Communicator Express
cross cultural communication systems, inc.
July 2011

The Malaria Challenge: A Biopsychosocial Interpretation

Zeneva Schindler
Children's Health in a Multicultural Context
Linwood Lewis
March 11th, 2011

Introduction:
Approximately every 40 seconds a child dies of malaria generating a daily worldwide loss of 2,000 lives per day (Sachs & Malaney, 2002, p. 680). Every year there are an estimated 300 to 500 million clinical cases of malaria, and one to three million deaths, mostly children, are malaria related (Sachs & Malaney, 2002, p. 680). Malaria is heavily concentrated in tropical and subtropical climates, partially due to the increased presence of the Anopheles mosquito, the species which carries malaria parasites *(Center for Disease Control and Prevention [CDCP], 2011)*. Malaria especially impacts children because of adult acquired partial immunity. Nevertheless, malaria has been almost entirely eliminated in many temperate zones, which historically were malarial areas. The elimination of malaria in these countries occurred through public campaigns promoting, antimalarials, netting and insecticides. Malaria levels remain high in tropical areas and seasonal prolonged exposure to infected mosquitos is often granted. The failure to implement malaria preventative in endemic areas reflects not only a resource deficit but also a lack of understanding of varied cultural explanatory models surrounding the disease. Access, resources, perceptions of causes and appropriate treatment all determine the reaction an individual has towards a malaria diagnosis. This paper will address the symptomatic biological, phenomenological, economic and social factors of malaria.

Symptoms:
The symptoms of malaria can range dramatically, depending on the severity of the case, the type of malaria, age, nutrition and health prior to infection. Symptoms vary in non-immune and partially immune children. In a clinical setting, children are considered immune if they are older than 6, have a history of malaria and reside in a malaria endemic country *(Stauffer & Fischer, 2003, p. 1342)*. In non-immune children, symptoms present as a high fever, often accompanied by a headache and chills. In partially immune children, malaria is more difficult to distinguish and symptoms may be more subtle *(Stauffer & Fischer, 2003, p. 1340)*. Plasmodium falciparum is the species of malaria most associated with increased complications and mortality. Patients with P. falciparum experience high fever, chills, sweating and headache. At times, the symptoms may include back pain and vomiting. In severe forms of P. falciparum children may exhibit seizures, and respiratory distress. In children, it is often misdiagnosed as acute gastroenteritis *(Stauffer & Fischer, 2003, p. 1341)*. In partially immune children, the symptoms may appear as jaundice, anemia and hepatosplenomegy. In other strains of malaria, the symptoms may manifest severely or they may infect but cause no symptoms.

CONTINUED

CCCS, Inc., PO Box 2308, Woburn, MA 01888, 781-729-3736; New Hampshire Regional Office: 43 Technology Way, Suite 2E3, Nashua, NH 03060, 1-888-678-CCCS

The Malaria Challenge

(CONTINUED FROM PAGE 1)

Biology of Malaria:
Malaria is a parasitic disease, which is transmitted through infected Anopheles mosquitoes. Once the parasite (sporozites) is in the blood stream it travels to the liver where it matures and multiplies in red blood cells (merozoites) *(CDCP, 2011)*. Within 48 to 72 hours these rupture and infect more red blood cells. The first symptoms occur from 10 days to 4 weeks after infection. Though, in some cases it can incubate for up to a year. Part of the variety of symptoms and outcome in malaria is due to the existence of several species of the parasite.

There are four primary species of malaria that infect humans. Plasmodium vivax and Plasmodium ovale are two similar species. P. vivax is mostly in Asia, Latin America, and in some parts of Africa. Due to population densities especially in Asia it is probably the most prevalent human malaria parasite. P. ovale is mostly found in Africa. P. vivax and P. ovale have dormant liver stages after which they can activate and invade blood cells. The release of hypnozoites may be years after the initial infection.

A third species, Plasmodium falciparum, is concentrated in sub-Saharan Africa and is prevalent through out Africa. Approximately 1 million people are killed by P. falciparum every year. This strain is a form of severe malaria and can lead to rapid multiplying creating extreme blood cell loss (anemia). Also the parasites can clog small blood vessels causing cerebral malarial, a potentially fatal complication. The forth-major human infecting species is, Plasmodium malariae, which is found worldwide. It has a three-day cycle while the other species have two-day cycle. Untreated, P. malariae can result in a chronic infection *(CDCP, 2011)*.

Diagnosis of Malaria:
Biomedical diagnosis of malaria may occur through several methods including: blood smear, rapid antigen detection tests, polymerase chain reaction (PCR), and antibody tests *(Stauffer & Fischer, 2003)*. Blood smear malaria tests often present false negatives and generally negative results must be yielded at least three times to achieve confidence in the result *(Stauffer & Fischer, 2003, p. 1341)*. However, in clinics, which lack funding and serve large numbers of patients blood smear tests may only be administered once leading to possible inaccurate diagnosis. A second from of testing is rapid antigen detection, distinguishes between P. falciparum and other strains of malaria, this test is used mostly outside of the United States. The third method is a PRC test that can detect even a low level of the malaria parasite but is mostly used in specialized settings. Antibody tests are given to individuals with enlarged spleens (an indication of chronic malaria) but who had negative blood smear results. This type of testing is mostly administered to immigrants entering the United States *(Stauffer & Fischer, 2003, p. 1342)*. Even with increased testing ability, more than 60% of cases of malaria in non-endemic areas are misdiagnosed *(Stauffer & Fischer, 2003)*. The consequences of misdiagnosis may include: chronic malarial infections, cerebral malaria neurological damage or death.

Treatment and Issues of Compliance:
Treatment of malaria depends on the species, if it is classified as severe or uncomplicated as well as the amount of drug resistance in the area. Severe P. falciparum, necessitates intensive care and monitoring, while uncomplicated P. falciparum can be treated with an oral tablet *(CDCP, 2011)*. Certain areas of the world have malaria strains that are more drug resistance. Chloroquine phosphate (Aralen) is the preferred treatment for all malaria, however, cannot be used for plasmodium chloroquine resistant strains. In such cases a combination of drugs are used, such as oral quinine with sulfadoxine-pyrimethamine. However, there are some malaria drugs, which are dangerous to use in young children, such as doxycycline. There are specialized tests to determine what drug resistant strains an individual has but these are rarely used. Drug resistance forms of malaria make treatment more complicated for a patient. The finances and accessibility of taking multiple prescriptions is more challenging for patients especially in rural low socio-economic situations with limited access to pharmaceuticals. In point of fact, much of the time malaria simply isn't treated. In areas where malaria is highly endemic adults usually develop a limited immunity due to repeated exposure to malaria parasites. Many children develop chronic drug resistant forms of malaria. This is particularly prevalent in children because the of the challenge of getting children to swallow bitter pills and difficulty diagnosing malaria in children *(Stauffer & Fischer, 2003, p. 1341)*.

Much of the effectiveness of treatment is tied to the notion of "compliance". Yet, ideas of what compliance is, are founded in a cultural context *(Etkin, 2004)*. The forms medicine should take and how long treatment should last are highly variable. Perhaps, the best illustration of this is the concept of "side effects." It is a given within the construction of biomedicine that pharmaceuticals will in

CONTINUED

Cross Cultural Communication Systems Inc., PO Box 2308, Woburn, MA 01888, 781-729-3736; New Hampshire Regional Office: 43 Technology Way, Suite 2E3, Nashua, NH 03060, 1-888-678-CCCS

The Malaria Challenge (CONTINUED FROM PAGE 2)

many cases produce side effects either before or after treatment.

In many contexts, removed from biomedicine (or even within it) side effects may be regarded as making an individual sicker *(Etkin, 2004)*. Many patients prescribed chloroquine do not experience side effects, however, for those who do they may include: nausea, vomiting, blurred vision, headache, depression, sore throat, dizziness, skin sensitivity, complete blindness and rash. Each malaria medication comes with its own set of possible side effects all of which may be weighed differently in varying cultural contexts. Chloroquine sometimes even produce psychiatric effects ranging from psychosis, fatigue to asthenia *(Etikin, 2004)*. "At the same time, both the symptoms of malaria and the various psychotropic effects of its therapy may be reinterpreted with regard to the particular position they hold in the progression of illnesses through a succession of physiological and psychological manifestations," *(Etkin, 1992, p. 105)*. Interpretation of side effects may vary from family to family and the value of the medication is not always deemed worthwhile. This is most likely, an interfering cultural factor incompliance with treatment and medication.

Perceptions of Malaria

Perceptions of malaria in endemic areas are often a combination of a biomedical explanatory model and a more traditionally based explanatory model. The interactions of these duel explanatory models influence how treatment is approached and administered. In a study conducted in a rural area of Gabon, mothers were interviewed on the causes of malaria and their reaction to the disease *(Pilkington, Mayombo, Aubouy, & Deloron, 2004)*. The two-hour interviews yielded a twofold perception of malaria, which they defined primarily as "fever." The mothers recognized that malaria was caused by "small animal bites" and that Western medication had an overall positive impact, yet, they also perceived supernatural origins for more severe fevers *(Pilkington et al., 2004, p. 827)*. These two types of fever were not mutually exclusive and could manifest in the same individual at once *(Pilkington, et al, 2004, p. 827)*. The mothers also described that they first sought help at a local health facility but if symptoms persisted or if they were very severe, it was thought Western medicine should be stopped and the child was brought to a Nganga *(Pilkington et al., 2004, p. 827)*. Examples such as this one, demonstrate how these merged explanatory models may inadvertently breed drug resistant forms of malaria.

Malaria presence globally is far reaching making no complete way to represent perceptions of the disease. However, this paper will attempt some broad generalizations of the perceptions of malaria in endemic areas (probably most applicable to Africa malarial areas). The term malaria is used in combination with the local term for fever *(Caroline & Williams, 2004, p. 157)*. Often the combination of these two terms are used to refer to signs of uncomplicated malaria. Uncomplicated malaria is generally regarded as an uncomfortable yet tolerable state of being *(Caroline & Williams, 2004, p. 157-158)*. In most malaria prevalent areas, uncomplicated malaria has been socially normalized and does not carry the stigma that diseases such as HIV or tuberculoses carry *(Caroline & Williams, 2004, p.158)*. The commonality of uncomplicated malaria creates little social pressure to seek treatment. The view of severe malaria differs and is most often seen as separate from uncomplicated malaria. For example, in sub-Saharan Africa, symptoms of severe malaria, such as splenomegaly and convulsions are not only regarded as a product of the supernatural but also as a threat to the larger community *(Caroline & Williams, 2004, p. 158)*. In these cases, treatment is prescribed socially by the community, however, the form that treatment takes, clinic or healer, varies on a case-by-case basis *(Caroline & Williams, 2004, p. 158)*.

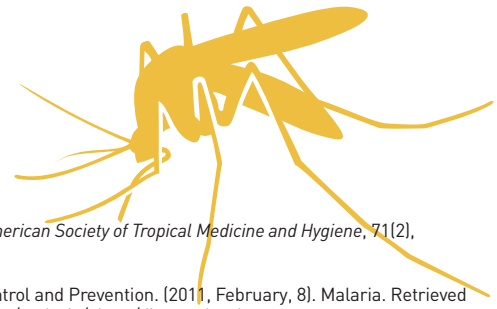
Another component in the decision between traditional and biomedical healing, is the availability of sustained access to allopathic medicine (Good, 2003). In most of the developing world, biomedicine falls very short in the provision of care, and traditional medicine is more accessible and sustainable (Good, 1990). Traditional medicine can provide patients with a number of valuable resources and treatments, including: relief from the uncertainty of illness, methods of treatment (treatment of illness), reduction stress and benefits (Good, 2003). Especially in a child targeting disease such as malaria, an explanation and treatment based within a cultural context is more likely to satisfy and relieve worried parents. In recent years, the incorporation of traditional healing into biomedicine has been increasingly advocated (Good, 2003). In terms of malaria prevention, the incorporation of traditional medicine would likely help compliance with biomedical treatment and decrease patient stress related to functioning outside their explanatory model of health (Good, 2003).

How an infected child with malaria interprets their illness is obviously rooted within their social and

CONTINUED

The Malaria Challenge

(CONTINUED FROM PAGE 3)



cultural context. In addition, severity of the strain will alter the level of symptomatic expression and likely shift a child's perception of their illness. In cases of severe malaria where seizures are present, a child likely experiences more anxiety and fear, especially, if they live in a context which recognizes the danger of servere malaria through supernatural explanations. A child's age will likely also influence their ideas of malaria. As Bibace and Walsh suggest, children proceed through certain developmental stages of understanding in distinguishing the causes of disease, treatment and symptoms (Bibace &Walsh, 1979). Both a child's cultural and developmental stage should be taken in account when medicine is administered, in order to more fully understand how the patient conceptualized their illness (Bibace &Walsh, 1979).

Works Cited

Bibace, R. & Walsh, M.E. (1979). Developmental stages in children's conceptions of illness. In G.C. Stone, F. Cohen, & N.E. Adler (Eds.) Health psychology: a handbook: theories, applications, and challenges of a psychological approach to the health care system. (pp.285-301). San Francisco: Jossey Bass.

Caroline, J. H., & Williams, H. A. (2004). The social burdens of malaria: What are we measuring? *The American Society of Tropical Medicine and Hygiene*, 71(2), 156-161.

Center for Disease Control and Prevention. (2011, February, 8). Malaria. Retrieved from http://www.cdc.gov/malaria/about/disease.html.

Etkin, N. (1992). "Side effects": Cultural constructions and reinterpretations of western pharmaceuticals. *Medical Anthropology Quarterly*, 6(2), 99-113.
Fernando, S. D., Gunawardenam, D. M., Bandara, M. R., De Silva, D. Carter, D., Mendis, K. N. & Wickremansinghe, A. R. (2003). The impact of repeated malaria attacks on the school performance of children. *The American Society of Tropical Medicine and Hygiene*, 69(6), 2003, pp. 582–588.

Fischer, P. R, & Bialek, R. (2002). Prevention of malaria in children. *Clinical Infectious Disease*, 34(4), 493-498. Retrieved, Febuary 28, 2011, from JSTOR database.

Good, C.M. (1990). Medical pluralism. In R. Ornstein & C. Swencionis (eds.) The healing brain: A scientific reader (pp. 43-62). New York: Guilford Press.

Pilkington, H., Mayombo, J., Aubouy, N. & Deloron, P. (2004). Malaria, from natural to supernatural: A qualitative study of mothers' reactions to fever. *Journal of Epidemiology and Community Health*, 58(10), 826-830.

PubMed Health. (2009, May, 30). *Malaria*. Retrieved http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001646/.
Sachs, J., & Malaney, P. (2002). The economic and social burden of malaria. Nature, 415, 680-685.

Stauffer, W., & Fischer, P. R. (2003). Diagnosis and treatment of malaria in children. *Clinical Infectious Diseases*, 37(10),1340-1348.

Turusov, V., Rakitsky, V.,& Tomatis, L. (2002). Dichlorodiphenyltrichloroethane (DDT): Ubiquity, persistence, and risks. *Environmental Health Perspectives*, 110(2), p. 125-128.

Going Green

Here are a few tips that will help your household more energy efficient and save some "green" at the same time.

- First and foremost, recycle
- Use your dishwasher instead of washing your dishes by hand
- Turn off the faucet while lathering in the shower or brushing your teeth, then proceed with rinsing
- Check your windows for cracks or misalignment, which may allow for drafts to sneak in, and seal them off
- Check with your energy provider on how to save energy when heating or cooling your home
- Unplug your electronic devices when not in use
- Always buy "energy saver" certified products

For more tips please visit
www.greenlivingtips.com
www.nationalgridusa.com
http://greenbuildingelements.com/2008/10/27/ten-tips-to-save-energy-this-winter

Answers to the CCCS Crossword - July 2011

Across

1. ABD
3. CVA
6. Thrombus
8. OD
9. Stroke
10. OU
12. Abuse
13. Down to Earth

Down

1. Aneurysm
2. LV
4. Cloth
5. Chloroquine
7. Mosquito
11. Fever

President's Corner

Dear Interpreter:

Thirty years ago, my father was asked by the newly independent Guiné Bissau (a very beautiful and small country in West Africa next to Senegal) to set up a training for the air traffic control through the United Nations.

I was so proud and excited about my father's role in building up the infrastructure of one important program set up to train and hire qualified national young men and women of a country that for generations was trying to free themselves from the Portuguese colonization forces. I made sure that I could visit my parents in Guiné Bissau as I had grown up with some friends who had moved back there. But before visiting them, I spent a few weeks getting all the appropriate shots and brought with me the daily quinine pills for the prevention of the very prevalent malaria disease.

I lived in the Azores, Lisbon and Boston most of my life and malaria was a disease I heard from the movies or at the table, but it did not seem as prevalent as it is. In my corner of the world, if I did not see, it not exist! Does that sound familiar?

Although the CDC describes the first symptoms of malaria as most likely fever, chills, sweats, headaches, muscle pains, nausea and vomiting, they are also common symptoms for other diseases like the flu, but in severe malaria, caused by Plasmodium falciparum, a patient may become confused, enter into a coma and show other serious health indicators that if not followed by a clinician, may lead to death.

According to the Center for Disease Control website, only 65 outbreaks between 1957 and 2009 in the United States were locally transmitted mosquito-borne malaria, but malaria is the fifth cause of deaths in Africa. According to the CDC, 3.3 billion people (half the world's population) live in areas at risk of malaria transmission in 109 countries and territories. Thirty-five countries (30 in sub-Saharan Africa and 5 in Asia) account for 98% of global malaria deaths. World Health Organizations estimate that in 2008 malaria caused 190 - 311 million clinical episodes, and 708,000 - 1,003,000 deaths, which 89% of malaria-related deaths worldwide occur in Africa.

Although in the USA, cases of malaria are not in significant numbers, they may be more prevalent among the population that interpreters are serving. Since immigration waves have changed in the USA and Europe, CCCS interpreters need to become familiar with this disease.

As I was visiting Guiné Bissau, my friend had a malaria episode. He described it as if he had a very bad cold, a high fever, lots of uncontrollable shakes, sweats, and overall body weakness. As a middle class member of the new country, he knew what to do if the symptoms got out of control, he had insurance and connections to the medical world. He knew about the diseases, he knew the symptoms and how to manage them and he had the resources to handle the flare ups. His episodes had a certain consistency, once to twice a year but according to the CDC "the malaria species that infect humans, *Plasmodium vivax* and *P. ovale* can develop dormant liver stages that can reactivate after symptomless intervals of up to 2 *(P. vivax)* to 4 years *(P. ovale)*". According to the CDC, there are two types (species) of parasites, *Plasmodium vivax* and *P. ovale*, which have liver stages and can remain in the body for years without causing sickness. If not treated, these liver stages may reactivate and cause malaria attacks ("relapses") after months or years without symptoms. People diagnosed with *P. vivax* or *P. ovale* are often given a second drug to help prevent these relapses.

Although the CDC describes the first symptoms of malaria as most likely fever, chills, sweats, headaches, muscle pains, nausea and vomiting, they are also common symptoms for other diseases like the flu, but in severe malaria caused by Plasmodium falciparum, a patient may become confused, enter into a coma and show other serious health indicators that if not followed by a clinician, may lead to death.

As an interpreter, when you have some free time, read our article on malaria in this issue and research this topic further by checking the Center for Disease Control website.

I hope that this brief story alerts you to the importance of becoming familiar with the common diseases of the populations that you serve so that you may develop a better understanding of their symptoms, treatment and vocabulary.

Zarita

Cerebrovascular Disease is an arthrosclerosis or hardening of the arteries; a systemic disease affecting the blood vessels supplying the heart and other organs such as kidneys and the brain.

Ask Dr. Lane

What is Cerebrovascular Disease?

Cerebrovascular Disease is an arthrosclerosis or hardening of the arteries; a systemic disease affecting the blood vessels supplying the heart and other organs such as kidneys and the brain. Atheromatous vessels become narrowed where fatty plaques develop within the walls of the artery. When an atheromatous blood vessel supplying the brain acutely plugs up because a small blood clot called a thrombus occurs, the subsequent injury and cell death in the brain is called a stroke. Sometimes a vessel can be stopped up when a fragment of the clot travels through the blood stream from another part of the body such as the heart or a larger blood vessel. This travelling fragment of the clot is called an embolus.

Some elderly people with hypertension are at risk of having a form of stroke that is associated with bleeding. The small arteries can balloon out and rupture. Headache and vomiting can precede this form of stroke. Often the deficits caused by a bleed have a good chance of improving even if the deficits are severe as the body clears the remnants of blood from the brain.

Young people can have bleeding into their subarachnoid space when congenital aneurysms rupture spontaneously. Clipping the aneurysm can stop this kind of bleeding. The kind of bleeding caused by hypertension in elderly people is usually not amenable to clipping. Another congenital problem that can lead to bleeding is an arteriovenous malformation. Increased pressure can lead to blood leaking out into the subarachnoid space.

Vocabulary-Cerebrovascular Disease

Aneurysm	A widening of the artery, that usually occurs in an artery. It may be a congenital defect or due to a weakness in the wall of the blood vessel.
Thrombus	A blot clot occurring in a blood vessel
Embolus	An embolus is many times a piece of a thrombus that has broken away. An embolus may also be pieces of plaque, air bubbles, or fat.
CVA	Cerebrovascular Accident
Arthrosclerosis	Hardening of the arteries
Stroke	Lack of blood flow to the brain. This may be due to a blood clot or a blood vessel that bursts.
Atheromatous vessels (AVM)	This occurs when arteries and veins become tangled. This appears to take birth during pregnancy or soon after birth.
Subarachnoid Space	A space in the meninges beneath the arachnoid membrane and above the pia mater that contains the cerebrospinal fluid.

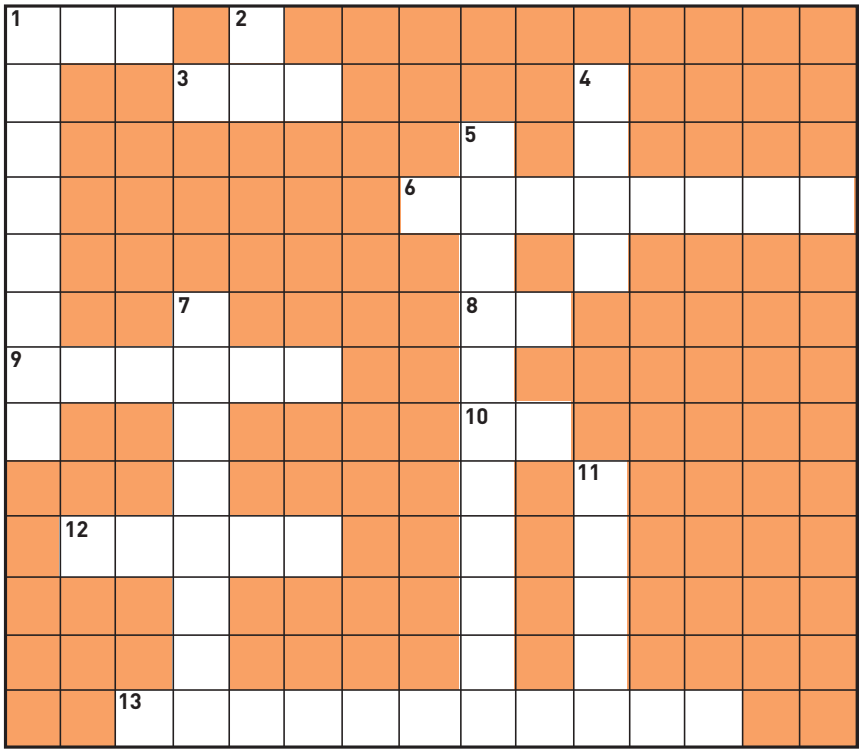
Bibliography

www.nlm.nih.gov/medlineplus/
www.umass.edu/strokestop/module_one/thrombus_embolus.html
Thomas, Clayton. Taber's Cyclopedic Medical Dictionary. New York:Eliot Books, Inc., 1981

Cross Cultural Communication Systems Inc., PO Box 2308, Woburn, MA 01888, 781-729-3736; New Hampshire Regional Office: 43 Technology Way, Suite 2E3, Nashua, NH 03060, 1-888-678-CCCS

English Idioms Explained

Idiom	Explanation	Example
To each his own	Everyone can decide for themselves	He says that he doesn't want to do it, so to each his own.
With bells on	To be punctual	Don't worry; I will be there with bells on.
Tell it like it is, straight shooter, don't mince words	To speak frankly	Frank told me that he that he feels that color of dress makes me look washed out; boy, he really tells it like it is.
An ounce of prevention is worth a pound of cure, a stitch in time saves nine	Being prepared helps save time and energy	Now is the time to get you emergency kit prepared, because "an ounce of prevention is worth a pound of cure."
Down to earth	A person that easily relates to the common person	Jerson is easy to get to know because he is so down to earth.



Across

1. Abdomen
3. Mini-Stroke
6. Blood Clot
8. Right Eye
9. Affecting the Brain
10. Both Eyes
12. Failure to report this may be a misdemeanor
13. A common person (3 words)

Down

1. Widening of an artery
2. Left Ventricle
4. Coagulated mass
5. Used in treating malaria
7. Transports malaria
11. Symptom

Abuse Reporting

Many, if not all, healthcare professionals are required by law to report suspected abuse or neglect of a child or incapacitated adult. There is not a clear cut answer about whether interpreters fall under that category or not, and the laws may differ from state to state. It is important that interpreters know whether or not they fall within a state's mandatory reporter category, as they could be liable for not reporting cases of child abuse. Failure to report cases of abuse is a misdemeanor in many states. Even though interpreters generally work in settings with a practitioner who is usually required to report, interpreters cannot assume that the practitioner will report a child abuse case.

It is not up to us to investigate or decide whether abuse has actually happened. Suspicion alone is what should be reported. In many states, when reports are made in good faith, the reporter is immune from any liability related to the case; the same immunity is in place for the investigation of the suspected abuse or neglect.

The Massachusetts law is shown on this website: http://www.mass.gov/legis/laws/mgl/119-51a.htm. The National Health Law Program has a helpful article on their website providing tips on how to find more information and questions to ask: http://www.probono.net/healthlaw/library/attachment.61990. The Child Welfare Information Gateway provides information on other states' laws: http://www.childwelfare.gov/responding/reporting.cfm.

Please review the copyrighted article by attorney Mara Youdelman:

Health Care Interpreters: Are they Mandatory Reporters of Child Abuse?

I. Introduction

As the nation continues to diversify and more health care providers are using interpreters to communicate with their patients, one issue that arises is whether interpreters are covered by mandatory child abuse reporting laws. Members of some professions are mandated by state law to report known and suspected cases of child abuse seen within the course of their employment.[2] While most states require health care workers to report child abuse, the laws are not clear if interpreters in health care settings fall within the parameters of the health care profession. It is important that interpreters know whether or not they fall within a state's mandatory reporter category, as they could be liable for not reporting cases of child abuse.Failure to report cases of abuse is a misdemeanor in many states.

Are Health Care Interpreters Mandatory Reporters?
Individuals who are required to report usually have direct contact with children. Some state statutes are very explicit in how they define health care workers, while others are not. Depending on the wording and interpretation of a statute, an interpreter may or may not fall into this designation and be a mandatory reporter. Although interpreters generally work in clinical settings with a practitioner who is usually required to report, interpreters cannot assume that the practitioner will report a child abuse case. The wording of a mandatory reporting statute may independently require the interpreter to report.

Whether an interpreter has a duty to report suspected or known child abuse depends on the laws of a particular state. Those who must report pursuant to state reporting laws generally fit into four categories.

The state breakdown is as follows:[3]

- Four states[4] require "any person" or "every person" to report
- Thirty-three states require health care workers or "hospital personnel" to report
- Thirteen states require "any person" or "every person" and health care workers to report
- Texas requires "any person" or "every person" and "professionals" to report

Ten states (including those with the highest LEP populations) were examined to ascertain whether interpreter's are required to report child abuse observed in health care settings.[9] None of the reporting statutes in those states specifically requires interpreters to report. However, three states have adopted statutes that require all persons to report suspected abuse regardless of their profession. Four states require "hospital personnel" to report, which may sometimes include interpreters (see below). Two of the ten states have adopted both the catch-all "any person"provision, and a specific health care worker provision. One state has an "any person" as well as a "professional" provision. Only one state clearly did not require health care interpreters to report child abuse.

a.The "Any Person" or "Every Person" requirement

Three of the ten states we examined require "any person" or "every person" to report suspected cases of child abuse. These states are Florida, New Jersey, and North Carolina. For example, in New Jersey, the

CONTINUED

Cross Cultural Communication Systems Inc., PO Box 2308, Woburn, MA 01888, 781-729-3736; New Hampshire Regional Office: 43 Technology Way, Suite 2E3, Nashua, NH 03060, 1-888-678-CCCS

Abuse Reporting (CONTINUED FROM PAGE 8)

statute states that "any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report...."[10] Thus, a health care interpreter would be required to report child abuse, regardless of the context within which she learned of the abuse.

Although Florida has an "any person" requirement, the state additionally requires health care workers to give their name when making a report of child abuse. Individuals who are not health care workers (or members of certain other professions listed in the statute) are allowed to report anonymously.[11]

b The "Health Care Worker" Requirement

Of the ten states we examined, California, Illinois, Massachusetts, and New York require some categories of health care workers to report suspected cases of child abuse.

New York requires "hospital personnel engaged in the admission, examination, care or treatment of persons" to report child abuse and neglect.[12] Thus, whether or not health care interpreters fall into this category depends on whether (1) they are hospital "personnel;" and (2) they are engaged in the "admission, examination, care or treatment of persons." For example, a full time interpreter employed by a hospital would likely be considered hospital "personnel," while an interpreter who independently contracted with a hospital might not be. If interpreters are hospital personnel, the second question is whether they are engaged in "admission, examination, care or treatment." If an interpreter is used to communicate with LEP patients in the hospital admissions process, they are likely to be considered mandatory reporters. Illinois and Massachusetts have statutory language that requires reporting from similar personnel, with the only difference being that hospital personnel engaged in admissions are not included.[13]

California exhaustively lists every profession that is required to report, but does not list interpreters or include a category as broad as "health care worker," as do the three states above.[14] While California's statute also requires child abuse reporting by persons who are currently licensed under a section of the Business and Professions Code;[15] interpreters are not among those so licensed. Therefore, health care interpreters are not mandated to report child abuse.

c. The "Any Person" and a "health Care Worker" requirement

A state with an "any" or "every" person mandatory reporting provision obviously requires all interpreters to report child abuse because they definitely fall within the catch-all "any"/"every" person. Of the states examined, New Mexico and Maryland have adopted the "any person" requirement, augmented by a specific requirement for certain types of health care workers to report child abuse. While Maryland has also adopted the "any person" requirement, it also has a separate requirement for health practitioners.[16] Maryland's statutory definition of health practitioner does note compass interpreters, yet the "any person" requirement obligates interpreters to report cases of child abuse. New Mexico's health care worker provision is limited to physicians, residents and interns, although interpreters would be included under the "every person" provision.[17]

d. The "Any Person" and "Professional" requirement

Like the states above which have a health care worker requirement in addition to an "any person" requirement, Texas requires "any person" as well as "professionals" to report child abuse.[18] In Texas, interpreters are obligated to report any suspected case of child abuse under the "any person" requirement.

Other states may use "professional" instead of " healthcare worker" and thus an examination of the Texas requirement may be helpful. The Texas statute defines a professional as "an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children."[19] Currently, Texas has no licensure or certification requirement for interpreters; how ever, an interpreter falls into this category if they are employed by a hospital or other licensed facility.

The question will therefore be the meaning of "employee" and it is likely independent contractors would be excluded under this provision.

III. Other Important Components of mandatory reporting Laws

There are several other important components regarding failure to report and protections for good faith reporting. Interpreters need to know these requirements because a failure to report can have negative repercussions.

Failure to report a suspected case is a misdemeanor in six of the states we examined –California, Florida, Illinois, New Mexico, New York and Texas.[20] In Illinois, a first violation is a misdemeanor and any subsequent failure to report is considered a felony.[21]

CONTINUED

Abuse Reporting (CONTINUED FROM PAGE 9)

Massachusetts fines non-reporters up to $1000. In New Jersey, a person is deemed a "disorderly person" for failing to report child abuse.[23] North Carolina and Maryland have no punishment for non-reporting.

Finally, most states give immunity from civil and criminal liability to mandatory reporters who report in good faith. If a healthcare interpreter suspects child abuse and reports it, but later the child abuse charge is determined to be unfounded, the interpreter cannot be held liable for reporting what he/she believed to be abuse. All ten states examined here give this immunity.

IV. Conclusion

To determine whether health care interpreters are required to report child abuse in a state, one should examine the state's child abuse and neglect statute regarding mandatory reporting. The National Clearinghouse on Child Abuse and Neglect Information has produced a chart with citations to every state's child abuse laws. The chart is also useful as a quick guide for the individuals and/or professions who must report child abuse and neglect.[24]

Checklist: What to look for in a state mandatory reporting statute:

- **Is there an "any person" requirement clause?**
  If yes, then all health care interpreters have a mandatory reporting duty, and you need not go any farther.
  If no, check if another provision may apply to interpreters.

- **Is there a health care worker, health personnel or hospital personnel requirement clause?**
  If yes, then look to see if a health care interpreter would fit within such a profession. If the terms are not defined within the clause, look for a definitions provision, usually in an earlier subsection of the statute or in cases decided by the courts in your state.

- **Is the interpreter considered a hospital "employee" or "personnel," as opposed to an in dependent contractor or an employee of an interpreter service?**
  If yes, the interpreter must report
  If no, check if another provision may apply to interpreters.

- **Is the interpreter engaged in the activities covered by the statute – e.g. admission, examination, care or treatment of patients?**
  If yes, the interpreter must report
  If no, check if another provision may apply to interpreters

- **Look for other relevant provisions:**
  Is there punishment for non-reporting?
  Is there immunity for good faith reporting?

2 There may be a similar reporting requirement for elder abuse, but that is beyond the scope of this paper.

3 For a breakdown of all states, see National Clearinghouse on Child Abuse and Neglect Information, Statutes At-a-Glance, Mandatory Reporters of Child Abuse and Neglect (Feb. 2002), available at http://www.calib.com/nccanch/pubs/sag/manda.pdf.

4 Florida, New Jersey, North Carolina and Wyoming. See http://www.calib.com/nccanch/pubs/sag/manda.pdf.

5 Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New York, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Vermont, Virginia, Washington, West Virginia, and Wisconsin. See http://www.calib.com/nccanch/pubs/sag/manda.pdf.

6 Delaware, Idaho, Indiana, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, Oklahoma, Rhode Island, Tennessee, and Utah. See http://www.calib.com/nccanch/pubs/sag/manda.pdf.

7 Although it may seem redundant and illogical, many state statutes contain a provision requiring health care workers or professionals to report child abuse in addition to having a provision requiring "any" or "every" person to do so. Why this is so and how it originated is beyond the scope of this paper.

8 Other states from the thirteen that have an "any" or "every" person and health care worker requirement may fit into this category, but that is beyond the scope of this paper and not available from the chart cited above.

9 The chosen states were California, Florida, Illinois, Maryland, Massachusetts, New Jersey, New Mexico, New York, North Carolina, and Texas.

10 N.J. STAT. ANN. § 9:6-8.10 (West 2002).

11 FLA. STAT. ANN. §39.201(1)(b) (West 2003).

12 N.Y. SOC. SERV. LAW § 413(1) (McKinney 2003).

13 325 ILL. COMP. STAT. 5/4 (2001 & Supp. 2003); MASS. ANN. LAWS ch. 119, § 51A (Law. Co-op 2003).

14 CAL. PENAL CODE § 11165.7 (West 2003).

15 CAL. PENAL CODE § 11165.7(21) (West 2003).

16 MD. CODE ANN., FAM. LAW §§5-704-705 (2002).

17 N.M. STAT. ANN. § 32A-4-3(A) (Michie 2002).

18 TEX. FAM. CODE ANN. § 261.101 (Vernon 2002).

19 TEX. FAM. CODE ANN. § 261.101(a)-(b) (Vernon 2002).

20 See CAL. PENAL CODE § 11166(b) (West 2003); FLA. STAT. ANN. § 39.205 (West 2003); 325 ILL. COMP. STAT. 5/4 (2001 & Supp. 2003); N.M. STAT. ANN. § 32A-4-3(F) (Michie 2002); N.Y. SOC. SERV. LAW § 420 (McKinney 2003); TEX. FAM. CODE ANN. § 261.109 (Vernon 2002).

21 325 ILL. COMP. STAT. 5/4 (2001 & Supp. 2003).

22 MASS. ANN. LAWS ch. 119, § 51A (Law. Co-op 2003).

23 N.J. STAT. ANN. § 9:6-8.14 (West 2002). A disorderly persons offense is a petty offense and is not a crime. N.J. STAT. ANN. § 2C:1-4 (West 2003).

24 National Clearinghouse on Child Abuse and Neglect Information, Statutes At-a-Glance, Mandatory Reporters of Child Abuse and Neglect (Feb. 2002), available at http://www.calib.com/nccanch/pubs/sag/manda.pdf.

Know your Acronyms and Abbrev.

Anatomy	
ABD	Abdomen
KUB	Kidneys, Ureters, Bladder
LUQ	Left Upper Quadrante
LV	Left Ventricle
OS	Left Eye
OD	Right Eye
OU	Both Eyes

Upcoming Conferences

October 2011

October 26-29

ATA 52 Annual Conference
Marriott Copley Place
110 Huntington Avenue
Boston, Massachusetts 02116
www.atanet.org

Zarita Araujo-Lane LICSW &
Dr. Rick Lane will present
"Learning Medical Terminology Through Medical Case Studies"
Date/Time of Session:

10/28/11, 2:30pm-3:30pm

Upcoming Trainings

GETTING READY FOR YOUR WRITTEN HEALTHCARE CERTIFICATION EXAM
This course will help prepare active qualified healthcare interpreters for both of the national certification written exams. In order to simulate the written certification exams, students will have the opportunity to take online tests during class time. These exams will help prepare the student to get the feel of how the certification exam will be presented and will allow them to receive instant feedback on their progress. Students will be able to use these exams as a tool to help gauge their progress, and as an indicator to help them determine their readiness for the certification exam. Click here for a complete overview of the course.

Online beginning November 01, 2011

THE ART OF MEDICAL INTERPRETATION: 60-HOUR CERTIFICATE PROGRAM
Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level," according to the industry standards. Click here to download the catalogue. If you are interested in more information please contact us at 781-729-3736 or by email, info@embracingculture.com.

This program has been approved by The American Translators Association(ATA) for 10 Continuing Education Points, and by International Medical Interpreters Association (IMIA) for 6 CEUs.

Woburn, MA : Tuesdays and Thursdays, September 8-November 1, 6pm-10pm
Manchester, NH: Saturdays 9am-3pm, October 22, 2011 - February 11, 2012

THE FUNDAMENTALS OF LEGAL INTERPRETATION: 60-HOUR CERTIFICATE OF ATTENDANCE PROGRAM
Pre-requisites: Applicant must be at least 18 years of age, with a minimum of a HS diploma or GED, and must pass a mandatory screening examination in English and the target foreign language(s) prior to acceptance in the program. Applicants must pass the screening at a minimum of "Advanced Mid-Level" according to the industry standards. There is a $55 non-refundable fee for this screening examination. If you are interested in more information please contact us at 781-497-5066, or by email at info@embracingculture.com.

Cost: $850 (materials are not included)
Sundays 9:00am-2:00pm, September 11, 2011-December 11, 2011

The American Translators Association has approved the Fundamentals of Legal Interpretation: 60-hour Certificate of Attendance Program for 10 Continuing Education Points.

Click here to download the catalogue. If you are interested in more information please contact us at 781-729-3736 X110 or by email at info@embracingculture.com.