minority community residents to allow themselves to be identified (e.g., as immigrants, for fear of trouble with immigration authorities). It is for this reason, in part, that developing the databases called for in Standard 10 would be best done by looking for localized demographic information. Localized demographics are frequently more valuable than national statistics, as national data often misrepresents the status of minority populations. Additionally, accurate and useful information may be collected by

intermediaries, such as MAAs or community Faith-Based Organizations with whom a trust relationship has been developed over time. These kinds of data collection programs are discussed in CLAS Standards 11, 12 and 13. Standard 11 calls for health care organizations to maintain current demographic, cultural, and epidemiological profiles of the community, as well as needs assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. Standard 12 promotes the development of participatory, collaborative partnerships with communities and the use of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. Standard 13 would ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients and consumers.

Standard 14 represents another procedure that should be customary in all national, State and local disaster and emergency services, as well is in similarly focused public and private disaster organizations. Standard 14 recommends that all organizations regularly make information available to the public about their progress and successful innovations in implementing the CLAS Standards, and furthermore, that organizations provide public notice in their communities about the availability of this information.

## **Conclusion**

Several groups must contribute to this process of cultural competency, each in its own way, yet frequently with overlapping interests and responsibilities. These groupings and their responsibilities include (Scott, 1999):

- Individual members and families, who should be aware of hazards and the related effects to which they are exposed so that they may take specific actions themselves to minimize their personal threat of injury, loss of life or damage to property.
- Community organizations, which should be culturally competent and familiar with the hazards to which they are exposed, and be able to understand the advisory information they receive. They should also be capable and willing to take appropriate action to ensure that warnings and related guidance are directed to those populations that are determined to be most vulnerable to a hazard risk. This is essential to engage the population in a way that increases their safety or reduces the possible loss of resources on which the community depends.
- State and local governments, which should exercise their responsibility to translate disaster knowledge into risk reduction practices, and which should prepare guidance and issue hazard warnings in a timely and effective manner.
- National organizations and government agencies, which should be able to provide specialized knowledge and expertise in support of the processes of risk reduction and disaster warning. National organizations can be crucial in linking macro-scale capabilities and “best practices,” including, for example, OMH CLAS Standards, to the particular needs of vulnerable communities, as well as to disaster affected areas. In doing so, they facilitate the sharing of effective risk reduction and early warning practices throughout the country.
- Business and industry, which rely on the mutual dependency of the employee-employer relationship. From a practical point of view, the "private sector" or

business community must not ignore the implications of natural disasters to their survival. The goal of business is continuity of operation, not just restoration of operation after an event. Preparedness is one key to continuity of operation. Another is ensuring the safety of employees who, along with their families, must feel protected and safe in order to continue to work.

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