Utilizing the ACCESS Model to Understand Communication With the Ultraorthodox Community in Beit Shemesh During the First Wave of COVID-19

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Abstract

Introduction: The coronavirus pandemic has disproportionately negatively affected the ultraorthodox in Israel. Their unique characteristics and slow adoption of preventative health guidelines resulted in a significant increase in morbidity and mortality. To lower these rates, health and government authority figures employed methods to change the ultraorthodox community health behaviors. **Methodology:** This study utilizes the ACCESS model for transcultural nursing to analyze the response by authorities to high infection rates in the large ultraorthodox community in city of Beit Shemesh during the first wave of the outbreak (through early May). **Results:** The authorities employed all model components to varying degrees and found moderate success in changing health behaviors of the ultraorthodox. **Discussion:** Employing the ACCESS model as a response to the health care crisis among the ultraorthodox community in Beit Shemesh led to some success in increased compliance, thus lowering morbidity rates. However, not establishing strong respect and rapport hindered the process.

Keywords

ultraorthodox, ACCESS model, culture, covid-19

Introduction: Statement and Significance of the Problem

Following the outbreak of the coronavirus pandemic in late 2019, public health experts worldwide urged governments to implement restrictions in an effort to slow disease transmission and prevent an untenable burden of illness on health care systems (Gilardino, 2020). In Israel, a 2-month lockdown was initiated by the Israeli government during late March 2020 to lower transmission rates (Ministry of Health [MOH], 2020). However, some populations, particularly the ultraorthodox community, suffered from high infection rates (Saban, Myers, et al., 2020). As of September 2020, over a third of all cases (34%) in Israel are within in the ultraorthodox sector, and they have higher mortality rates and higher hospitalization rates compared with the general Israeli population (Malach & Cahaner, 2020; Taragin-Zeller et al., 2020; Waitzberg et al., 2020).

7% (Malach & Cahaner, 2019). This community has several unique characteristics, stemming from their strong commitment to Jewish law and tradition. Due to this commitment and attempts to minimize outside influences on their traditions, the community has little contact with the general population (by choice). As a result of this, it is a very close-knit community. Additionally, the community has a low rate of representation in the national labor force (particularly in the health care industry). This is also a result of their commitment to Jewish tradition as many men will choose study full-time in Yeshivas (religious schools) as opposed to working (Malach & Cahaner, 2019).

Additional characteristics include the central role of the rabbi in community actions and behaviors, large families crowded in small apartments in overpopulated neighborhoods, limited income, and strong community bonds (Friedman,

Literature Review

The Ultraorthodox Community in Israel

The ultraorthodox community in Israel accounts for 12% of Israel's total population and has an annual growth of 4% to

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1991; Libman, 2020; Waitzberg et al., 2020). All of these unique characteristics create a culture that is separate from that of the general population in Israel (Waitzberg et al., 2020). Of note, the ultraorthodox community can be split into two main subpopulation groups, the Lithuanian (non-Hasidic) stream, and the Hasidic stream (composed of many smaller, different Hasidic communities).

The ultraorthodox maintain separate educational and civil-life systems. Many community members use the older Yiddish as opposed to modern Hebrew. They consume their own media that, for the most part, reflects community-related news; general public information is covered to a lesser extent. There is also limited consumption of online content. Instead, to quickly disseminate ideas and news, the ultraorthodox community heavily relies on broadsides, called “pashkevlim” (pashkevil, sing.; Rosenberg & Rashi, 2015). This Yiddish (and now Hebrew) term was adapted from the term “pasquile,” from Pasquino who spread ideas by hanging writing on statues and pedestals in public areas in the 16th century.

Another area in which the differences between the ultraorthodox and general Israeli population are prevalent is health care. Israel has a universal health care system. However, consumption of health care services among the ultraorthodox differs from the rest of the general population. Ultraorthodox are less likely to own supplementary insurance, partially due to the added expense (Horowitz, 2016). Furthermore, they are more likely to forgo medical care, and have a lower health literacy than the general population (Chernichovsky, 2018; Saban, Shachar, et al., 2020; Zicherman, 2014). Studies have also shown that health care decision making among the ultraorthodox generally involves seeking the opinions from rabbinical leaders, who sometimes rule in opposition to the physician (Coleman-Bruckheimer et al., 2009; Levin & Prince, 2010; Rier et al., 2008). Additionally, ultraorthodox are less likely to work in the field of health (Horowitz, 2016). All of these factors can have significant ramifications on the overall health of the community (Woelf & Aron, 2013).

Public Health Interventions Among Unique Populations

A public health intervention can be key to stopping or mitigating disease or negative health outcomes in a population. These interventions are even more important among distinct minority populations, such as religious or linguistic groups, as minorities tend to have worse health outcomes compared with the general population (Agency for Healthcare Research and Quality, 2010). However, to be effective, public health actions must take into consideration the unique needs of each population and tailor interventions accordingly. Aspects that need to be taken into consideration include communication methods, the ability to gain trust, and understanding cultural values that may influence an individual’s response (Vaughan & Tinker, 2009).

Examples of culturally sensitive public health interventions among unique minority populations range from the development of targeted health education programs for religious minorities and interventions for drug and alcohol abuse among specific ethnic minorities (Dickerson et al., 2016; Treaster et al., 2006).

The ACCESS Model for Transcultural Nursing

The ACCESS model, developed by Aru Narayanasamy in 1999, outlines a framework for nurses on how to deliver transcultural care; that is, care, which is culturally sensitive to the patient and takes into account their culture, beliefs, and values while providing health care. In a study conducted among both nurses and student nurses, this model was found to be helpful for treating patients of different cultural backgrounds (Narayanasamy, 2002).

There are six components to the model: assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity, and safety. Assessment is the evaluation of a patient’s cultural background, taking note of their health beliefs and practices. Communication, one of the key components to delivering transcultural care, is being aware of and using the cultural communication norms of the patient, both verbal and nonverbal. The cultural negotiation and compromise component is awareness of cultural differences and understanding how the patient perceives the health care issue. Establishing respect and rapport is vital for a patient to maintain their dignity. When a health care worker shows respect for the patient’s culture and beliefs, the patient will have more trust for the health care worker. This is especially important during a time of crisis. The sensitivity component is the sensitivity shown toward patients during their interactions with health care workers, such as utilizing terms they understand to explain their health situation and trying to understand their needs pertaining to their culture and beliefs. Finally, safety is the idea that a health care worker does not to engage in any action that disrespects the patient’s culture, which would cause a patient to feel culturally unsafe (Narayanasamy, 2002).

Our study will apply the ACCESS model for transcultural nursing to explain how the actions undertaken by various authorities in the Israeli city of Beit Shemesh both overcame barriers, but were at times hindered in delivering communications and care to the ultraorthodox community during the first wave of the coronavirus pandemic (through May 2020), and to show that this model can be applied to health-related situations outside a clinical setting. The city of Beit Shemesh, where almost 65% of the population is ultraorthodox, will be our case study.

The Case Study: Beit Shemesh’s Ultraorthodox Community

Beit Shemesh, a Jewish Israeli city, and the only other city in the Jerusalem district, is a microcosm in Israel’s diverse

society. Built in 1950, it has a population of over 120,000 in 2020 (National Insurance Institute, 2020). During its early years, residents were primarily immigrants of mid-eastern or eastern European descent, who immigrated to Israel shortly after 1948 and the city was little more than a transit camp. The early and mid-1990s saw an influx of Anglo-Saxon immigrants, many of them educated, and of middle to high socioeconomic status. During that same period, the ultraorthodox began moving to neighborhoods in Beit Shemesh, as a more affordable alternative to Jerusalem. This growing ultraorthodox community is comprised of smaller communities with different community leaders and levels of stringency and insularity. Currently, these communities make up 65% of the overall city population. As many of the ultraorthodox are not part of the local labor market, 45% of the population in Beit Shemesh is living on an income below the minimum wage (National Insurance Institute, 2020; Regev & Gordon, 2020).

The Problem

The ultraorthodox community in Beit Shemesh was slow to adopt public health measures and make behavioral changes in response to the spread of the coronavirus, and some ultraorthodox communities blatantly opposed to adoption (Martinelli, 2020). This delay contributed to the quick spread and rising rates in the ultraorthodox communities with serious consequences (Birenbaum-Carmeli & Chassida, 2020; Schattner & Klepfish, 2020). Beginning in April, the average number of confirmed infected per 10,000 residents in Beit Shemesh was higher than the national average (18.7 vs. 16 per 10,000 residents). Almost all cases in Beit Shemesh occurred in ultraorthodox neighborhoods (Coronavirus Information and Knowledge Center, 2020a; Malchi et al., 2020; Saban, Shachar, et al., 2020; Waitzberg et al., 2020).

The ultraorthodox were slow to change their behavior for a number of reasons, including reasons related to their access to information, religious reasons, and reasons related to their lifestyle. Regarding their access to information, the ultraorthodox are less likely to consume conventional media, particularly online information. Indeed, the ultraorthodox sector had delayed access to information on coronavirus. This meant that while the rest of the country was exposed to a lot of information related to the virus from the beginning, the ultraorthodox population had less access and gaps in the information they did receive (Malchi et al., 2020). Religious reasons included the roles of rabbis and other community leaders responsible for making decisions regarding behavior and community norms. Without rabbinical rulings, many in the ultraorthodox society will not act, as they do not regard the State as an authority (Libman, 2020; Malchi et al., 2020). Furthermore, in some communities, the rabbis defied the government regulations (Martinelli, 2020). Other religious reasons include the belief that God will save the community from the virus, the central role of the community in everyday

life events (such as daily communal prayers, large weddings, funerals, religious schools, etc.). Finally, the ultraorthodox lifestyle characteristics, including large families in small apartments and high population density in ultraorthodox neighborhoods, lent itself to a situation with quick and uncontrolled spread (Malchi et al., 2020; Sharon, 2020).

The delayed response among the ultraorthodox community was further exacerbated by the initial lack of effort to tailor information by the local authorities in Beit Shemesh and the MOH. Furthermore, messages were sporadic and not always clear. (Rossner, 2005; Slobodin & Cohen, 2020; Waitzberg et al., 2020).

Discussion and Analysis: Analyzing the Responses to the Challenge Through the Framework of the ACCESS Model

According to the United Nations comprehensive report, effective communication among diverse populations in relation to COVID-19 should promote three themes: science, solidarity, and solutions. Science aims to enhance research and global knowledge related to the COVID-19 pandemic, while solidarity and solution aim to promote collaboration between local and global policy makers to protect and support underrepresented and vulnerable population groups such as women, children, and older adults (United Nations, 2020). Effective public health policy requires tailored strategy for the different sectors in the population (Corcoran, 2007; Kreps, 2003; Marks et al., 2011; Vaughan & Tinker, 2009). In light of rising transmission rates in the ultraorthodox community, both local and national authorities recognized the need to change their approach to this specific population (Malchi et al., 2020). While not in a clinical setting, we posit that the various steps taken to tailor efforts and communicate with the ultraorthodox population in Beit Shemesh fit the ACCESS model.

Assessment

Assessment, the first stage of the ACCESS model, is the assessment of the patient's cultural background, which, in this case is the ultraorthodox community (Narayanasamy, 2002). Early on during the pandemic, it was clear that there was an issue of compliance in this community (as part of a nationwide issue). In assessing the situation in Beit Shemesh, the municipality understood how difficult it would be for the ultraorthodox to adhere to the MOH guidelines, both from an environmental perspective and a religious perspective. From an environmental perspective, many ultraorthodox have large families living in small apartments in dense neighborhoods; and with the closure of yeshivas, children who may have boarded at school were sent home. Ultraorthodox are also more likely to use public transportation, as less of them own cars, and many have limited to no access to computers or smartphones, making it harder for parents and children to

work and learn remotely (Waitzberg et al., 2020). From a religious perspective, many religious commandments and rituals are community-based. Since the ultraorthodox regard their rabbis as the ultimate authority figure and not the State, when they weigh new State regulations against their traditional religious ones, it would be hard for the State regulations to be validated without broad rabbinical support (Ashkenazi, 2020; Libman, 2020; Malchi et al., 2020).

The issue of rethinking the approach to the ultraorthodox community was brought to the forefront already in the early stages of the first lockdown, in late March. On a national level, the Knesset was presented with an in-depth analysis of the ultraorthodox community, as well as potential challenges and recommendations (Malchi et al., 2020). At the local level, the Beit Shemesh municipality recognized that there is a need to change the perception of what needs to be prioritized in relation to the pandemic, and that this change should come from work done within the confines of the community's culture. Working with the community as opposed to undermining it would likely increase compliance and thus lower morbidity and mortality (Ashkenazi, 2020; Waitzberg et al., 2020).

Communication

The second component, communication, discusses the use of familiar themes and language when speaking to patients (Narayanasamy, 2002). In our case study, this was particularly evident in both the media and the language used to convey the message. Pashkevilim, in particular, are widely recognized as an effective and quick means of communication in the ultraorthodox community, were utilized to the extent that they became "breaking news" outlets. Additional methods included loudspeakers and enlisting the help and support of rabbis and other community leaders.

The pashkevilim and other media incorporated language familiar to the community. As is common with pashkevilim, they were printed in Hebrew and Yiddish and used biblical and religious verses familiar to the audience (Harlap, 2010). For instance, the cover of one of the earliest pashkevilim had the message: "The Angel of Death is in the streets—return home!" The message was framed using language that the ultraorthodox understood, using religious concepts (Angel of Death) to accentuate the importance of the message (Haimowitz, 2020). Others included messages about the sanctity of life, an important theme in Jewish tradition and messages that rabbinical rulings have decreed that people are not to be out on the street (Cohen, 2020).

Both the Department for Health Advocacy among the ultraorthodox in the MOH and the Beit Shemesh municipality, began distributing pashkevilim and setting up drivers to drive around ultraorthodox neighborhoods, explaining the MOH restrictions in Yiddish through loudspeakers (Sultan, 2020). The majority of the pashkevilim were posted by United Hatzalah, an independent nonprofit emergency

medical services organization. With a large portion of their volunteers from the ultraorthodox community, they had a better understanding of how pashkevilim could be utilized (Cohen, 2020).

Cultural Negotiation and Compromise

In response to the awareness of differences in understanding situations, the different authority players, including municipality and health authorities, understood they needed to work within the cultural boundaries of the community, dictated by their religious life, to increase compliance (Narayanasamy, 2002). In our case study, we found three areas where negotiation and compromise were needed to advance understanding of the COVID-19 transmission and application of public health measures, while respecting the beliefs of the members of the population. These areas are communications and messaging; approaches to the educational institutes; and housing and quarantine approaches.

For communications and messaging, the aforementioned pashkevilim, as recognized methods of communication were utilized in addition to loudspeakers on cars (Cohen, 2020; Taragin-Zeller et al., 2020). Approaches to closing the educational institutes in the ultraorthodox community was central to cultural compromise and negotiation, particularly as many ultraorthodox were against it, not understanding how closing institutions of Torah learning is important to combating the pandemic (Taragin-Zeller et al., 2020). Ultraorthodox schools remained open by the directive of leading rabbis, in spite of a mandate set by the Israeli government to close all schools on March 14 (Waitzberg et al., 2020). This included all ultraorthodox schools in Beit Shemesh. As a result, the government worked to gain trust with the ultraorthodox leadership in order to negotiate school closures, speaking to numerous leading rabbis to gain their support and explain the necessity in closing schools (Be'eri et al., 2019; Waitzberg et al., 2020). Leading rabbinical figures were approached by the MOH and asked to add their names to a letter encouraging the ultraorthodox community to adhere to guidelines set by the MOH and other medical experts in relation to COVID-19. This way, adopting the new health guidelines became acceptable behavior in the community, as leading rabbis promoted it. A few days later, a number of ultraorthodox schools in Beit Shemesh closed their doors and by the end of March, rabbinical leadership ordered all ultraorthodox schools to be shuttered (Ibn Zur & Friedman, 2020).

Housing and quarantine were also central to cultural compromise and negotiation. National efforts were made to negotiate with ultraorthodox community leaders, to encourage the transfer of stable COVID-19 patients with minor symptoms to designated "corona hotels" under the authority of the Israel Defense Forces Homefront Command to reduce potential spread at home. This was particularly important for the large families in the ultraorthodox community. While communicating health guidelines could stem some transmission,

quarantining in small apartments with a large number of people is not feasible. Therefore, to encourage the ultraorthodox to utilize these hotels, accommodations were made to ensure that they would be able to adhere to their religious life (Rotman, 2020; Waitzberg et al., 2020).

Establishing Respect and Rapport

Showing respect for the patient's cultural background and beliefs is key to the establishment of respect and rapport between the health care worker and the patient (Narayanasamy, 2002). By speaking in a language and media with which the ultraorthodox were familiar, and involving rabbis and other community leaders, the authorities attempted to establish some respect and rapport and create a trusting relationship to increase adherence rates and lower transmission (Waitzberg et al., 2020). However, this was not fully realized. When lockdown restrictions began easing up, Beit Shemesh was originally made a "red city" (not safe to reopen); however, when stratifying by neighborhood, it became clear that the higher rates of infection were in the ultraorthodox neighborhoods. Instead of keeping the entire city in lockdown, the government decided to close the communities that had the highest infection rates (Kol Hair Editorial Board, 2020). This angered a significant number of residents, and some went as far as to post pashkevilim comparing the lack of easing restrictions with the creation of a ghetto in these neighborhoods (Goldberg, 2020). Furthermore, there were a number of cases in which ultraorthodox disregarded the guidelines to hold public prayers, funerals, and weddings in Beit Shemesh (Fridson & Cohen, 2020). These incidents served to increase tensions between ultraorthodox and nonultraorthodox residents.

Sensitivity and Safety

Components five and six, sensitivity and safety, were applied in the appeal of ultraorthodox municipality leaders. Sensitivity is delivering care in a manner that is sensitive to the cultural background of the patient. Safety is the delivery of care in a manner that is not only sensitive to the patient's cultural background but that nurtures the unique cultural background of the patients (Narayanasamy, 2002). These elements were apparent in the utilization of ultraorthodox municipality leaders, so these leaders could relay messages to the community in terms they understand and in a way that is acceptable to them (Malchi et al., 2020; Waitzberg et al., 2020). These leaders were of utmost importance in transmitting the message that the community members would be culturally safe while adhering to the rules (Martinelli, 2020).

An example of this is a dedicated hotline for coronavirus-related updates (regarding schools, business closures, new regulations) for the ultraorthodox community that is not connected to the internet. This hotline was run by the municipality spokesperson for the ultraorthodox media (Rabinow,

2020). Another example of how sensitivity and safety was employed was in the appeal by ultraorthodox leaders in the matter of the aforementioned coronavirus hotels. These hotels were a vital link in stopping the spread of the virus in this community. Ultraorthodox municipality leaders posted pashkevilim about the "corona hotels," explaining that the ultraorthodox would be able to maintain their way of life—including kosher dietary standards, Shabbat, and the separation of men and women (Ravid & Cohen, 2020; Shadmi et al., 2020; Waitzberg et al., 2020).

Additionally, these leaders also sided with the ultraorthodox community when they believed they were being treated unfairly by the government. Such was the case when the government extended the lockdown for certain neighborhoods. These leaders went on record stating their disagreement with the decision and sent letters to that effect to various Knesset members (Kol Hair Editorial Board, 2020). These statements were made to prevent the ultraorthodox to feel as though they were culturally unsafe.

Aftermath

Weeks after the lockdown, the transmission and mortality rates among the ultraorthodox in Beit Shemesh were significantly lower (Coronavirus Information and Knowledge Center, 2020b). However, the ultraorthodox communities struggled with stigma as rule-breakers and disease-spreaders (Gilman, 2020). Mainstream Israeli media highlighted cases of rule-breaking among the ultraorthodox, despite the majority of culprits being fringe elements of the community (Taragin-Zeller et al., 2020). However, the differences presented between the responses of the general Israeli public and the ultraorthodox population to the COVID-19 public health crisis intensified already erratic communication methods between segments of the Israeli population, and accentuated the cultural conflicts between the ultraorthodox community and the rest of the Israeli population (Guttentag, 2020).

Following the easing of lockdown restrictions, the nature of communication, mainly via pashkevilim, between the authorities and the community changed. These pashkevilim focused more on personal fear and threats, were less dramatic, and had clear instructions: face masks, social distancing, and hand washing. However, a lot of damage had already been done and, combined with feelings of despair, fatigue, and impatience, antiultraorthodox rhetoric was widespread among mainstream Israeli media (Guttentag, 2020; Sharon, 2020).

Authorities had a harder time establishing respect and rapport among the ultraorthodox community, despite attempts to communicate with them using culturally sensitive language. Some theories as to the reason behind this is the miscalculation among state authorities as to the importance of communal activities, and the role of rabbis and leaders (Gilman, 2020). This inaccurate assessment may have led to a lack of fully understanding the culture and likely affected the success of the communication.

Another possible reason could be the singling out of a specific population group as “problematic” and the need to address them as a separate issue. During the second wave, ultraorthodox leaders were quick to point out what they deemed hypocrisy in allowing political protests (as a basic right) but not allowing public prayer. This stoked an already-tenuous relationship between ultraorthodox communities and the general Israeli population (Gilman, 2020).

Conclusions

Policy makers and health advocates need to embed cultural sensitivity within their practice prior to outreach campaigns meant for specific populations in order to have influence on the communities’ health behavior. However, leaders involved with in handling a crisis on a large scale should first promote solidarity and mutual respect within their community and then build an internal outward-facing community-led strategy (United Nations, 2020).

Based on the present analysis, public health interventions among the ultraorthodox community require understanding of the culture of the community and the establishment of mutual respect between health and municipal authorities and the ultraorthodox leadership. For the ultraorthodox community, and likely other communities with strong, centralized leadership, having public health officials work together with community leaders, in a dedicated committee or as consultation, to tailor interventions and regulations would likely increase compliance rates. Additionally, utilizing familiar language and themes for public health intervention communication methods (which should also be tailored to the community), especially among populations with unique linguistic needs, can also positively affect compliance. Finally, considering community needs, such as a religious lifestyle, are key to building a successful intervention.

Interventions for public health can benefit from employing all or some of the components of the ACCESS model for health care services, and especially the establishment of respect and rapport, and embrace the idea of tailoring interventions to specific communities, implementing transparency, mutual respect, and decency with its audiences.

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