

Working With Immigrant/Refugees

Life revolves around relationships, and it shows up in our health care system. As a healthcare/service provider it is your responsibility to help the client/ patient understand how what you do will impact their lived experience of their illness/ condition/ situation, as well as your being aware of and addressing their fears/concerns about their health/ situation.

- The visit with you as a provider should be a client-centered experience which reflects the realities of the person everyday life which includes their current behaviors, practices, attitudes and beliefs, and lifestyle.
- Some specific client characteristics that are relevant include gender, age, education and income levels, ethnicity, sexual orientation, cultural beliefs and values, primary language(s), and physical and mental functioning.
- Additional considerations include their experience with the health care system, attitudes toward different types of health problems, and willingness to use certain types of health services.
- Individuals want information about prevention and wellness as much as about medical problems. Individuals want be able to make informed decisions for better health.

It is important to recognize that low-education and low-income groups remain less knowledgeable and less likely to change behavior than a higher education and income groups, which creates a knowledge gap and leaves some people chronically uninformed.

Health literacy is increasingly vital to help people navigate a complex health system and better manage their own health. Differences in ability to read and understand materials related to personal health as well as how to navigate the health system contributes to poor health outcomes and health disparities.

People with low health literacy are more likely to report poor health, have an incomplete understanding of their health problems and treatment, and be at greater risk of hospitalization.

Working With Immigrant/Refugees

Access to Services

- We all have cultural values. (our behaviors, rituals and practices)
- We all communicate differently (distinguished by pronunciation, grammar, or vocabulary, speech pattern, characteristic of specific localities).
- We all stereotype other people.

Status

Refugee - A person who cannot go home.

Immigrant - A person who came to America for a job, education, etc.

Limited English Proficient (LEP) – A person who is unable to speak, read, write, or understand the English language at a level that permits him or her to interact effectively with health and social services agencies and providers.

Cultural Problems

- Mistrust, embarrassment, shame
- Emotional reactions
- Family members (Interference by relatives)
- Unintended offense
- Physical distraction
- Folk beliefs

Prior Experience of Service Providers

- Tradition based versus knowledge or skilled based
- No accountability
- No consistent process nor transparency
- Power/position abuse
- Bribery common practice
- Poor gets short end of the stick
- False impression about the providers with whom they come in contact with in host country

Customer Expectations

- To be kept waiting for no more than twenty minutes
- To feel as though someone cares about them – eye contact and a smile (be treated with dignity and respect)
- To be offered clarifications when necessary
- To be have things explained in words they understand
- To be given something to do between visits that that will help improve their health and well-being

Common Dos and Don'ts

- Do greet but don't shake hands with the opposite sex unless extended to (Arabic/Muslim)
- Do watch clients face for reactions. If they appear confused or doubtful, ask whether he/she understands or has any questions
- Do ask client to repeat instructions to you to help assure that they understand

- Do speak slowly and clearly, with frequent pauses to allow for phrase-by-phrase interpretation/understanding
- Do allow time for client to ask questions and seek clarifications
- Don't raise your voice or shout
- Don't call someone with your finger
- **BE PATIENT!!!!**

Stress over Immigration status in United States

- **Alien Emergency Medical Assistance** – Special category of Medicaid for non-citizens, regardless of immigration status, including undocumented, visitors
 - Only covers treatment for “emergency medical condition”, including labor and delivery
 - Doesn't cover prenatal care, preventative care, organ transplants, long-term care
 - Income verification can be tough
 - Phony Social Security Numbers – don't ask for if not needed
 - Information on immigration status is not needed

Cultural Understanding

Somali

- Somalis come from an oral society
- Talking is a lifeline to the majority
- Poetry and folklore are enjoyed
- A great deal of attention is given to words said

Health Decision Making

- Elders are consulted to help solve problems
- Solutions mediated by the elders are commonly accepted

Hispanic/Latino

- Family is very important (primary support network)
- Family are expected to participate in important medical decisions
- Male/Female roles in families may vary. Father head of household. Mother educates children and nurtures
- High value is placed on the decision of elders or the role of the eldest male in families
- Likes to touch, personal space is small, therefore sit close, leaning forward, use gestures when speaking
- Show respect: Respect is based on age, sex, social positions of authority
- Shake hands at the beginning of each meeting – address adults by title and family name.
- Speak directly to the patient, make eye contact
- Respect authority figures. Direct disagreement with a provider uncommon; the usual response is silence and noncompliance
- Time frame reference: Always in a hurry, live in present not so much in future, might be late.
- Body Imbalance: Hot/cold – hot illness must be treated with a cold substance. Hot and cold foods not combined.

- Use natural remedies: herbs, teas.
- Use services of an Curandero – holistic healer.

Health Decision Making

- Family members are consulted to help solve problems
- Solutions mediated by the religious leader are commonly accepted

Why It's Important To Address Racial/Ethnic Health Disparities?

Although the issue of racial and ethnic health disparities can be improved through broader health care insurance. This is however, only part of the puzzle.

Healthcare is among the most expensive commitments made by government, businesses, and individuals. Unfortunately, both government and business have continued to cut back on health care benefits and shift the cost of health care coverage to the individual, and in some situations, have eliminated health care coverage completely.

The poor as well as racial and ethnic minority groups have not only experienced more than their fair share of these cuts, the impact is felt more profoundly by these groups... and as we have heard today (or as we all know), lack of health insurance has been shown to have extremely negative effects on access to health care.

This inequity compounds the disparity in health status and outcomes that is experienced by racial and ethnic minority groups, who consistently face higher rates of morbidity and mortality than majority groups. These higher rates are experienced not just for one disease, but across a broad spectrum of diseases and conditions (diabetes, hypertension, cancers, heart disease, STD/HIV, infant mortality, asthma, mental health and injuries (car, bike, on-the-job).

There is compelling evidence that these health disparities are usually not because racial and ethnic minority groups experience either a different set of illnesses or because their symptoms are worse. They are due to a broad range of social, economic, and community conditions which interact with individual factors that may intensify susceptibility and outcome.

These conditions include: **deteriorated housing** (more likely to be a source of lead, insect dust, and other harmful contaminants); **toxic sites** concentrated in areas where low-income or minority populations reside creating air, water, soil pollution, **poor education, chronic and higher stress levels, limited employment opportunities, limited household income and resources.**

Inadequate access to healthy foods, and increased **advertising of products such as tobacco and alcohol** in low-income neighborhoods, which may also have a higher population of racial and ethnic minority groups, also exacerbate health problems.

These neighborhood conditions often lead to poor health status and outcomes. There is significant evidence supporting a strong relationship between place, ethnicity, and poverty to poor health outcomes. Illness and injury also generate tremendous social cost in the form of low productivity, absenteeism, and expenditure for disability, workers compensation and public benefit programs.

- 1) All health care providers and administrators must **read and discuss**, the Institute

of Medicine Report on Unequal Treatment: Confronting Racial & Ethnic Disparities in Healthcare.

This report emphasizes that inadequate and unequal treatment of those who belong to racial and ethnic minority groups, persists, irrespective of disease state, health insurance coverage and ability to pay. It points out that even if we controlled for access issues and disease state, unequal treatment for some continue to exist.

Therefore, we must look for ways to not only create better sustainable access to health care services (including improved broader health care coverage); but to enhance the quality of care given to all people irrespective of race and ethnicity and enhance prevention efforts to help decrease risk factors and onset of preventable diseases.

Access to health care must mean access to high quality screening/diagnostic services, excellent treatment and preventive services and other needed services for all, irrespective of income, race and ethnicity.

- 2) Health care providers should ensure availability of appropriate interpretation and translation services for those individuals who have low English proficiency.
- 3) Health care providers must use clear language in all health care encounters and ensure that all written materials are culturally appropriate and written at appropriate reading levels.
- 4) Concurrently, we must help empower racial and ethnic minority groups by providing education regarding prevention options for decreasing risk factors, early detection/diagnosis, treatment options and the best ways to optimize health care encounters.
- 5) Finally, providers of healthcare should constantly and consistently assess policies, procedures and practices to assure that interactions with diverse population groups are culturally appropriate.

In closing I would invite you to: **Think and Talk With Others About:**

“Why It’s Important To Address Racial/Ethnic Health Disparity?”

Sociocultural Barriers To Care

A **Laotian patient** at a health clinic is told to give her child one teaspoon of medicine every four hours. The only spoon in her house is a porcelain soup spoon; the medicine runs out long before the prescribed ten days.

In an effort to be friendly, a doctor greets an **African-American grandmother** by her first name. The woman does not respond warmly to what she considers to be disrespectful behavior.

A **Thai patient** speaks to an intake worker who takes notes in red ink. The patient is alarmed because in Thailand **red ink is only used in criminal proceedings**.

A doctor in a clinic ponders how to relieve the suffering of a **Hispanic child** with intestinal problems that the mother describes as **empacho**, a condition in which “food becomes ‘stuck’ in the stomach.” The doctor has never studied this illness.

It's easier to recognize that patients and clients are members of a cultural group, than it is that we healthcare providers belong to a cultural group also. From the patient's perspective, socio-cultural barriers to healthcare fall into four major categories:

(1) American Medicine is an Alien Culture.

The healthcare delivery system is based on very specific, often Anglo-American cultural values that translate into attitudes and behaviors of providers, and policies and procedures of organizations.

Some of the assumptions of this healthcare culture are:

- causes of illness are scientifically based, entirely divorced from spiritual or religious beliefs.
- an individual is expected to consent to treatment, with little regard for the role of the extended family in decision-making.
- a person can play a role in maintaining good health and preventing disease (in contrast to the notion that fate determines health).
- schedules and appointments are necessary to save time, a precious commodity for future-oriented planners, but much less important for people who are oriented to the past and present.

Our healthcare delivery system is designed to offer diagnosis and a choice of treatments to an individual patient who is expected to make decisions and follow through on treatments.

It is assumed that the patient and perhaps a family member will arrive for care at an appointed hour and will understand the nature of the illness and course of treatment. Such expectations, foreign to many cultural groups, erect barriers to care, which may well be exacerbated by problems such as fragmented care, the difficulty in getting an appointment, eligibility procedures, long waits for short encounters with the medical provider, inhospitable staff and facilities, and poor signage. Taken together these factors may become insurmountable barriers for many people.

(2) No One Speaks My Language.

Six percent of Americans do not speak English “very well.” Language differences are the most powerful sociocultural barrier to care and the most concrete one to address, through interpreters and translation of materials.

Aside from language barriers, miscommunication can occur because of culturally based, nonverbal communication styles such as body language, eye contact, tolerance for silence, physical closeness, and level of expressiveness. (African-Americans consider an essential ingredient of an interaction with providers *is to be respected*, which can be shown by addressing a person by his or her last name, making eye contact, and actively listening.)

(3) My Customs Are Not Understood or Respected.

A person’s health practices and beliefs, gender and family roles, and customs that differ from those of the provider can prevent him or her from seeking needed services.

Patients from many cultural groups rely on traditional remedies for cures and relief from symptoms. These remedies are likely to be more in keeping with the patient’s belief system than is a trip to the doctor or hospital. Often, patients seek treatment from both a traditional healer and a doctor. Gender and family roles are critical cultural attributes to understand and respect. The individual patient is part of an extended family and community usually with a strict hierarchy. (In many Hispanic families, for instance, authority runs from older to younger and from male to female.)

(4) How Can I Trust Them?

The history and reputation of an institution in relation to its community plays a big role in determining patients’ level of trust in its medical services. Also, the “medical establishment” in general may be viewed with distrust as well. (**African-Americans** are aware of such affronts as the 40-year Tuskegee study in which the U.S. Public Health Service withheld treatment from 400 black sharecroppers infected with syphilis in order to learn about the course of untreated syphilis.

Similarly, there is a lingering distrust of the **Indian Health Service** because in years past Native American women were used as research subjects without their permission.) These obstacles to care often result in inefficient and inappropriate use of healthcare resources. Poor, immigrant and refugee patients rely on the Emergency Room care because they avoid seeing a doctor until they have no choice; they use traditional remedies in addition to or in lieu of Western medicine because of reluctance to completely trust the doctor; and they do not comply with prescribed treatments because of a lack of understanding or mistrust. Such culturally based barriers are exacerbated by the presence of problems related to unemployment, inadequate housing, crime, substance abuse, and lack of basic services. In areas of persistent poverty these problems can create overwhelming obstacles to providing high-quality care. Ultimately, consumers and providers are dissatisfied with the quality of care being received.

Cultural Awareness

(We Assess Ourselves By Our Intentions; Others Assess Us By Our Actions)

As a health care service provider what do you know about the immigrant/refugee/racial/ethnic minority populations who rely on us to provide the services they need?

These questions are food for your personal thought and review.

1. As a health care service provider what role do you play in creating and maintaining an awareness of the health and well being needs of immigrant/refugee/racial/ethnic minorities.

The role I play is as follows:

2. What role can you play in helping to resolve the incidence of the health disparities (Infant Mortality, Cancer, Cardiovascular Disease, Diabetes, HIV/AIDS, Violence/Homicide, Accidents, Immunizations) experienced by immigrant/refugee/racial/ethnic minorities in Central, Ohio?

The role I see myself playing is:

3. In what way can you and the services you provide help make a meaningful difference in achieving better health and well-being outcomes for immigrant/refugee/racial/ethnic minorities in Central, Ohio?

I can do the following:

4. In what ways does your life experience enable or prevent you from understanding the needs of immigrant/refugee/racial/ethnic minorities in Central, Ohio?

Please think about the barriers (personal and system generated) that prevents you from providing your best service.

5. What each of us knows about physical health (exercise and sports) is a result of our family tradition (culture). Did you know that in order to enjoy good health physical mobility is essential? What does your culture teach you about managing your physical activities and physical health?

In what ways does your culture influence your capacity to teach immigrant/refugee/racial/ethnic minorities how to achieve balance in their physical health?

6. What each of us knows about biochemical (food and nutrition) needs is a result of our family tradition (culture). You are living the end result of the food, vitamins, minerals, and supplements you do or do not eat?

In what ways does your culture influence your capacity to teach immigrant/refugee/racial/ethnic minorities how to achieve balance in their use of food, vitamins, minerals and supplements?

7. What does your family tradition (culture) teach you about attending to emotional (relaxation and meditation) health? What is your outlook on life? What has your family tradition (culture) taught you about how to respond to anger, conflict, fear, distress, disappointments?

In what ways does your day-to-day management of your emotional health influence your capacity to attend to the needs of immigrant/refugee/racial/ethnic minorities? Please describe how a person's language, dress, cultural

What can you do to help others **feel good** about coming to you to get the services they need? You have complete control over three things:

What you think
What you say
How you behave

People come to us for services because we are the recognized solution they need to help address their health care needs. How are you doing in understanding the needs of racial and ethnic minorities who rely on us to provide services?

Refugee

There are two categories of refugees in Ohio: (1) primary refugee those who come to Ohio from their homeland or an overseas refugee camp; (2) secondary refugees, those who migrate from other parts of the United States.

The United Nation's definition, which the U.S. has adopted, considers a refugee "any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."

Refugees flee persecution, sometimes for their lives, with little if any prior planning. Therefore, they can be viewed as "pushed" from their country of origin rather than "pulled" into a new land for economic or social benefit.

The health needs of refugees are broad and vary depending on their ethnicity. Conditions in refugee camps vary greatly around the world, dependent on both local and global political factors, but typically only the basic needs of refugees can be met, which may or may not include appropriate health and social care.

Refugee resettlement in the United States is best described as a government-private sector partnership. The government entities, at the federal level, include Congress, which in conjunction with the President approves overall refugee admission numbers for each fiscal year.

Under those guidelines, the Justice Department conducts overseas interviews, most frequently in refugee camps, to evaluate the "well-founded fear" basis.

The State Department provides for overseas cultural orientation for those refugees approved for resettlement. The Public Health Service arm of the Health and Human Services Department conducts the overseas medical examination, screening specifically for "excludable" conditions:

- a. Communicable diseases of public health significance
- b. Current or past physical or mental disorders that are or have been associated with harmful behavior
- c. Drug abuse or addiction

This examination is not an exhaustive health physical. In certain circumstances, even when an excludable condition is diagnosed, a medical waiver can be granted to allow immigration, on humanitarian grounds. This condition must then be followed-up by the local health department.

Once a refugee is approved for resettlement (**Family Reunification Program**), the voluntary agency facilitates placement. This includes providing for or arranging housing, medical attention, job training and procurement, social security and school enrollment and any other services needed for a finite period of time. The exact specifications of financial assistance and responsibility vary according to factors such as direct sponsorship by the agency versus a sub-sponsorship, like a church group, a family reunion case versus a "free case".

Immigrant (Common Immigration Terms)

Who is An Immigrant?

As a general term for new arrivals, this includes legal immigrant, refugees, asylees, parolees, and others. Legal immigrants are granted admission to the United States on the basis of family relation or job skill. The Immigration Act of 1990 permits up to 675,000 immigrants to enter in 1995; this figure is adjustable dependent upon visa usage in the previous year.

Who is A Non-Immigrant?

Aliens who are allowed to enter the United States for a specific purpose and for a limited period of time are non-immigrants. Examples include tourists, students, and business visitors.

Who is a Lawful Permanent Resident (LPR)?

A person who lives in the United States permanently and qualifies as a refugee, asylee, or immigrant, or who has been granted amnesty other than suspension of deportation is an LPR.

Who is a Refugee?

A refugee is a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. Refugees are eligible for federal resettlement assistance.

Who is an Asylee?

Similar to a refugee, this is a person who seeks asylum and is already present in the United States when he or she requests permission to stay.

Who is a Parolee?

The Justice Department has discretionary authority to permit certain persons or groups to enter the United States in an emergency or because it serves an overriding public interest. Parole may be granted for humanitarian, legal, or medical reasons. These entrants are granted temporary residence, are ineligible for special federal benefits and are not on a predetermined path to permanent resident status. Parolees may qualify for work authorization, depending upon personal circumstances.

Who is an “Illegal Alien?”

Also known as an undocumented immigrant, this is someone who enters or lives in the United States without official authorization, either by entering without inspection by the INS, overstaying their visa, or violating the terms of their visa.

Who are Cuban/Haitian entrants?

This category was created for the Cuban and Haitian arrivals in 1980, who were allowed to obtain work permits and to apply for public assistance. Cuban and Haitian entrants are eligible for refugee services.

What does PRUCOL mean?

For the purpose of determining benefit eligibility, PRUCOL (Permanently Residing Under Color of Law) status means that an alien is considered to be legally residing in the country for an indefinite period of time. PRUCOL is not, however, a method for entering the country, but indicates that an individual is legally present under statutory authority and may remain under administrative discretion. (PRUCOL is no longer qualified under the 1996 Welfare Reform Legislation.)

Who is a “Qualified Alien?”

“Qualified alien” refers to permanent residents, refugees, asylees, parolees after one year, those whose deportation is withheld, and conditional entrants before 1980. This new term was created to define immigrants eligible for public benefits in the 1996 welfare reform legislation, now public law 104-193.

What does “Deeming” mean?

Some legal immigrants come to the U.S. with the aid of citizens who serve as their sponsors. That sponsor signs an affidavit of support agreeing to help support and sustain the immigrant. Should the immigrant apply for public benefits, agencies must consider, or “deem,” the income of the sponsor and his/her spouse available to the immigrant when determining program eligibility.

What is an affidavit of support?

An affidavit of support is the contract that an immigrant’s sponsor signs, agreeing to financially assist the immigrant to prevent him/her from becoming a public charge. Following the welfare reform legislation of 1996, affidavits of support will become legally binding documents and are enforceable until the immigrant naturalizes.

Who is a Public charge?

Immigrants who become dependent upon public assistance, fail to find employment, and are unlikely to be self-supporting in the future may be deported on the ground that they have become a “public charge.”

What is Naturalization?

Naturalization is the process by which a foreign-born individual becomes a citizen of the United States. Naturalization requires that the person be over 18 years old, lawfully admitted to the U.S., reside in the country continuously for five years, and have a basic knowledge of English, American government, and U.S. history.

What is Temporary Protected Status (TPS)?

TPS is granted to people living in the U.S. who from designated countries where unsafe conditions make it a hardship for them to return. The countries that have been designated under the TPS program in the past include El Salvador, Kuwait, Lebanon, Somalia, and Liberia. TPS authorizes recipients to remain in the U.S. for a specific period of time and to work. TPS recipients are not considered to be PRUCOL.

Language Interpretation/Translation Services

Columbus Public Health Policy

Overview and Purpose

Columbus, Ohio is home to many people who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with providers of health and social services. Because of language differences these citizens can often be excluded from programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information. Services denied, delayed or provided under adverse circumstances have serious and sometimes life threatening consequences for these citizens and generally will constitute discrimination on the basis of national origin, in violation of Title VI.

Accommodation of these language differences through the provision of effective language assistance (written and oral) will promote sensitive culturally competent care. Moreover, accommodating language differences help ensure accurate client histories, better understanding of exit and discharge instructions and better assurances of informed consent. As a provider, the Columbus Public Health, in accommodating language differences we are able to better protect against tort liability, malpractice lawsuits, and charges of negligence.

Statement of Policy

Columbus Public Health shall provide effective language assistance (written and oral). There are three avenues available for interpretation services for Columbus Public Health customers:

- (1) Onsite interpreters for Spanish and Somali speaking individuals (available Monday through Friday);
- (2) Access to scheduled interpretation services for a variety of languages; and
- (3) TeleLanguage Services (over-the-phone interpretation service) dial 1-888-804-2044 available 24 hours per day, 7 days per week, for over 140 languages.

Interpreters are to interpret the messages in an impartial and unbiased manner, refraining from personal opinions and unsolicited comments. Interpreters often must interpret not only across language, but also across culture. If possible, the requestor of services should avoid the use of slang, jargon, and acronyms that may not interpret well into other languages and cultures. Rules of confidentiality of information are to be maintained by interpreters. They are not to make recommendations except to the requestor of service as it pertains to assisting the communication process.

Written translation services should not be requested of the interpreters. Request for translation of written materials should be directed to the Office of Minority Health by interoffice mail or phone at 645-1542.

Accessing Interpretation and Translation Services

Access to language and translation Services is based on the need for the type of service to effectively serve the clients of the Columbus Public Health.

Somali and Spanish Interpretation on site at 240 Parson Avenue

1. Call the appropriate interpreter: Somali at 645- 6756 or page at 637-9786
Spanish at 645-6911 or page at 637-0357
Spanish at 645-2454 or page at 637-4415

The interpreter will return your call and request identification of program area and staff person requesting services. If he/she is currently providing services for another program the interpreter will give approximate time of availability. If currently available he/she will come to the program requesting services. Interpretation services will be provided for programs in the order that the request is received. If you need interpretation for a Medical Emergency, please add 911 to the end of your four digit extension.

2. When the interpreter arrives greet and brief the interpreter by summarizing what you wish to accomplish and then begin to relay your messages accurately and to the point.
3. When the interpretation service has been completed per the decision of the CHD staff member, inform the interpreter.
4. During times when the interpreter is not providing face-to-face interpretation, he/she may be requested to make telephone calls as appropriate for appointment reminders, etc. Priority is given to provision of face-to face services.

TeleLanguage Services, Over-the-Phone, Interpretation Services

Available 24 hours per day, 7 days per week, for over 140 languages.

A speakerphone with three-way calling features is best for optimal utilization of this service.

1. Dial 1-800-514-9237
2. When the interpreter answers, tell them:
 - Where you are calling from
 - Your 4-digit customer code (7600)
 - Your name
 - Your department name
 - Other information for tracking the call, ie client name, client number etc.

3. If the patient/client is in the room with you switch the phone to “speakerphone mode” and wait for the interpreter. Once the interpreter is on line, brief the interpreter on what you would like to accomplish, give any special instructions and begin your message to be interpreted.
4. If the patient/client has called your program/service, place the caller on conference hold and proceed per number (1) and (2), add the patient/client to the line and wait for the TeleLanguage Service operator to contact the interpreter.
5. Once the interpreter is on line brief the interpreter on what you would like to accomplish, give any special instructions and begin your message to be interpreted.
6. If you are calling the patient/client, follow steps (1) and (2) above, place the interpreter on hold after briefing the interpreter on what you would like to accomplish, give any special instructions, call your patient/client using the three-way calling feature and begin your message to be interpreted.
7. Say “end of call” to the interpreter when the call is completed.
8. Keep documentation of the interpreters identification number.

To Schedule Interpretation Services:

Please call (614) 645-1542 to schedule interpretation services. Call at least 48 hours before the appointment time if possible. Give the following information:

(1) Language needed, (2) Client’s name, (3) Address, (4) Phone number. Include (5) date, (6) time and (7) location of service, give (8) program contact person and call back number.

Translation Services

Written translation services should not be requested of the interpreters. Request for translation of written materials should be directed to the Office of Minority Health by inter-office mail or phone at 645-1542.

Revised May 1, 2009

Title VI of the Civil Rights Act of 1964 and EO 13166 (2000)
Translation of Documents
(March, 2001)

Title VI, 42 U.S.C. § 2000d et seq., was enacted as part of the landmark Civil Rights Act of 1964. It prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.”

The intent of Title VI is better explained in the words of President John F. Kennedy in 1963: "Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination.”

The Web page on Executive Order 13166 describes the Order as “Improving Access to Services for Persons with Limited English Proficiency” (LEP).

What does it all mean in layman's terms?

In layman's terms it means that nobody can be discriminated because of limited English proficiency and EO 13166 makes provisions for access to individuals to federally assisted and federally conducted programs and activities.

EO 13166 contains two major initiatives. The first is designed to better enforce and implement an existing obligation: Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating based on national origin by, among other things, failing to provide meaningful access to individuals who are limited English proficient (LEP). The Executive Order required federal agencies that provide federal financial assistance to develop guidance to clarify those obligations for recipients of such assistance.

Second, the Executive Order sets forth a new obligation: Because the federal government adheres to the principles of nondiscrimination and inclusion embodied in Title VI, the Executive Order requires all federal agencies to meet the same standards as federal financial assistance recipients in providing meaningful access for LEP individuals to federally conducted programs. Each federal agency must thus develop a plan for providing that access.

A federally conducted program or activity is anything a Federal agency does. Aside from employment, there are two major categories of federally conducted programs or activities covered by the regulation: those involving general public contact as part of ongoing agency operations and those directly administered by the department for program beneficiaries and participants. Activities in the first part include communication with the public (telephone contacts, office walk-ins, or interviews) and the public’s use of the Department’s facilities (cafeteria, library).

Activities in the second category include programs that provide Federal services or benefits (immigration activities, operation of the Federal prison system).

State and local laws may provide additional obligations to serve LEP individuals, but cannot compel recipients of federal financial assistance to violate Title VI. For instance, given our constitutional structure, State or local "English-only" laws do not relieve an entity that receives federal funding from its responsibilities under federal anti-discrimination laws. Entities in States and localities with "English-only" laws are certainly not required to accept federal funding – but if they do, they have to comply with Title VI, including its prohibition against national origin discrimination by recipients of federal assistance. Failing to make federally assisted programs and activities accessible to individuals who are LEP will, in certain circumstances, violate Title VI.

How does it affect people, entities and the translation industry?

This EO was written in 2000 and it gave agencies until December 11, 2000 to develop and implement such plans. Obviously these measures are already in effect today and we have all experienced the effects.

Federal agencies, hospitals, state and local governments, etc. have been translating materials into many languages and providing interpreter services to their clients, and they continue to do so on a regular basis affecting the translation/interpretation industry.

This is because a key component of Title VI and EO 13166 requires that written materials routinely provided in English must also be provided in regularly encountered languages other than English.

Vital documents must be translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be affected by the program or activity.

A document will be considered vital if it contains information that is critical for obtaining the federal services and/or benefits, or is required by law.

Vital documents include, for example: applications; consent and complaint forms; notices of rights and disciplinary action; notices advising LEP persons of the availability of free language assistance; prison rule books; and written tests that do not assess English language competency, but rather competency for a particular license, job, or skill for which English competency is not required; and letters or notices that require a response from the beneficiary or client. For instance, if a complaint form is necessary in order to file a claim with an agency, that complaint form would be vital. The obligation is not limited to written translations. Oral communication between recipients and beneficiaries often is a necessary part of the exchange of information.