Establishing Cultural Competency:

Effective and Appropriate Health Care Communication for Multicultural Females on Texas Christian University's Campus

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Abstract

Multicultural females are less likely to report being in good health, and frequently face more barriers to health care and health care information than their White counterparts. While multiple studies have verified that minority women lack access to healthcare, the barriers to information seeking in regard to their own health has not been studied nearly as in depth. If the barriers to health care information were understood-- the appropriate steps were taken to overcome them—health care providers could be one step closer to ensuring equal access to health care for all women. I took a cross-cultural approach in my research using cross-cultural communication theory and media complementary theory in order to address these concerns. The goal of my study was to examine how the issue of health information access and health care communication applies to self-identified multicultural college females at Texas Christian University (TCU); heath care and health information access can always be improved through our Brown-Lupton Health Center. Health information seeking and the role of the Internet were examined in terms of positive and negative effects on multicultural females seeking health information. A focus group was used to dig deeper into these findings with TCU multicultural female students in particular. These students unanimously recognized that as English-speakers with an education, they had a much easier time accessing health information than family members who did understand English well or have a college education. Nonetheless, these students recognize health care providers on campus need to pay particular attention to the Internet, the role of education, and reliance on media in the face of mistrust of healthcare professionals when targeting multicultural students with health information. In-depth interviews with health care providers, student affairs administrators, and on-campus International Services confirm that Texas Christian University needs to improve translation services, education on health care practices in other cultures, and commitment to the discovery of global citizenship. Case studies of best practices at the University of Michigan and the University of Texas at Austin helped inform suggestions for improvement at TCU's Brown-Lupton Health Center, namely a social marketing campaign for both students and staff and cultural competency training. Limitations, suggestions for future research, a white paper for the TCU Health Center Staff, and resources for cultural competency training and information are included.

Introduction

Women's life expectancy has nearly doubled over the past century, yet non-white women tend to lag behind white women in allotted years. Minority women still fare worse than white women in terms of health status and mortality. For some conditions, the disparities are even increasing despite new technologies and medical advances. For example, the decline of breast cancer mortality has been much greater among white women than black women (Agency for Health Care Research and Quality, 2010). Moreover, 66 percent of black women are living with AIDS compared to 22 percent of white women. According to the Centers for Disease Control and Prevention (CDC), a patient's self-assessment of health is a reliable indicator of one's actual health. When asked about health status, women of other racial and ethnic groups are more likely to report their health as fair or poor than white women--17 percent of Hispanic women, 15 percent of black women, and only 11 percent of white women self-reported their health as such. Moreover, compared with men, women of all races are more likely to be in fair or poor health.

It is established that access to health care services, which clearly has a significant effect on health care use and health status, is lacking for these women in particular. Their consistent lower socioeconomic status and inability to acquire health insurance may be a factor, as compared with white women, black women are twice as likely and Hispanic women are nearly three times as likely to be uninsured (Agency for Health Care Research and Quality, 2010). Clearly non-white

females encounter difficulties in obtaining health care, and access to basic health information, or information about health care services, could help.

While multiple studies have verified that minority women lack access to healthcare, the barriers to information seeking in regard to their own health has not been studied nearly as in depth. Minority university female students are not exempt from these disparities, and still face the common issues encountered by college students, such as obtaining birth control, initial pelvic exams, and alcohol education. For example, chlamydial infections in black women are seven times more likely to be seen than in their white counterparts. This is due to the social factors that create health disparities, discrimination in health care environments, and a lack of culturally competent health care (Steele, Richmond-Reese, & Lomax, 2006).

Many programs have been established in other universities—such as at the University of Michigan and University of Texas, detailed later—to improve patient care for non-traditional students. Texas Christian University actually ranks not far from the national average in terms of ethnic diversity nationwide (no. 933 out of 1,798 in College Factual's 2012 ranking of the most ethnically diverse colleges and universities offering four-year undergraduate programs), yet still does not have a similar program geared toward this population in place (College Factual, 2012). If the barriers to health care information were understood, and consequently steps were taken to overcome them, we could be one step closer to ensuring equal

access to healthcare for all women and become a model for other universities to follow.

Purpose

In this study, I take a cross-cultural approach and examine how the issue of health information access and health care communication applies to self-identified multicultural college females, and how we can improve deficiencies on our own campus through the Texas Christian University (TCU) Brown-Lupton Health Center. The male to female ratio in higher education has steadily moved in favor of females since the 1970s; in 2008 59 percent of students in private universities and 56 percent in public universities were female (Borzelleca, 2012). Female students from different demographic backgrounds likely have different experiences in regard to their minority group or socioeconomic status that could provide insights about the various barriers this group faces when searching the media for health information.

My study aims to fill this void and provide a springboard for understanding how to better communicate health issues with females cross-culturally. We need to understand the barriers multicultural women on Texas Christian University's campus face when searching for health information, and from there learn how to best assist them in overcoming their specific challenges. For the purposes of this study, cross-cultural communication will operationally be defined as "interaction with persons of different cultural, ethnic, racial, gender, sexual orientation, religious, age and class backgrounds" as well as "a process of exchanging, negotiating, and mediating one's cultural differences through language, non-verbal

gestures, and space relationships" (Clarke and Sanchez, 2001, 51). Multicultural females will be operationally defined as encompassing those on our campus who consider themselves to be representative of one or more non-dominant cultural, racial, or ethnic groups.

Literature Review

Health-Information Seeking

There are personal differences between people who have trouble accessing health information through the media and those who don't. A 2002 study of 225 women surveyed within six months of a breast cancer diagnosis looked at the relationship between the female patients' barriers to accessing health information and their psychosocial health outcomes, and related this to their own perceptions of dealing with health-related issues. Patients who had a harder time accessing the needed health information had lowered emotional, functional, and social/family wellbeing, the study found. These individuals also perceived themselves as having poorer health competence, and "patient perceptions of health competence mediated the relationship between barriers to accessing information" and ultimate patient outcomes (Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002, 37). This study shows a need for designing and implementing more effective communication techniques to meet the needs of female patients, who often are not able to rely solely on health care providers for their health information.

A lack of trust in seeking information from doctors or a lack of cultural competency by doctors is common among "women of color" (Tindall and

Vardeman-Winter, 2011). Interviews from women of color across the United States revealed that constraints to seeking health information included a lack of trust in the information obtained from doctors, not understanding medical jargon, not having enough time, a lack of finances or insurance, the perceived lack of cultural competency by doctors, inconvenience, concern over religious differences, and past problems with medical encounters with health care professionals (Tindall and Vardeman-Winter, 2011). These researchers concluded that those disseminating health information should not package messages into a uniform communication campaign for all women, or even all women of color. Even when women of color are the intended targeted audience for health information, the personal realities of these individuals are often not adequately researched or realized, making for inappropriate or ineffective messages.

A Finnish study of Swedish-speaking minorities confirmed that barriers to health information are widespread. Women especially were found to be active seekers of information about health and medicine, but also faced more barriers to information, including feelings of inferiority, lack of time, or confusion caused by contradictory findings (Eriksson-Backa, 2008). Information seekers may fail to understand medical jargon or fail to possess communication skills altogether. This problem is likely amplified when taking cross-cultural communication into account. A study of nursing students confirmed that vocabulary is a major issue when searching for information. "Students' main concern was frustration caused by the challenge of choosing appropriate words or phrases to query databases. The

central theme that united all categories and explained most of the variation among the data was 'discovering vocabulary'" (Duncan, 2012, 20).

The language barrier is arguably the largest problem with cross-cultural healthcare communication. Many patients who need medical interpreters have no access to them. A 2006 study found that no interpreter was used in almost half of emergency cases involving patients who spoke limited English (Flores, 2006). Language barriers can have disastrous effects for women trying to obtain health care or understand health information or aftercare instructions. Patients who face such barriers are less likely to have a consistent source of medical care and receive preventative services. These patients are more likely to leave the hospital against medical advice, less likely to return for follow-up appointments, and have a higher risk of complications. Finally, patients who encounter language barriers experience lower levels of patient satisfaction (Flores, 2006).

A lack of information can lead to incorrect and even dangerous health behavior. Health professionals are the preferred source when medical information is required, but patients are often dissatisfied by their ability to acquire information from their healthcare providers (Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002; Tindall and Vardeman-Winter, 2011). Therefore, informal—and less reliable—sources, such as friends and family, are often turned to as a substitute (Eriksson-Backa, 2008). The Internet may be another source that women turn to, but in order to profit from medical information on the Internet, a fairly high level of education is required, which is less common among minority women (Berland et

al. 2001). Moreover, such information may not be found in languages understood by minority information seekers.

Role of the Internet

A study of African American females seeking health information found that the Internet might be a valuable tool for accessing health information among lower-income women if barriers could be reduced. Using qualitative research methods, the researchers looked at the role of racial, cultural, and socio-economic status identities on the women's perceptions of barriers to seeking health information through traditional and online media. Participants saw the Internet as a valuable tool for seeking health information, which they believed could be a source of empowerment (Warren, Kvasny, Hecht, Burgess, Ahluwalia & Okuyemi, 2010). The eighteen lower-income participants invoked racial, cultural, and socio-economic identities as common barriers to seeking health information via the Internet. The digital divide unfortunately affects access to health information, as increasingly more information is provided through online sources.

Greater use of health information is associated with better overall health status, and motivation to seek health information comes from perceptions about the source of the information and the ease of access to the information (Warren, Kvasny, Hecht, Burgess, Ahluwalia & Okuyemi, 2010). Additionally, individuals who actively seek health information on their own, and not just through physicians who may not facilitate adequate understanding (Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002), may end up more motivated about their

health in general. The Internet is a popular and valuable source for obtaining this information, and "motivated individuals may use this resource to enhance their capacity to play a more active role in health decision-making and prevention" (Warren, Kvasny, Hecht, Burgess, Ahluwalia & Okuyemi, 2010, 81).

While the digital divide is indeed a true problem, digital media still has the capacity to offer new opportunities for health information seeking, potentially lowering barriers to health information (Dobransky and Hargittai, 2012). A recent study looked at how a diverse group of college students searched for health material, finding that those highly skilled with the Internet are more likely to use it when seeking health information, and that Internet experiences are especially important when determining who turns to online discussions in this area (Dobransky and Hargittai, 2012). While college students are more likely to have experience with the Internet, 25 percent of adults still do not go online, so the percentage of health information seekers is lower among the total population; 59 percent of adults in the United States look online for health information, but it is a growing tendency (Fox, 2011).

Women, non-Hispanic white individuals, younger people, and those with higher education levels and income are the demographic groups most likely to gather their health information online. Women and men are equally likely to have Internet access, but women are more likely to use it to get their health information. While this is good news, the statistics for minorities are less optimistic. Less than half of African Americans and Hispanics use the Internet to access health

information, while 66 percent of whites in the general population do. Nonetheless, education seems to be the most influential variable. Only 38 percent of adults with less than a high school degree go online at all, but 89 percent of Internet users with a college degree seek health information online (Fox, 2011). This comprehensive study from *Pew Research Center's Internet & American Life Project* shows a significant gap in information access; education is an important factor, but again, white women are those most likely to achieve a higher degree in the first place.

Moreover, those who are seeking health information online aren't always the people who need to be. According to health economist Jane Sarasohn-Kahn, many of those with chronic conditions are the same people who do not have access to the information, or do not use the Internet as their medium of choice when researching health information. The digital divide may as well be called the "health information divide" between ill and well people (Sarasohn- Kahn, 2011). Much of disease and disability is due to environmental and social factors like air quality, availability of healthy and affordable food, and excellent schools- many of the same factors that ban individuals, particularly multicultural individuals, from online health information access. Sarasohn-Kahn asserts a lack of access to the Internet keeps people from equality with more fortunate, healthy individuals and she emphasizes the importance of broadband access to health. "Once broadband breaches this divide, the needle will move on the proportion of people with disabilities and chronic conditions who lack Internet access. That, then, bolsters health engagement and health outcomes" (Sarasohn- Kahn, 2011).

Communication researchers R. J. W. Cline and K. M. Haynes confirm that consumers frequently engage in health information seeking using the Internet but access is, in fact, inequitable. Positive benefits of broadband access include intractability, information tailoring, and anonymity (Cline and Haynes, 2001). More than 70,000 websites disseminate health information, but information seekers have navigational challenges due to disorganization, technical language, and lack of permanence. Many information consumers are vulnerable due to their lacking information-evaluation skills, and much of the health information on the Internet may be inaccurate (Cline and Haynes, 2001). This 2001 study calls for more research to focus on the digital divide and information quality. We need to understand the influence of the Internet on health beliefs and behaviors, as well as on medical outcomes and the health care system as a whole.

A 2004 study on women seeking health information also noted the fact that health information on the Internet may not be reliable. Using a sample of 199 women, the research assessed the process of seeking women's health information and the search strategies they employed to navigate the media when researching their needs. Results revealed that there were conflicting responses regarding the ease of locating information, the usefulness of information found, and whether the initial health questions were answered (Warner and Procaccino, 2004). The study also found low awareness of specific health and medical information resources. It seems that a major problem for women seeking health information is that they

don't know where to turn. The Internet can be a valuable resource, but access is not available for all, and the quality of information cannot be guaranteed.

As there are personal differences among those who have trouble accessing health information in general (Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002), there are also differences common among those who use the Internet when seeking health information and those who don't. There are cross-cultural differences in the types of sites used as well as how online information is used (Morahan- Martin, 2004). An exploratory study using data from a probability sample of 569 Internet users found that when going online, people are usually looking for four clusters of health-related information: "Information on (a) health improvement, (b) medical treatment, (c) family health, and (d) health issues that are difficult to talk about" (Leung, 2008, 565). The study discovered that those who often use the Internet for health information are individuals who have high expectations of the value and quality of health information websites, especially in regards to their relevance and reliability. These individuals are also more likely to perceive the Internet in general as playing an important role in life decisions or see the Internet as central to their lives (Leung, 2008).

Another study argues, however, that credibility of websites is often ignored. Dr. Janet M. Morahan-Martin worries about the unreliable quality of online health information. Morahan- Martin's 2004 study discovered that most people looking online for health information use general search engines, enter short, often misspelled phrases, and don't often go beyond the first search results page. The

general Internet information consumer suffers from limited search and evaluation skills, and even though users may be concerned about the quality of online health information, they often ignore indicators of credibility when looking at websites (Morahan-Martin, 2004). Morahan-Martin encourages professionals to recommend sites and promote more useful search and evaluation skills. In addition, there should be a movement toward developing and promoting uniform standards for websites offering health information, which would hopefully enhance quality reliability.

Solutions

A solution to communicating health information to multicultural females is multifaceted and far from a one-size-fits all answer. Texas A&M University's Zeba Imam asserted in a 2008 conference paper for the National Communication Association that "cultural distinctiveness of the target audience [must be] taken into account in designing and launching health campaigns." Imam focused on the need to pay attention to ethical dilemmas in multicultural health communication; those that look very similar may have drastically different beliefs and attitudes toward health care. It is important to recognize the risk of acknowledging the dominant cultural norm at the cost of combining the various identities within and among numerous cultural groups. Finally, health care providers and administrators must not lose sight of the inequities, no matter how subtle, when focusing so much on the cultural practices themselves (Imam, 2008).

A review of "culturally competent" health care systems (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003) defined cultural competency as "proving culturally and linguistically appropriate services" that reduce health disparities among racial and ethnic groups. One of the main problems identified by the Task Force on Community Preventative Services is that clients do not understand what they are being told by their health care providers and health care providers may be uneducated, apprehensive, and insensitive to cultural differences. This combination can not only make it uncomfortable for multicultural females to seek health care information and services out of their dominant culture, but can sacrifice quality health care outcomes.

Physicians and researchers Melanie Tervalon and Jann Murray-Garcia think part of the answer is for medical students to be taught how to deliver health care information effectively and appropriately to multicultural females. An obvious challenge is defining what educational and training outcomes align with this goal. Nonetheless, physician education is incomplete without the more concrete goal of cultural humility, according to these California public health administrators. Cultural humility is defined as:

> "A lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations" (117).

This requires the health care provider to become a student of the patient, rather than the expert, and allow the patient to be seen as a capable and full partner, or the "leader" of the health care communication and/or information-seeking act. The atmosphere fostered by a health care atmosphere should create an environment that enables—and does not hinder— multicultural female students' telling of their own wellness story or illness concerns (121).

The American Journal of Preventative Medicine (2003) has proposed interventions with the goal of providing cultural competent services that can "improve health outcomes, increase the efficiency of clinical and support staff, and result in greater client satisfaction with services (68). The first initiative is to recruit and make an effort to keep onboard staff members who reflect or make a commitment to learn about cultural diversity on campus. In addition, the Task Force recommends the use of interpreter services or bilingual providers for those students who may have limited English proficiency. Cultural competency training should be enacted for those providing health information and health care services to multicultural females. Finally, "use of linguistically and culturally appropriate health care education materials and culturally specific health care settings" should be implemented (68).

The University of Michigan Health System has put into play an admirable program for multicultural health, which other universities could benefit from emulating. Their mission statement is as follows:

> "The Program for Multicultural Health provides education for faculty, staff, students and the community on culturally competent and culturally appropriate patient-centered care while working to improve health equity amongst diverse populations. We do this by using evidence-based practices to engage the community and developing resources that improve knowledge and provides access to care."

Their four-pronged approach includes research on 1) "evidence-based and evaluative health promotion interventions for multicultural populations," 2) education for patients, health professionals, and community members on concepts and strategies for health information dissemination, 3) community engagement to identify partnerships and mobilize resources to change and create campus programs and practices, and 4) policies to reduce inequalities in health to facilitate the education and promotion of ways to improve access to health care and health information. These initiatives embrace values of health equity, cultural competency, quality service, and collaborative partnerships to benefit students in need and provide a model for other universities, such as our own Texas Christian University.

According to a 2002 field report funded by The Commonwealth Fund, "cultural competence should not be a stand-alone process or outcome but should be integrated into all levels of the organization" (Betancourt & Carrillo, 6). As part of this research, Washington's Department of Social and Health Services recommends health services collaborate with federal partners, establish a cultural

diversity board on campuses, include an appropriate number of interpreters (in addition to a establishing a standard for interpreter certification, testing, and monitoring), and have a plan in place to assess the reading level of written materials and translation. Arguably most important, however, is the notion to put in place reliable and continuous data collection, assessment and evaluation. A health care system should continuously measure their success in health care communication, such as evaluating student satisfaction with campus health centers, measuring any improvement in health status, or even complaints of inappropriate racial or ethnic differences in treatment and information dissemination—or, on the other hand, increased satisfaction from these groups (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003).

Theory

Clearly, online health information is an important resource used by many women used to fill an information void, and cultural competency training is necessary for health care administrators and practitioners to complement students' information-seeking behavior. College women's information-seeking conduct and health care providers' behavior can positively or negatively affect health-related decisions and behavior of users. The barriers women, including minority women, face when seeking this information play a large role in the quality of the information found, as do the practices followed by a campus health center. Therefore, media complementarity theory and cross-cultural communication theory are constructs that will underpin this proposed two-fold study.

Media Complementarity Theory

Media complementarity theory asserts that access to a medium is not as important to information-seekers as the effectiveness of that medium in fulfilling their needs/goals. People will use media in a complementary fashion, using as many sources as necessary to satisfy their needs (Dutta-Bergman, 2004). From this perspective, the driving force is content, not method of delivery. A study among college students on complementarity media usage when seeking health information found that while the Internet is a growing influence, it is unlikely to replace traditional media channels for college students seeking health information. In fact, it was found that college students, independent of demographic variables, use traditional media sources in in tandem with the Internet when looking for health information (Fries, 2010).

Tian and Robinson used media complementarity theory in a 2008 study to compare sick and well individuals' use of media channels for health information. According to this study, complementarity of media channels when seeking health information is validated in three ways: "complementarity among mass media channels, including traditional media and the Internet; complementarity between the interpersonal channel and mass media channels; and complementarity between the interpersonal channel and mass media channels after controlling for illness severity" (Tian and Robinson, 2008, 184). This study supports media complementarity theory, and suggests that sick and well individuals use the media for health information differently. A recent study also used media complementarity

theory to explain how contemporary information seekers usually use multiple channels in the health-information seeking process. The information-seeking behavior of 3,392 respondents was analyzed and indicated that sources were used complementarily based on tailorability and anonymity during searches for health information (Ruppel and Rains, 2012).

Although people may use multiple channels to meet their personal health information-seeking needs, there are likely differences among the media preferred between multicultural and white women in the United States. A study on Korean Americans' exposure to mass media and health information-seeking behaviors looked at demographic characteristics that could influence variations in exposure to different health information sources. Like other minorities, many Korean Americans have higher levels of disease incidence, like cancer, and lower screening rates. They also lack adequate health information. The researchers surveyed 254 Korean Americans and found that ethnic media sources and the Internet are important sources they use regularly. Age, education, and English proficiency significantly predicted the likelihood of Internet use. Lower-income Korean Americans with less education preferred ethnic-traditional media, whereas those who had obtained higher education and were English proficient were more likely to go online (Oh, Kreps, Jun, Chong & Ramsey, 2012). The most trusted source among survey respondents was a health care professional, but due to language barriers and other social factors, patients were often dissatisfied by their

ability to acquire health information from their healthcare providers (Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002).

Cross-cultural Communication Theory

Research using cross-cultural communication theory seeks to understand how people from different countries and cultures behave, communicate, and perceive the world around them. Language is often a factor, but other cross-cultural influences, such as non-verbal interpretations or beliefs about modesty, can encumber understanding when seeking or communicating health information cross-culturally. According to Dr. Anita D. Misra-Hebert of the Cleveland Clinic Foundation, "several issues may cause problems in cross-cultural encounters: authority, physical contact, communication styles, gender, sexuality, and family" (Misra-Hebert, 2003, 289). These factors can play a role whether patients are meeting personally with healthcare professionals or searching for health information on their own. We need to be aware of our own values and belief systems, as engrained biases may affect the way minority patients are cared for and the way health information is presented to them.

Different cultural groups have varying ideas on how to best be informed about health and perceived barriers to health information. A 2009 study used 19 focus groups- six with African Americans, four with Chinese, three with Vietnamese, four with Caucasians, and two with American Indians- to look at different groups' ideas about how to inform and motivate them to seek health information. Participants themselves recommended a multimedia approach to be

informed about their health, consistent with media complementarity theory (Dutta-Bergman, 2004). Chinese and Vietnamese participants suggested word-of-mouth and testimonials were most effective in transmitting health information. African Americans and American Indians suggested health education at church. Participants, regardless of ethnicity, perceived barriers to seeking health information to be watching too much television and the presence of confusing media information (Friedman, Laditka, Hunter, Ivey, Bei, Laditka, et al., 2009). These findings make it clear that communication strategies for reaching diverse racial/ethnic groups need to be further researched, as they desire and seek information from distinct and separate sources, via the media and otherwise.

Method

I conducted a two-phase exploratory study-- a focus group and three in-depth interviews-- to gauge the barriers Texas Christian University multicultural college females face when seeking health information and to develop solutions that could be implemented by the Health Center staff to bridge them. After reviewing current literature on the topic, I confirmed that the Internet will play a large role in how college women in general seek out health information, but my main research query was to examine how diverse groups of women on our campus specifically report facing different barriers when looking for health information online, through other media, and/or in person. The secondary goal of my in-depth interviews was to identify problems from the perspective of health care administrators and

practitioners in order to arrive at tangible suggestions for improvement for the Texas Christian University Health Center.

TCU is a private, religiously affiliated coeducational university of roughly 9,925 students, 8,640 of which are undergraduates, located in North Texas. Women make up about 57 percent of the student population, while men make up about 43 percent (University Fact Book, 2013). Approximately three quarters of the student population is white, but the population of non-white individuals has been increasing over the past few years, especially for Hispanic students. Currently almost 10 percent of undergraduate students are Hispanic, five percent are African American, and three percent are Asian (StateUniversity.com, 2012). The school has been trying to encourage more minority applicants through the Community Scholars Program, events such as "Black Senior Weekend" and "Hispanic Senior Experience," as well as diversity partnerships within the Neeley School of Business; the Neeley School recently received the 2013 DiversityFIRST™ Corporate Commitment Award by the greater Fort Worth advisory board of the Texas Diversity Council.

The out-of-state ratio is also steadily increasing. In 2011, 60 percent of applicants were from out of Texas, and currently more than half of the first-year student body is from out-of-state (Princeton Review, 2012). About 20 percent of TCU's annual incoming undergraduates are now transfer students. TCU welcomes approximately 650 international students—about five percent of the total university population-- from over 90 different countries. Although average household income

information was not available, the medium household income for the TCU- West Cliff area was $68,635, with an income per capita 79.1 percent greater than the Fort Worth average and 85.9 percent greater than the Texas average (Texas Christian University, 2012). Finally, 87 percent of TCU full time faculty is white with only 12 percent self-identified minorities, numbers also significantly skewed from both the Texas and national average (The Chronicle of Higher Education).[1]

Phase One- Student Focus group

Recruitment

A convenience sample was used, with respondents being recruited from those who voluntarily responded to two advertisements placed on the campus-wide forum TCU Announce (Appendix C). A chance to win a $25 gift card was offered as an incentive to participate. Personal reminder emails were sent one week and one day in advance, and consent forms were delivered electronically and in person (Appendix D).

Sample

Out of the seven individuals who expressed interest, three showed up for a focus group and one participated in an individual interview at a later date. One freshman, two juniors, and one graduate student were in attendance. Ages ranged from 19-29 years old, with two African Americans, one Pacific Islander, and one Latina. All participants were born in the United States, with two being born in Texas. Three out of four participants indicated that English was the primary

[1] See Appendix F for detailed demographic information/minority statistics.

language spoken in the home, and one reported Spanish as the primary language. Two students were employed part-time, one full-time, and one was an unemployed full time student. Annual household income ranged from $20,000 to over $70,000. All participants reported being heterosexual and all participants had health insurance.

Procedure

Questions were asked in a semi-structured format, allowing participants to tell their own stories while still keeping the group on topic (Appendix A). At the conclusion of our discussions, a short demographic questionnaire (Appendix B) was administered that included a plethora of demographic questions to encompass the wide range of experiences diverse groups of women may have.

Results

These students unanimously recognized that as English-speakers with an education, they had a much easier time accessing health information than family members who did understand English well or have a college education.

> *"My mom is a minority and avoids going to the doctor even though she has stage four ovarian cancer. I tell HER how to take care of her body. There needs to be someone proactive in the family."*
>
> *"I'm pretty confident in my ability to get health information because I have access to the Internet, but obviously others don't have the resources. We have access to so much more information as college students."*

"Those with less education take things as a reliable source of information that may not be. WebMD is scaring moms everywhere"

"My mom would have a hard time [looking for health information], but I'm okay as I get older and better with English. There isn't much out there in different languages and it is translated very badly when it actually is there. You don't study medical terminology when learning English."

Throughout the discussions, three additional themes came up consistently among all four subjects: the Internet, the role of education, and reliance on media in the face of mistrust of healthcare professionals.

Internet

Even before being asked, participants primarily cited the Internet as a reason why they are confident and motivated to seek health information.

"I Google EVERYTHING. Most of the time it's kind of true!"

" The Internet is [inherently] social. I can see what other people think, read reviews, and see that I am not the only one with this problem."

"[The Internet] is visually appealing, time efficient, and gives greater access for the larger population."

"It is definitely more informative than [anything like the] the phone book; you can get reassurance that things are common and you're going to live!"

However, these individuals did recognize potential problems with the Internet, such as identifying credible sources and dealing with information overload.

" [The most frustrating part of my search] is information overload. Those with less education may take [less credible sites] as a reliable source of information."

"It is overwhelming how much information there is. Do I have the flu or do I have cancer? It's just too much."

"I get so much that I end up wasting time and getting nothing."

Education

While discussing the role of the Internet, many students recognized that their education was what allowed them to have broadband access and the knowledge to use this medium effectively.

"We have access to so much information beyond just search engines as college students. I'm in the perfect situation; I know how to use a computer, I have health services on campus, and I see marketing strategies [on how to stay healthy] from the health center."

"I like being in a position to learn about stuff so people can come to me. I know that people aren't always comfortable talking to doctors or strangers."

"We learn how to take everything with a grain of salt in regard to the media. For example, make sure [the website] doesn't end in '.com'"

Reliance on Media/Mistrust of Healthcare Professionals

Finally, the reason these study participants discussed the role of the Internet and education so positively is because of their (and their families') poor experience with healthcare professionals.

> One young woman had a personal experience where her bronchitis was diagnosed as simple asthma: *"It is frustrating when you get the wrong information from those who you are told to trust; it lowers your confidence."*
>
> *"Health insurance is all doctor's care about. It comes down to money and education."*
>
> *"People in the healthcare industry jump to conclusions. You are pushed in and out and health insurance determines how much time they spend with you. I used to have awful health insurance and they know they will make more money off those with better insurance."*
>
> *"I'm afraid of them doing something bad to me or my kids."*
>
> *"Language barriers keep you from wanting to seek health services. Everyone gets frustrated- even the workers. Translators aren't fluent. It is always a money thing."*

Phase Two- Health Care Provider In-depth Interviews

Recruitment and sample

Emails were sent to staff at Student Services, the Brown-Lupton Health Center, and International Student Services at Texas Christian University. In addition, I reached out to health care administrators on the various University of

Texas campuses. I secured three interviews with 1) Kelle Tillman, MSN, RN, Director of Nursing and Clinical Services at the Texas Christian University Health Center, 2) Lizbeth Branch, Assistant Director of International Services at Texas Christian University, and 3) Susan Hochman, Assistant Director for Health Promotion and Public Information at the University of Texas-Austin. The three interviews took place in March of 2014, Hochman by phone and Tillman and Branch in person.

Procedure

After describing the purpose and goals of my research, I asked questions specific to each interviewee's role and place of employment (Appendix E). Potentially ambiguous terms, such as modesty or self-efficacy, were defined before moving forward with the topic. Interviewees were assured that "I don't know" was an acceptable answer to many questions, as this very phenomenon may be part of the problem and a hint at the solution to inadequate multicultural health care communication on the Texas Christian University campus.

Results

Kelle Tillman expressed concern over educating the staff on different cultures on our campus and what their practices are; many are not aware of health care practices in different cultures, so she said there could be improved education on both the employee and service side. The language barrier was seen as a top concern at the health center, as we don't have enough or high quality translation services. "All I have is an AT&T language line…is the person on the other line a

medical [professional]…I don't know," she said. She believes we need something interactive to reach the multicultural female population, but admits she doesn't quite know what that would look like. The only event she could recall this year was a new outreach initiative when international students came in August to talk during orientation; international students are required to take the student health insurance, so an insurance specialist from the health center talks to them then.

Tillman recalls having an Asian female patient's boyfriend ask for an appointment for her because she didn't know how or what to do. Beyond including more health topics on the website, and perhaps letting students know they can email questions to health care providers on campus, Tillman admitted to the staff not knowing "how to make [multicultural females] more comfortable in that setting." Luckily, the staff is ready and willing to help improve the situation and is reported as being comfortable with physician-patient and family communication dynamics on campus. Accommodations *can* be made; if it helps, a roommate or significant other could come to help interpret or help write discharge instructions in a native language. This process doesn't exist now, but could be useful to enhance understanding in those with a language barrier.

Tillman reports observing hesitancy in "non-traditional students" who visit the health center. They may be concerned over appearing different and don't want to experience judgment or bias. As one responsible for educating the staff in options currently available and continuing to explore options that would improve communication, one of Tillman's goals for the health center is to make

multicultural female students comfortable. She is curious about using an online check-in system or email for some initial communication to avoid initial embarrassment among traditional students in the waiting room. She enjoys a collaborative relationship with the international student office, where I continued to explore these issues with Lizbeth Branch.

Branch emphasized many of the same issues as Tillman in regard to health care communication and information dissemination to multicultural females on campus. Moreover, she reflected how "I've never seen any health communication on campus." Although the health center is there and we have orientation, Branch questions how much they get from orientation and if multicultural students are even aware we have a health center.

Language is also a concern from the perspective of International Student Services. "My dad [a physician] used to say there's nothing better than getting sick in your own language," she reveals. Branch herself admits to having a doctor that speaks her native language for that very reason, because they can communicate with each other well. Some feelings, such as pain, don't translate literally across cultures. Even the smiley-face pain scale graphics have different meanings across cultures, Branch emphasized. As Tillman noted as well, translation needs to be improved to start providing information in other languages. Not only is translation lacking, but icons, meanings, phrasing, and symbols can produce various nonsensical meanings cross-culturally. Nonetheless, Branch doesn't see language as the top barrier these students face, but rather general cultural differences. For

example, "Asians will do anything before they turn to Western medicine or a doctor in person…they may go to the Internet first or use alternative medicine before the seek help here," says Branch.

As for the health center staff, Branch says, "I know they are aware of cultural differences, but I don't think they are aware of how to handle the differences." Her department does go and talk to the health center about differences in culture and use skits and games to practice. "They find themselves in a position where it's hard to communicate; the idea is to put themselves in the shoes of someone that doesn't feel comfortable or who's language is not the same," she said. Branch proposes that even those in her department aren't experts in other cultures. "We need people from those other cultures that have successfully crossed over to be able to talk to and inform [the health center]."

We can't convince students to trust Western medicine who have not been raised that way and are unfamiliar with a new culture. These students may feel more comfortable going online, but the issue is finding reputable websites, "so then they can [go on to] seek the help they need in person," Branch says. But, "with different cultures or different languages they may only go to sites in their own language, and who knows who wrote that. They trust what is written by their own peers, but we don't know the credentials of that person…[and that can be] dangerous."

For improvement, Branch recommends a great tool for administrators would be to send health care providers to study how they provide health care in other

cultures. Part of our mission as a university culture is to discover global citizenship. "We want the whole university, staff, and faculty who never had the opportunity to go abroad to develop some of those sensitivities and skills," Branch suggests. Those providing health care services and organizing health care communication for multicultural students need to see it in person and work more with other cultures. Alternatively, and more budget-friendly, would be to bring in professionals from other cultures to train staff and give lectures. "Nothing is as good as immersion, but we have to go to the next best thing; if we can't take TCU out to the world, let's bring the world to TCU," Branch concluded.

Lastly, after speaking with Susan Hochman at The University of Texas at Austin, also a diversity chair who aims to ensure health care isn't perceived as a privilege but rather a right, it became clear that their public information team's diversity initiatives can and should be adopted for Texas Christian University's Health Center to summon similar outcomes.

University of Texas at Austin: A Case Study

By law, as a public institution, the University of Texas at Austin (UT) has to take the top 10 percent (GPA) of high school graduating classes, and the tuition is less than half of that of TCU. That being said, UT still serves as an important model for health communication and information dissemination in a university setting with its large, diverse population. We, at TCU, still have to be sensitive to the even smaller populations seen here.

At The University of Texas, it is important that health problems aren't a barrier to academic performance. The University Health Services has an information team in place and a marketing communication team for multicultural students specifically. Goals are defined by both student affairs and health services to engage students where they are outside of a clinical setting, such as on the website or social media. Yearly communication goals are defined in terms of target audiences and key messages.

Surveys help determine who does and does not use campus health services, and it has been found in the past some populations feel they aren't eligible whether due to perceived biases, fear of being judged, etc. For international students, one of the main barriers there is familiarity with the university health care system, Hochman said. Health literacy, understanding things like insurance, or even just the saliency of health care consumer information is a reported focus of their team. Hochman revealed that not all providers feel comfortable to deal with different cultural norms, such as Muslim women's apprehension on undressing, and the university has embraced cultural competency training to deal with such issues. "Our views aren't always the right or only way," Hochman recognizes.

In addition to hired professionals, students can help in cultural competency training. For example, over the past winter break the university had students that represented different populations talk about their experience on campus, what they are looking for specifically, and what they want health care providers to ask about. In a student population of about 52,000 students in 2013, with 26,000 female

students, 2,000 identifying as "foreign" and nine percent international, to date, the University of Texas at Austin's health services system hasn't experienced underrepresentation of any patients; the 5,300 Hispanic females, 1,500 African Americans, 3,800 Asians, and 58 American Indians are indeed represented in the health services' patients.

As for marketing materials and the dissemination of health care information, the UHS system makes sure that images are not white-dominant and even cartoon figures are often race and gender neutral. Using many different colors in images, cartoons, photography, etc. allows campaigns to be representative of all students. In addition, avoiding heteronormative (a viewpoint that heterosexuality is the status quo instead of being one of many possibilities) statements and having a separate women's health clinic allows the health care system to feel more approachable by all kinds of non-traditional or apprehensive multicultural students.

Hochman shared that bias on campus is a concern in terms of how it can impact health conditions. Hispanic/Latino and African American students were more likely to perceive bias and experience academic disparity due to health-related impact in a Columbia study. In another example, multicultural mental health students are less likely to seek help from a white provider. Hochman says it's important to "identify with a provider and have similar characteristics to feel comfortable. We want all providers to acknowledge the diversity of the student experience." This can be as simple as asking clarification questions and being able to listen. "We want to make sure our providers represent the student population;

we look for diversity among our staff," Hochman shared. Bilingual providers are preferred, but language translation services can also help bridge potential language barriers. As depicted earlier, Tillman sees these translation resources lacking, especially in-person, on our own TCU campus.

Just because the student population is represented well in the university health care system to date doesn't mean the job at The University of Texas at Austin is complete. The university continues to look at patient data and make sure they are remaining representative of the population. It is important to observe trends over time and see what is working and what areas of outreach need improvement. Hochman recommends asking providers how they have incorporated what they have learned from cultural competency training into their practice, as continuing the conversation is so important. "Did you talk about [what you've learned] with a coworker, family member, or student?" she recommends asking.

Meetings with the student government and student health advisory committees can serve as the eyes and ears of health care administrators and providers—the key is to listen to how students perceive the system. Having an internal review, and partnering with student groups and a multicultural engagement center can make sure health services stays informed and conveys a message of openness and accessibility. Targeted outreach can help gain trust and ask the ones who need it how to best reach out to them. "Tell us how to best reach out to you;

tell us how we can meet your needs," emphasized Hochman; it is all about keeping an open dialogue and conversation with the population at need.

Discussion and Implications

As expected, research revealed the Internet was found to be the main source college students use when seeking health information (Warren, Kvasny, Hecht, Burgess, Ahluwalia & Okuyemi, 2010; Dobransky and Hargittai, 2012; Fox, 2011). Students commented on ease of use, accessibility, efficiently, and the social nature of looking for health information online. Nonetheless, TCU students, as well as Kelle Tillman and Lizbeth Branch, recognized the potential downfalls such as evaluating credible information and information overload (Cline and Haynes, 2001; Morahan- Martin, 2004; Warner and Procaccino, 2004). Also, education was cited as a strong predictor of confidence and motivation for health information seeking (Berland et al. 2001; Fox 2011) and distrust or apprehension of health care professionals was a frequent reason for turning to the media for answers (Tindall and Vardeman-Winter, 2011; Arora, Johnson, Gustafson, McTavish, Hawkins & Pingree, 2002). My phase one results supported media complementarity theory, as the main concern of respondents was finding a medium to fulfill their needs efficiently on their own terms.

My focus group expressed seeing barriers in less-educated or non-English speaking friends and family toward which they act as a liaison. In this scenario, cross-cultural communication theory can be applied to how multicultural college females can assist those like themselves but with less ability and knowledge of

health information. Similarly, Kelle Tillman and Lizbeth Branch worried about language barriers, a lack of translation services, and insufficient cultural competency among health center staff. Susan Hochman at The University of Texas at Austin confirmed the success of programs to recruit and retain diverse staff members, as well as training in cultural competency.

Combined with the impact of the Internet found in my primary and secondary research, I suggest a social marketing campaign for multicultural female students, as integrating health information promotion to multicultural females into programs and policies aligns with social marketing's premise of using business resources to develop or implement behavior change to improve things like overall public health. This should take into account the population of interest's own views via research through implementation and evaluation stages. Providing tangible solutions tailored to segmented audiences will make for the most effective communication. In addition, I propose cultural competency training for the health center staff at TCU, and a motion for additional resource allocation for interpretation services, including assistance with the development of linguistically and culturally appropriate health education materials (Appendix G).

Limitations and Suggestions for Future Research

Limitations

It is important to note that there may be marked differences among international students of different incomes and domestic minority respondents that may not be considered wealthy. Additionally, as a consequence of seeking a

targeted pool who self-select and were offered an incentive, the focus group results cannot be generalized to the entire population at TCU. A potential limitation with this method could be self-selection with a health-based survey. As previously mentioned, minority groups may have different attitudes toward health information and may self-censor answers based on beliefs about modesty or anonymity. Nonetheless, this sample in particular may be less prone to such infamous drawbacks. The Oslo Health Study in Norway studied the impact of self-selection in a population-based survey. Response rate was positively associated with educational attendance, higher income, being female, and born in a Western country, among other variables. Moreover, "self-rated health, smoking, BMI and mental health (HCSL) in the attendees differed only slightly from estimated prevalence values in the target population when weighted by the inverse of the probability of attendance" and "self-selection according to sociodemographic variables had little impact on prevalence estimates and social inequality in health by different sociodemographic variables seemed unbiased" (Søgaard, Selmer, Bjertness & Thelle, 2004, 3). These results show that the target audience for my research was likely honest when self-reporting potentially sensitive information. To bolster these chances, I ensured confidentiality and anonymity for focus group respondents and assured interviewees no patent names would be associated with any examples given. Finally, group synergy/groupthink in a mini-focus group could potentially have produced more uniform responses than would have been seen in a larger, more diverse sample, but the similar responses from the additional student

interviewee and three staff interviews increase confidence in the themes uncovered.

Future Research

Future studies should recruit more participants for a larger sample size to increase changes of generalizability. Research could also incorporate focus groups, interviews, and questionnaires in multiple languages, so respondents can choose to answer in the language they are most comfortable with. Using an equal number of "majority" Caucasian female TCU students native to the United States could also serve as a future basis for comparison, and the different groups encompassing the multicultural female pool—minority students, first vs. second generation students, international students, transfer students, etc.—could be separated to study individual differences and variables within the broader multicultural group.

Conclusion

My study fills the research gap on barriers to health information seeking among multicultural female college students and provides insights on proven solutions and best health communication practices to address said problem. In addition, it makes a meaningful contribution to research on these groups in the college population who are more likely to have access to a wider variety of media than the general population (Fox, 2011). The unique demographic and psychographic variables of groups of TCU females unveil enlightening information about the media used and problems faced when seeking health information. These insights fuel an ongoing call for a continuous in-depth investigation of ways to help

multicultural college women overcome specific barriers to health information seeking, resulting in appropriately tailored media for certain groups, appropriate resource allocation, effective cultural competency staff training, and ultimately improved health care outcomes for these individuals.

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Appendix A- Focus Group Questions

Opening:

•Purpose of my research

•Want to know what they *really* think

•Introductions- Name, major, year

1. Tell me about your level of confidence in your ability to get the health information you need. Do you find it difficult to find health information?

2. Where are the first places you go when you need to search for health information?

3. What frustrates you the most in your health information search?

4. Describe what motivates you to search for health information via the media.

5. How do you feel about reaching out to family and friends for health care advice?

6. How do you feel about discussing your health with health care practitioners? What are your main concerns about talking to health care practitioners?

7. Tell me about the role language barriers play in your health information seeking. (If necessary, probe with: jargon, information not accessible in your native tongue, etc.…)

8. Tell me about how you use the Internet to search for health information. (If necessary, probe with: Is it easier/harder than other methods? More/less time consuming? More/less credible?)

9. What aspects do you find most challenging when using the Internet to search for health information?

10. What are your concerns over using the Internet to access health information?

11. On the other hand, what are the main benefits of using the Internet to search for health information?

Additional comments or questions in regard to health information-seeking barriers?

Appendix B- Demographics Questionnaire

Please indicate your year in studies at TCU.

□ Freshman

□ Sophomore

□ Junior

□ Senior

□ Graduate Student

How old are you? _____

Which race/ethnicity to you primarily define yourself as? (Check all that apply)

□ African American

□ Caucasian

□ Latina

□ American Indian

□ Asian

□ Other

□ None of the above

□ Prefer not to answer

Where are you originally from?

□ Texas

□ The United States, but not Texas

□ Out of the United States

If you checked out of the United States, please indicate your country of origin

_____

Is a language other than English the primary language spoken in your home?

□ No

□ Yes If yes, please indicate your primary language _____

In addition to being a TCU student, are you currently employed?

□ Full time

□ Part time

□ Unemployed

□ Prefer not to answer

Which of these categories includes your household's total annual income?

□ Under $20,000

□ $20,000- $29,999

□ $30,000- $39,999

□ $40,000- $49,999

□ $50,000- $59,999

□ $60,000 or $69,999

□ More than $70,000

□ Prefer not to answer

How would you describe your sexual orientation/identity?

□ Heterosexual

□ Homosexual

□ Bisexual

□ Transgender

□ Other

□ Prefer not to answer

Do you have any dependents?

□ Yes

□ No

Are you a veteran?

□ Yes

□ No

Do you have health insurance?

□ Yes

□ No

□ Prefer not to answer

Appendix C- Recruitment Materials on TCU Announce

Win $25 gift card for participating in small focus group- seeking minority college women

Source: natalie.raymond@tcu.edu
Modified: 04/07/2013 5:50PM

I am a graduate student looking for minority college women to speak to me in a small focus group (approx. 1 hour long/ 6 or so people) about barriers faced when searching for health information. $25 gift card will be given away to participants at random.

I am a graduate student looking for minority college women to speak to me in a small focus group (approx. 1 hour long/ 6 or so people) about barriers faced when searching for health information.

At the conclusion of the focus group, a $25 gift card will be given away at random.

Please let me know if you have any questions about my research study, would like to participate, or know someone who would be interested.

Focus group will be held on campus in April.

Thank you for your assistance!

Natalie Raymond/ natalie.raymond@tcu.edu

$25 gift card for 1 hour focus group- seeking minority college women

Source: natalie.raymond@tcu.edu
Modified: 03/25/2013 1:56PM

I am a graduate student seeking minority college women to participate in a small focus group (approx. 1 hour long) about barriers faced when searching for health information.

I am a graduate student looking for minority college women to speak to me in a small focus group (approx. 1 hour long/ 6 or so people) about barriers faced when searching for health information.

At the conclusion of the focus group, a $25 gift card will be given away at random.

Please let me know if you have any questions about my research study, would like to participate, or know someone who would be interested.

Focus group will be held on campus in April.

Thank you for your assistance!

Natalie Raymond/ natalie.raymond@tcu.edu

Appendix D- Consent Documents

Texas Christian University
Fort Worth, Texas

CONSENT TO PARTICIPATE IN RESEARCH

Title of Research: Exploring Barriers College Women Face When Seeking Health Information: A Cross-Cultural Approach

Funding Agency/Sponsor: None

Study Investigators: Natalie Raymond under Principal Investigator Wendy Macias

What is the purpose of the research?
The purpose of this research is to examine how the issue of health information access applies to college females, and compare barriers faced among students who attend college in-state, out-of-state, and internationally. My goal is to understand the personal differences among those who have trouble accessing health information and identify what those barriers are.

How many people will participate in this study?
Seven self-identified minority females currently enrolled at TCU will be participating in the focus group discussion.

What is my involvement for participating in this study?
You will be asked a series of questions involving your ability and confidence with searching for health information. As a group, we will discuss the various challenges to seeking health information and identify common barriers and ways they could be overcome. At the conclusion of the focus group each individual will fill out a five-minute demographics questionnaire.

How long am I expected to be in this study for and how much of my time is required?
The focus group will last approximately one hour, and the survey at the conclusion of the focus group should take no more than five minutes of your time. We will meet in the Moudy South first floor study lounge.

What are the risks of participating in this study and how will they be minimized?
Risks of participating in this study may be psychological in nature, as a result of discussing potentially sensitive or embarrassing information. Participation is voluntary and participants can leave at any time. Personal information can also be discussed individually instead of in front of the entire group.

What are the benefits for participating in this study?
By understanding the barriers faced by cross-cultural females seeking health information, you can help bring us one step closer to finding ways to better communicate with these individuals about health here at TCU.

Will I be compensated for participating in this study?
A $25 gift card will be given away at random to one participant at the conclusion of the focus group.

What is an alternate procedure(s) that I can choose instead of participating in this study?
If you would prefer to discuss your answers to focus group questions in private (in a one-on-one setting) these needs can be accommodated.

How will my confidentiality be protected?
The final research report will code common themes among respondents and no names will be mentioned. Any information analyzed will not be tied to a particular individual. After the conclusion of the study, notes will be stored in a locked cabinet and recordings will be deleted.

Is my participation voluntary?
Yes

Can I stop taking part in this research?
You may stop taking part in this research at any time without penalty.

What are the procedures for withdrawal?
You may terminate participation in the study before or during the focus group and your responses will not be recorded. You may also choose for your responses to not be analyzed after the conclusion of the focus group.

Will I be given a copy of the consent document to keep?
Yes

Who should I contact if I have questions regarding the study?

Natalie Raymond
Natalie.raymond@tcu.edu
847-380-0553

Professor Wendy Macias
w.macias@tcu.edu
817-257-4577

Who should I contact if I have concerns regarding my rights as a study participant?
Dr. Tim Barth, Chair, TCU Institutional Review Board, Telephone 817-257-4320.
Dr. Bonnie Melhart, TCU Research Integrity Office, Telephone 817-257-7104.

Your signature below indicates that you have read or been read the information provided above, you have received answers to all of your questions and have been told who to call if you have any more questions, you have freely decided to participate in this research, and you understand that you are not giving up any of your legal rights.

Participant Name (please print):
_____

Participant Signature: _____
Date:_____

Investigator Name (please print):_____**Date:**_____

Investigator Signature: _____
Date:_____

Thank you for participating in my focus group and taking the time to complete a short questionnaire. The purpose of this study is to understand the barriers various groups of college women face when seeking health information. Obtaining feedback from students like you is vital to improving the communication of health-related information. This focus group will take about one hour, and the concluding demographics questionnaire should take no more than five additional minutes of your time. Your participation is voluntary and you can terminate the survey at any time. Responses will not be identified on an individual basis; your answers will be kept confidential and anonymous. Participants are eligible to win a $25 gift card, given away at random at the conclusion of our discussion. If you have any questions or concerns, please contact Natalie Raymond at Natalie.raymond@tcu.edu. If you have any questions about your rights as a study participant, you can contact Dr. Meena Shah, Chair of the TCU Institutional Review Board, at 817-257-7665 or Dr. Janis Morey, Director of Sponsored Research, at 817-257-7516.

☐ By checking this box you consent for your answers to be analyzed as part of this research.

X_____

(Your signature here)

Appendix E- In-Depth Interview Guide

1. How can we better communicate health issues with females cross-culturally?
2. How are we doing right now, in your opinion?

3. What initiatives have been taken at UT/TCU to communicate health information to multicultural female students?
4. How about with health center services/offerings?

5. How can health care practitioners and/or administrators address the issue of modesty within this population seeking health information?

6. What are your opinions on how self-efficacy can be improved for multicultural females seeking health information?

7. How can/have health care providers overcome barriers such as:
    a. Language
    b. Cultural differences
    c. Ethnocentrism

8. Can you comment on the current level of awareness of physician-patient and family dynamics on campus?

9. What kind of evaluation and training tools in cross-cultural efficacy can we/have you implemented?

10. How can health care providers overcome intercultural anxiety?

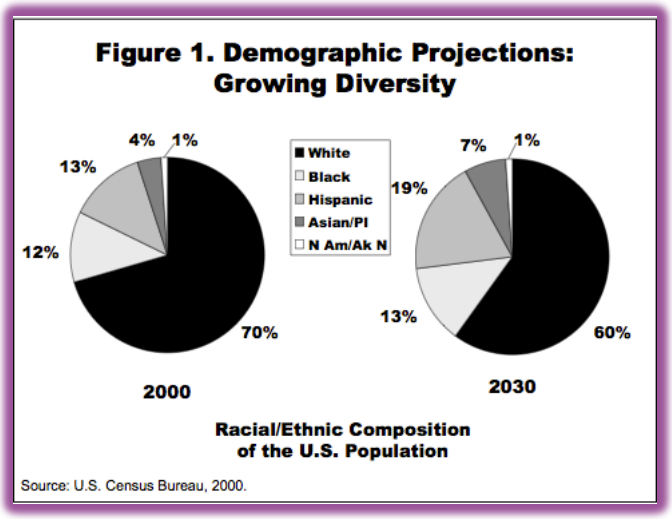
11. How can we increase cultural sensitivity and effective intercultural communication?

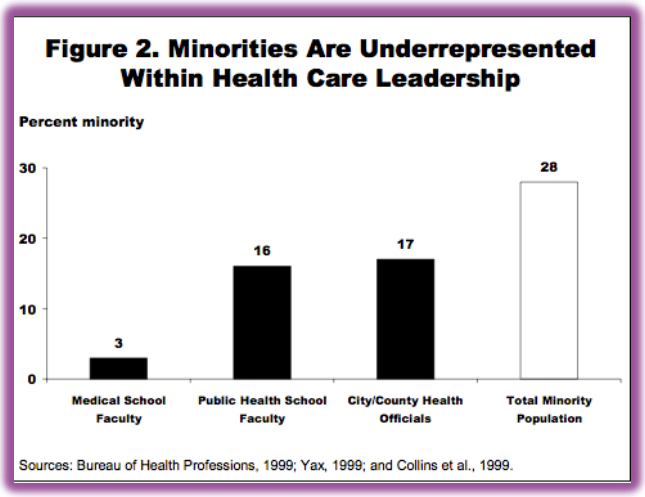
12. Describe the role higher education administrators, health care providers and student services can play in increasing access to health care information for multicultural female undergraduate students.

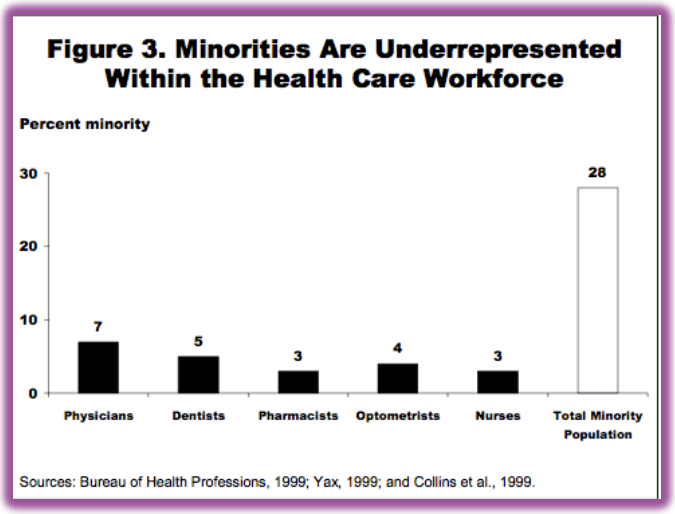
Findings for further probing;

- Programs to recruit and retain staff members who reflect the cultural diversity of the community served.
- Use of interpreter services or bilingual providers for clients with limited English proficiency.
- Cultural competency training for healthcare providers.
- Use of linguistically and culturally appropriate health education materials.
- Social marketing campaign—what would it look like?

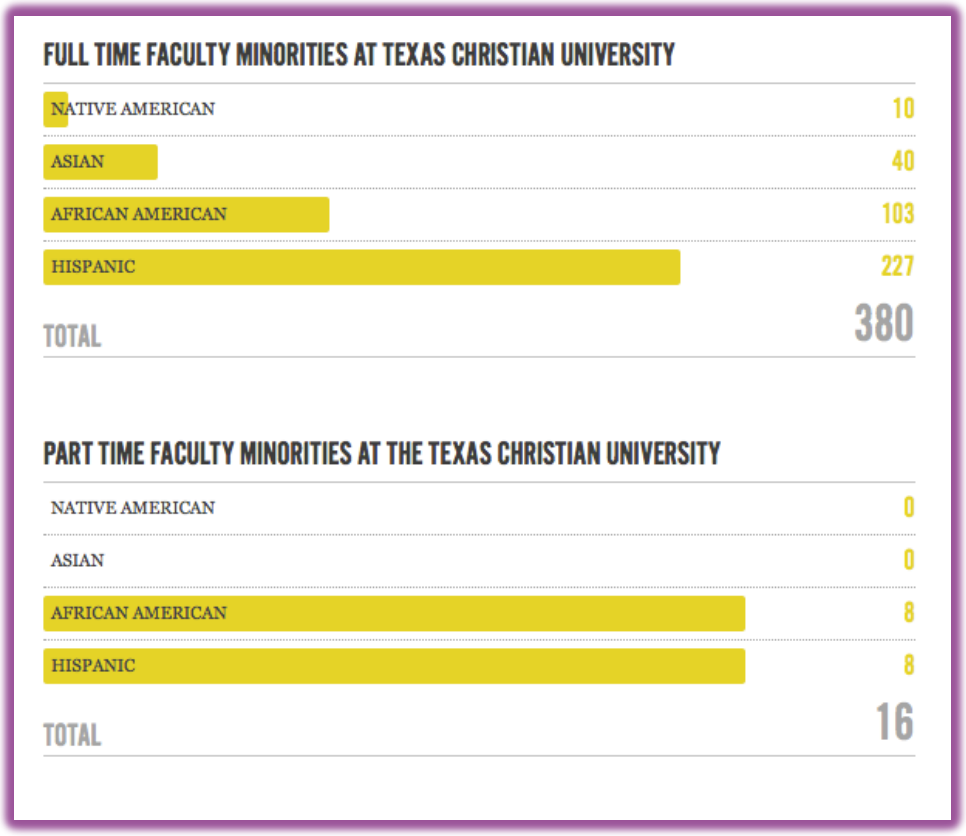
Appendix F: U.S. Population Minority Statistics (2000 Census)

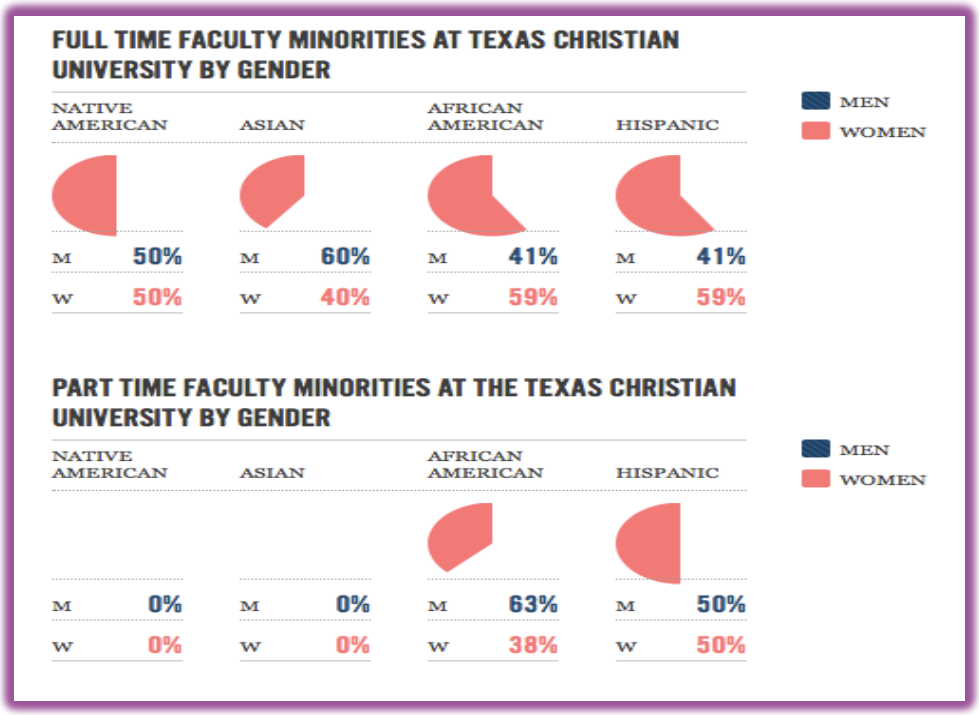




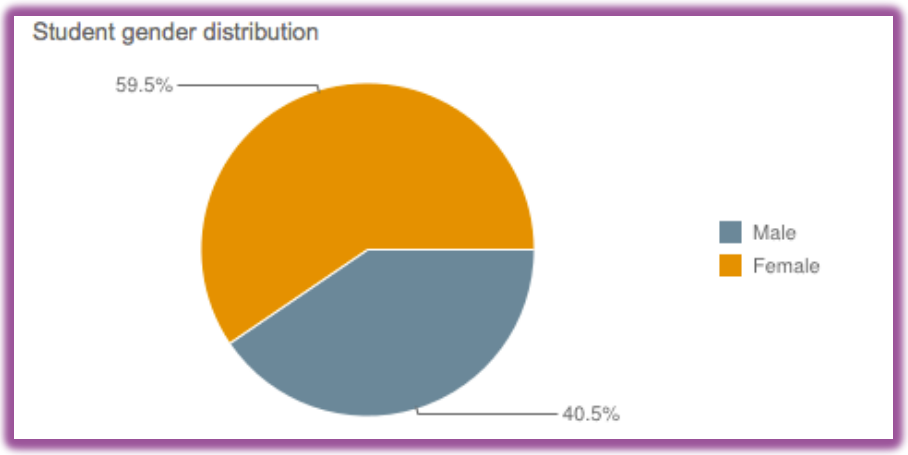


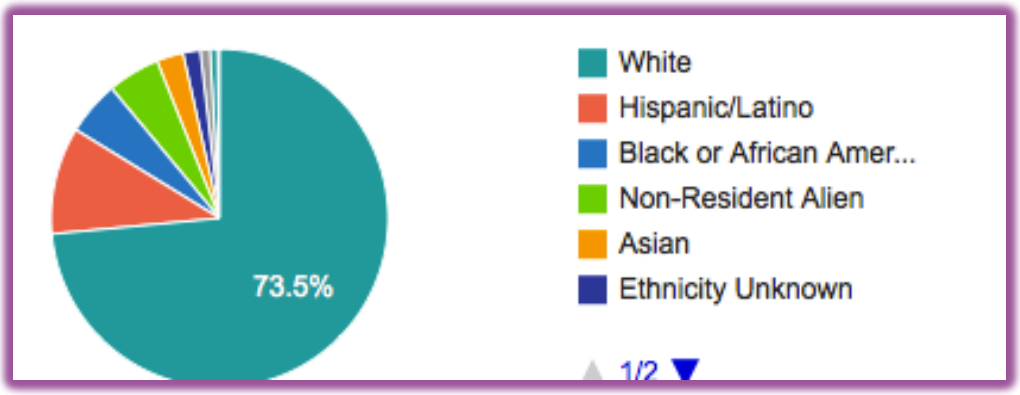
Texas Christian University Minority Statistics (educationnews.org)
(Faculty n=2,027/ Student n=9,925)





Texas Christian University 2012 Statistics (U.S. News & World Report)





Appendix G- TCU Health Center Handout – Facts At A Glance

Problem Definition: When asked about health status, women of other racial and ethnic groups are more likely to report their health as fair or poor than white women--17 percent of Hispanic women, 15 percent of black women, and only 11 percent of white women self-reported their health as such. Moreover, compared with men, women of all races are more likely to be in fair or poor health. Interviews from women of color across the United States revealed that constraints to seeking health information included a lack of trust in the information obtained from doctors, not understanding medical jargon, not having enough time, a lack of finances or insurance, the perceived lack of cultural competency by doctors, inconvenience, concern over religious differences, and past problems with medical encounters with health care professionals (Tindall and Vardeman-Winter, 2011).

What our Students Say: In addition to the obvious language barrier, the Internet, the role of education, and reliance on media in the face of mistrust of healthcare professionals are both solutions and challenges for them when seeking access to health information on TCU's campus.

What our Health Care Practitioners and International Service Administrators Say: There is a concern over educating the staff on different cultures on our campus and what their practices are; many are not aware of health care practices in different

cultures; there could be improved education on both the employee and service side. Language barriers and sub-par translation services are just the tip of the iceberg; icons, meanings, phrasing, and symbols can produce various nonsensical meanings cross-culturally

Examples of how other Universities are Successfully Addressing These Barriers:

The University of Michigan: Their four-pronged approach includes research on 1) "evidence-based and evaluative health promotion interventions for multicultural populations," 2) education for patients, health professionals, and community members on concepts and strategies for health information dissemination, 3) community engagement to identify partnerships and mobilize resources to change and create campus programs and practices, and 4) policies to reduce inequalities in health to facilitate the education and promotion of ways to improve access to health care and health information. These initiatives embrace values of health equity, cultural competency, quality service, and collaborative partnerships to benefit students in need.

The University of Texas at Austin: The University Health Services has an information team in place and a marketing communication team for multicultural students specifically. Goals are defined by both student affairs and health services to engage students where they are outside of a clinical setting, such as on the website or social media. Yearly communication goals are defined in terms of target audiences and key messages. Surveys help determine who does and does not use

campus health services, and it has been found in the past some populations feel they aren't eligible whether due to perceived biases, fear of being judged, etc. For international students, one of the main barriers there is familiarity with the university health care system, Hochman said. Health literacy, understanding things like insurance, or even just the saliency of health care consumer information is a reported focus of their team. The university continues to look at patient data and make sure they are remaining representative of the population. It is important to observe trends over time and see what is working and what areas of outreach need improvement. Hochman recommends asking providers how they have incorporated what they have learned from cultural competency training into their practice, as continuing the conversation is so important. "Did you talk about [what you've learned] with a coworker, family member, or student?" she recommends asking. Meetings with the student government and student health advisory committees can serve as the eyes and ears of health care administrators and providers—the key is to listen to how students perceive the system. Having an internal review, and partnering with student groups and a multicultural engagement center can make sure health services stays informed and conveys a message of openness and accessibility. Targeted outreach can help gain trust and ask the ones who need it how to best reach out to them.

Proposed Goals and Solutions: Kelle Tillman and Lizbeth Branch at Texas Christian University worried about language barriers, a lack of translation services, and

insufficient cultural competency among health center staff. Susan Hochman at The University of Texas at Austin confirmed the success of programs to recruit and retain diverse staff members, as well as training in cultural competency.

Combined with the impact of the Internet found in my primary and secondary research, I suggest a social marketing campaign, including the use of social media, for multicultural female students, as integrating health information promotion to multicultural females into programs and policies aligns with social marketing's premise of using business resources to develop or implement behavior change to improve things like overall public health. Social marketing is a common technique used to encourage actions aimed at changing or maintaining people's behavior for the benefit of individuals and society as a whole—in this case, the campaign could be promoted toward health care providers and administrators as well, encouraging acceptance and change in the workplace. This should take into account the populations of interests' own views via research through implementation and evaluation stages. Providing tangible solutions tailored to segmented audiences will make for the most effective communication.

In addition, I propose cultural competency training for the health center staff at TCU (see resources below), and a motion for additional resource allocation for interpretation services, including assistance with the development of linguistically and culturally appropriate health education materials.

Cultural competency training will help health care providers to develop a concrete set of values and principles and demonstrate actions, attitudes, policies, and structures that enable them to work effectively with students cross-culturally.

Resources for Cultural Competency Training and Information

Aetna Cultural Competency Courses
The *Quality Interactions*® course series is designed to help bridge cultures, build stronger patient relationships, care more effectively for patients from ethnic and minority groups, and work with patients toward better health outcomes.
http://www.aetna.com/healthcare-professionals/training-education/cultural-competency-courses.html

Catholic Charities Fort Worth
Translation and Interpretation Network (TIN) is a socially conscious business venture of CCFW designed to generate operational income and support the mission of CCFW. The mission of TIN is to bridge the language gap between providers and their clients/patients/students, becoming the voice of those who cannot speak for themselves.
http://catholiccharitiesfortworth.org/tin

Cigna Cultural Competency Training
No-cost cultural competency resource (CultureVision™) for staff proving insights and understanding of patient care centered on more than 50 cultural communities. Topics include communication, etiquette, diet and nutrition, treatment protocol, ethnopharmacology, and family patterns. Login: CignaHCP Password: doctors123!
http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/health-and-wellness-programs/health-equity

Families USA
Important updates, policy news, and in-depth analysis of heath care issues faced by communities of color.
http://familiesusa.org/issues/health-equity

National Center for Cultural Competence - Policy Briefs 1-5
The Georgetown University Center for Child and Human Development offers suggestions for cultural competence in primary health care, linguistic competence, rationale for cultural competence, a suggested partnership checklist, and culturally competent strategies for emerging diverse communities.
http://nccc.georgetown.edu/resources/publicationstitle.html#P

National Council on Interpreting in Health Care
The NCIHC is a multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States. Offers code of ethics, standards of practice, and NCIHC working paper series along with individual and organizational membership packages.
http://www.ncihc.org

National Institutes of Health
Tips on health literacy, cultural competency Q&A, and a list of selected NIH-funded projects.
http://www.nih.gov/clearcommunication/culturalcompetency.htm

Think Cultural Health Program
Free access to *The Blueprint*'s extensive explanations of each *National CLAS Standard*, including implementation strategies.
https://www.thinkculturalhealth.hhs.gov/


“Our views aren’t always the right or only way...Tell us how to best reach out to you; tell us how we can meet your needs." – Susan Hochman
“We need people from those other cultures that have successfully crossed over to be able to talk to and inform [the health center].” – Lizbeth Branch
“Problem identification, description of target audiences, development of the change technology, and process and outcome evaluation” can be used to educate health information consumers, health service providers and administrators, policy makers, and news organizations through a strategic marketing planning approach (Corrigan and Gelb, 2006; Thackeray, Keller, Heilbronner, and Dellinger, 2011).
“I know they are aware of cultural differences, but I don’t think they are aware of how to handle the differences." - International Student Services
"I don't know how to make [multicultural females] more comfortable, but luckily the staff is ready and willing to help improve the situation and is comfortable with physician-patient and family communication dynamics on campus." -Kelle Tillman