Attachment E

Outside the Public Hearings

McDermott, Timothy [LEGIS]

From: Freeman, Mary Lou [LEGIS]
Sent: Wednesday, October 05, 2005 3:11 PM
To: McDermott, Timothy [LEGIS]
Subject: FW: New Iowans Interim Committee Public Hearings

From: Cyndi Chen [mailto:mscyndichen@yahoo.com]
Sent: Mon 9/26/2005 2:28 AM
To: Bolkcom, Joe [LEGIS]; McKinley, Paul [LEGIS]; Hahn, James [LEGIS]; Hatch, Jack [LEGIS]; McCoy, Matt [LEGIS]; Tinsman, Maggie [LEGIS]; Freeman, Mary Lou [LEGIS]; Berry, Deborah [LEGIS]; Eichhorn, George [LEGIS]; Ford, Wayne [LEGIS]; Tymeson, Jodi [LEGIS]
Cc: Chen, Cyndi [DVRS]
Subject: New Iowans Interim Committee Public Hearings

Dear Committee members,

I applaud for your commitment to get public input instead make decisions based on proceed notions.

Unfortunately I won't be able to attend any of the hearings. Here are some thoughts about new Iowans especially immigrants and refugees:

Education -
a) Support new comers for advanced English learning and advanced education

b) Recruit minority teachers and teacher aids earlier in the spring and offer them contracts as soon as possible to secure their acceptance; provide mentors, support groups to increase the retention;

c) Grow our own minority teachers and teacher aids and provide incentives.

4) Provide more foreign language learning opportunities; encourage students study, do internship, or travel abroad, so they would have a better understanding of being a different culture setting and speaking a different language other than English

FYI: There are two extremes in the Asian Iowan population:
1. A group came to Iowa as students to pursue advanced degrees. They are well educated and highly skilled professionals. Their average income is much higher than average. Their home values are higher than average. However, majority of them are still lacking of knowledge about how U.S. government works, what services are available, how to get involved in community, or how to serve on a board, etc.

2. The other group came to Iowa as SE Asian refugees during 1970s and 80s. They only had 3 months time to learn very basic English so they can get jobs and starting support their families. Three month English is not enough to make them into the mainstream. This group has high poverty rate and lower home-ownership. While their children encounter academic challenging, their parents won't be able to help.

Asian Iowan's poverty rate is 14% higher than 9% of Iowa as a whole; householders rate is only 46% much lower than 73% of state average.

I have a friend who was a French language teacher and a math teacher in Laos, he came to Iowa in 1970s. He and his wife only had the opportunity to learn basic English in the first 3 months right after his family arrived in Iowa. They had to find a job right away to support the family. He works as a custodian; his wife, also a former teacher, works on the assembly line at a window manufacture for four 10-hour days per week. It has been about 30 years. They have no complaint as long as their children are doing well.

Asian young people especially boys' high school dropout rate is pretty high. They are struggling with identities; they are caught between two cultures (home - traditional; and outside of their homes) and don't see role models who has similar skin colors and understand their needs.

2. Healthcare -

a) Most of Asian immigrants have no concept of preventative healthcare. Quite often when they go to see doctors, it's too late for treatments. Easy access and affordable acre are important.

b) Develop a universal medical record format with various language available so people can carry them for emergency. It's a challenge to go to the medical care center - filling out form with page after page full of medical terms.

c) Recruit healthcare staff with cultural competencies.

3. Job creation and outreach efforts:

a) working with various ethnic groups and commissions.

b) provide business etiquette 101 trainings and job related skills for new comers at corporation sites

c) establish strong interpreters and mentoring programs

d) establish support groups for new comers.

4. Public safety:

a) Make drivers' licenses available to all new comers

b) Provide trainings on Government 101, finance 101, insurance, real estate property acquisition, self-advocate, etc.

Please feel free to contact me if I can be helpful. Thank you!

Cyndi Chen, Chairperson
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McDermott, Timothy [LEGIS]

From: Kevin & Laurie Conner [connerkl@msn.com]
Sent: Tuesday, October 04, 2005 10:40 AM
To: McDermott, Timothy [LEGIS]
Cc: stricklers@ihaonline.org; lconner@dallascohospital.org
Subject: New Iowans Study

Dear Mr. McDermott,

My name is Laurie Conner, CEO of Dallas County Hospital in Perry, Iowa. I have currently reviewed the New Iowans Study Committee charge and felt the need to share the experiences of our hospital when attempting to care for the health needs of immigrants, migrant workers and refugees.

In March of this year, I traveled to Mexico to learn of the health care delivery system that the Latinos and Mexicans are familiar with accessing. Two weeks ago, we hosted six physicians from Mexico in exchange so that they may learn of our health care system and improve upon their delivery system as well as teach the immigrants how to access our health care system in Iowa. This was a very eye-opening experience.

From my point of view as the hospital CEO, I have listed the issues we must overcome in order to achieve our goal to care for this population:

1. create trust, trust, trust
2. create a sub-delivery system that they are familiar with accessing
3. educate the population on the appropriate use of emergency
4. find the silent leaders in this population to communicate our process
5. have translation services 24/7 for patients
6. build upon diversity training within the workplace
7. attempt to recruit representatives from this population to governance roles of the hospital
8. work with business leaders who employee this population to educate persons on healthy living
9. find funding to offset the expenses to tailor healthcare program for immigrants
10. create a finance system (i.e. charity care application process, sliding fee scale, savings plans, mission health services, etc. .) to empower this population to become familiar and utilize resources to be fiscally responsible individuals

This population is not familiar with an "insurance" program - they are familiar with government subsidized health care, dollars automatically withdrawn from their paychecks, OR paying what they can for services, while the remainder of the bill is written off. I received a survey from a Latino patient the other day - they ranked our services very high. They wrote a note that stated " I do not make much money so please do not charge me much". This is the system they are used to accessing. As a county hospital, our mission is to care for these patients but our revenue will not be able to cover this process for very long.

Perry, Iowa is now approximately 40% Latino/Mexican. It is a small town of approximately 7,000+ population. The hospital must also be very careful how far we tailor our health care system to this population as there are very strong biases from the community. This population is perceived as "invading" the community, creating a "bad name" for the community, etc. .We have determined that we will develop a program to the best of our ability for "ALL uninsured" no matter what the culture.

Continuing education is also an issue. As a county hospital, we have a budget of $5,000/year for continuing education. We have created an environment where we encourage employees to take advantage of this opportunity. We are just now starting to receive applications for our Latino population to go to nursing/certified nursing assistant/LPN school. After only 3 months of this FY, we have asked

our board to increase our tuition assistance program to $30,000 this year to subsidize this need to educate these people to become graduates of the health care programs available to them. Again, we will need to find the dollars to pay for this service.

Lastly, I would like to close with a situation that occurred while the Mexican physicians visited our hospital.

I was giving them a tour of our facility when I introduced them to one of our cooks who is from Guadaljara. He He just turned in his resignation to work for the factory in town. He indicated it was for more money. I shared this with the physicians. These physicians strongly reprimanded this young man. They indicated that he needs to show America what great people the Mexicans can be. They told him he needed to not follow the dollars but follow his heart and work where he makes a difference. They told him to make them proud!!!

By the end of the day, this young man was in my office in tears. He shared with me the REAL reason he was resigning from his position. His work visa was up to expire on October 12th. He lives paycheck to paycheck and had to put down a deposit on an apartment and had no cash to send with the application. His mother put him in touch with a lawyer (whom we are not sure of his credentials or legal capability). This lawyer informed this man to quit and go work for a smaller organization (not government owned) and "fly under the radar" for a while. I asked him where his passion was - he indicated at the hospital. He said " many Mexicans can say I work at the factory - not many can say I work at the hospital". He said all of his friends ask him how can we work for a place like that?

I indicated we would pay for his application and verify with our legal counsel that what we are doing is adequate. He denied our assistance. He stated "some of my friends have had their company pay for these things and now they are slaves to that boss". In the end, we created a way by which all employees in his department received a "thank you" and his went to pay for his application. Again, these are dollars which are not budgeted for - but we are in the business of helping others. We are now researching all of the legal documentation criteria and ways to legally assist our immigrant workers.

I apologize for such a lengthy, detailed correspondence. I am very passionate about caring for this population and how we as a business are called to help others. I would be happy to visit with you on the phone or in person at any time. You may reach me at 515-465-7600 or lconner@dallascohospital.org. Thank you for taking the time to hear my point of view. Laurie Conner

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2005-10-03

To: Senator Joe Bolkcom
Co-Chair
New Iowans Interim Study Committee

From: Thomas Andre, Ph.D.
Professor and Chair

Re: New Iowan's hearings

This memo provides brief information about contributions that Iowa State makes with respect to the educational needs of New Iowans. I will summarize our contributions briefly and invite a request for additional information. Faculty member in teacher education at ISU have particular expertise that may be relevant to issues identified by the committee.

1. As part of its teacher education program, all teacher candidates at Iowa State complete a course in multicultural education. This course deals with a range of diversity issues including students newly immigrated to the United States. It helps future teachers understand the cultures of such students and learn educational strategies to promote learning of students from different cultural backgrounds. At important aspect of the course is information and teaching strategies related to English Language Learners. While we encourage and expect our teacher education graduates to be lifelong learners in this and other areas, we believe this course provides students with an initial base of skills and knowledge relevant to effectively teaching English Language Learners upon which they can build over there future teaching careers.

   Faculty involved with teaching the class include: Dr. Katherine Richardson Bruna, Dr. James McShay, and Dr. Warren Blumenfeld. Dr. Bruna, in particular, is expert in the needs of and educational strategies for English Language Learners. I will discuss some of her additional work later.

2. Iowa State has long had a program in teaching English as a second language. It is a collaborative program between the Department of English and the Department of Curriculum and Instruction. Dr. Roberta Vann, of the English department, leads the program. The ESL program is an add-on endorsement; a teacher candidate being recommended for licensure in an area such as Elementary Education or Secondary Education can complete the requirements for the ESL endorsement. This can be done either prior or subsequent to graduation and receipt of the initial licensure.

3. Unlike many elementary education programs, Iowa State's requires teachers to demonstrate a minimal level of training in a foreign language. The elementary education program requires the same demonstration of foreign language training as the College of Liberal Arts and Sciences at ISU. Many students elect Spanish as the language. While insufficient in itself, this requirement contributes to a broadened understanding of other cultures and of the language of many of the immigrants to Iowa.

4. Experts from Iowa State worked with the Iowa Department of Education to offer education and training in working with English Language Learning for Iowa teachers. Funded by a grant from the Iowa Department of Education, Drs. Roberta Vann, Katie Bruna, Joanne Olson, Dan Douglas and John Levis, presented a very well received workshop this summer in which Iowa teachers learned about English Language Learners and how to teach such students effectively.

5. Dr. Bruna is involved in a research and development program with the Marshalltown schools in which she works with teachers of ELL students and helps develop deeper understanding of these students' needs and effective educational approaches for them. As this is her research area, as well as part of her engagement efforts with the state, Dr. Bruna participates extensively in the schools. In addition, she has brought the students to Iowa State to learn about college opportunities and to work with our teacher education students to help them better understand the needs of ELL student. She has also traveled to the home communities in Mexico of the students in order to gain a more in –depth understanding of the cultures from which these students come. She uses this experience to inform her classes for teacher education candidates at Iowa State as well as to contribute to effective education for Marshalltown students. Dr. Bruna brings to this work extensive training is English language learning and participation in a major grant project involving English language learners in her previous employment in California

Iowa State teacher education faculty members are pleased to partner with Iowa schools and the Department of Education and other organizations to provide excellent educational opportunities for new Iowans. We are deeply committed to producing teachers with the knowledge and skills to effectively teach new Iowans.

If your committee would like additional details of any of this work, it would be best to contact me or the faculty members directly. I have attached relevant emails below.

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Caring for Diverse Seniors:

A Health Provider's Pocket Guide to Working with Elderly Minority, Immigrant, and Refugee Patients

Michele Yehieli, Dr.P.H.,
Mark A. Grey, Ph.D., and
Annie Vander Werff, M.A.

HEALTH FOR ALL IOWANS
PROJECT EXPORT
CENTER OF EXCELLENCE
UNIVERSITY OF NORTHERN IOWA
NATIONAL INSTITUTES OF HEALTH

New Iowans
A program of the
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This book was produced as part of the outreach and training efforts of the University of Northern Iowa (UNI) Project EXPORT Center of Excellence on Health Disparities and New Iowans Program. These programs represent the University of Northern Iowa's commitment to welcoming immigrant and refugee newcomers in Iowa and the United States, and helping to address the needs of long-time minority populations as well. Several UNI administrators have been particularly supportive of these programs on campus. They include UNI President Dr. Robert Koob; Dr. Patricia Geadelmann, Special Assistant to the President for Board and Governmental Relations; Keith Saunders, Associate Director of Governmental Relations; Dr. Susan Koch, Associate Vice President of Academic Affairs; Dr. Julia Wallace, Dean of the College of Social and Behavioral Sciences; and Dr. Christopher Edginton, Director of the School of Health, Physical Education, and Leisure Services.

The authors would especially like to thank the following professionals from the cultural communities discussed in this guidebook for their invaluable assistance as reviewers: the Black Hawk County Minority Health Coalition, the Cedar Valley Hospice (Stacey Taylor and Tina Hubbard), Dr. Roberto Clemente, Eileen Corcoran, Dr. Robin Gurien, Dr. Yulia Komarova, Dr. Joel Longie, Carlos Macias, Yana Cornish, Patricia Teran Yengle, Dr. Sang-Min Kim, Clementine and Israel Msengi, Dr. Rahdi Al-Mabuk, John Sagala, Dr. Christina Thomas, Hagai Yehieli, Janice Edmunds-Wells, Peladija Woodson, Dr. Catherine Zeman, and Dr. Douglas Zhu.

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About this Pocket Guide

This pocket guide is a practical resource for health care and other providers who work with the growing number of older immigrants, refugees, and minorities in the United States. These populations typically experience unique cultural, social, age, and economic barriers that can significantly affect their health status. Working with diverse elder populations can pose a number of rewards and challenges for hospitals, clinics, Medicare organizations, non-profit organizations, health care providers, and other entities that serve these groups. The information provided in the guide comes from a number of different sources, including the background of the authors who have extensive field and academic experience addressing the health needs of immigrant, refugee, and minority populations. Other sources include the body of professional health literature and the knowledge of many providers who have shared their experiences with us. Most importantly, clients and professionals from each of the minority populations have provided extensive input.

Minority, immigrant, and refugee seniors come from a very diverse set of nationalities and ethnicities. Therefore, in addition to general information about working in a culturally competent manner with seniors, this pocket guide will also address some of the specific key differences between these groups of seniors, and how these cultural and ethnic experiences impact their ideas about health, the American health care system, and how to access it. The guide also provides valuable information about the best ways to approach health issues for seniors from individual ethnic groups. However, this guide is not meant to stereotype any person, and health providers must recognize the tremendous diversity in individual practices, beliefs, and personalities of all patients, regardless of their countries of origin.

About this Pocket Guide

This guide responds to several questions:

1) What are the cultural backgrounds of some of the most significant minority and newcomer elder populations in the United States?

2) How do the cultural, religious and socioeconomic backgrounds of these minority seniors impact their perspectives on health and the health care system? How do these seniors from different cultures define "health"?

3) What should health care providers know about these minorities and newcomers that will help them provide the best possible care to the aging?

Part I

Minority Elders in the United States

Changing Demographics of the Elderly

America's cultural landscape is changing. The United States is becoming more ethnically diverse. Not only are the nation's established minorities growing but immigrants and refugees make up a significant part of the country's population growth. As these diverse populations grow so will the number of diverse seniors.

A look at population change between 1990 and 2000 bears this out. According to the US Census, in 1990, there were about 6 million Asian Americans, Native Americans, Hispanics and African Americans ages 60 and over. In 2000, that figure jumped to 7 million. Reflecting the rapid growth in the Hispanic population, the number of Hispanics aged 60 or older grew by 45% between 1990 and 2000 to nearly 2.5 million. The number of senior Native Americans grew by 24% in the same decade.

Related to the growth in the elderly among established-resident minority populations, is growth in the nation's immigrant and refugee senior populations. In 1995, the US Census estimated the number of foreign-born residents aged 55 or older was 4,887,000. By 2003 the estimate of elderly foreign-born residents grew to 6,865,000, a 40% increase. Many newcomers, including Latino immigrants, are counted among the nation's minority populations. But many are not. For example, Bosnian refugees are not counted as minorities. Regardless of their ethnicity or eligibility to be counted as minorities in the Census, immigrant and refugee newcomers bring unique issues to health care settings.

Health Conditions among Senior Minorities

Serving the health care needs of elder minorities, immigrants, and refugees can present special challenges for health care providers. Health status varies dramatically by ethnic group in the United States. In general, minorities are disproportionately affected in comparison to the white majority population by chronic illnesses, infectious diseases, mental health challenges, accidents, intentional injuries, and other conditions. Interestingly, only a small portion of this disparity is considered to be a result of genetic differences that cannot be changed. More typically, broad differences in income, education, living conditions, lifestyle practices, insurance coverage, family support systems, and other socioeconomic factors have far greater impact on the health status of minorities than do inherent biological differences between races.

Differences in health status among the races can become even more magnified, though, as people age. For instance, as a whole, African Americans and Native Americans tend to die much younger than white Americans. Also, many chronic diseases such as diabetes and arthritis show up earlier among underserved minority groups than in other populations. Many minority seniors may not actively participate in preventive screenings and behaviors, and therefore often enter the health care system at a late stage when diseases are more advanced and treatment options are limited. In general, health providers should expect that their elderly minority clients may suffer from multiple related health conditions. Chronic conditions such as cancer, stroke, heart disease, obesity, and diabetes can be quite common among diverse elderly clients, as prevalence and incidence rates for many of these diseases are significantly higher than those for white seniors. Also, in comparison to whites, more low-income minority seniors have difficulty completing various activities of daily living such as bathing, managing their own finances, or cooking for themselves, and may need formal assistance with these tasks. Accurately following a complicated prescription regimen can also be particularly difficult for minority seniors, especially if they have limited literacy and English language skills. Greater rates of hunger and poor nutritional status are seen among minority seniors than whites, and depression, mental stress, poor dental health, limited vision and hearing, accidents,

and falls are usually more common as well. Minority seniors are less likely to have access to medical devices that can help them, such as wheelchairs, hearing aids, and canes, but more likely to live in low-income communities where crime, environmental hazards, and poor living conditions affect their safety and well-being.

Financial Barriers

Financial access to care is the greatest barrier to good health for minorities and newcomers in the United States, and this challenge can become more significant as people age. There are approximately 45 million Americans who do not have medical insurance, and minorities are disproportionately represented among the uninsured. Millions of others are under-insured or represent the working poor. Immigrants who are in the United States without the proper legal documentation are even more likely to be uninsured. Many seniors such as women, minorities, and widows are especially vulnerable to falling below poverty levels and being unable to afford health care. As people age, they tend to need more medical services. However, as many minority seniors were employed in their younger years at lower paying jobs, they may have only limited savings, pension payments, and Social Security benefits. While they may eventually qualify for Medicare, the national health care program that helps pay for health costs of seniors, most of the aged will still face significant out-of-pocket bills for their medical, preventive, dental, mental, vision, and prescription drug care. Furthermore, the United States government will not pay for most long-term care costs of the elderly until the patients "spend down" their savings, fall below poverty, and qualify for federal assistance. As most long-term costs can average at least $4,000 per month in a nursing home, this type of assisted living is almost impossible to access for many, especially poor minorities who were unable to afford private long-term care insurance.

Transportation and Geographic Barriers

However, money is not the only barrier to care for minority seniors. Geographic and transportation restraints are also significant. Health services are not always located conveniently in ethnic neighborhoods where minority and immigrant elders live, and they may not have easy car or bus transportation to better medical facilities in white

areas. Medical conditions and handicaps can make the use of public transportation especially challenging for the elderly. Likewise, health services that are offered only 9:00 a.m. to 5:00 p.m., Monday through Friday, off-site in a building staffed by all white providers would typically not be well utilized by many minorities. Many seniors may need to rely on their working adult children to provide them with transportation to medical providers. However, many lower income minority and immigrant workers are employed in multiple jobs, and may have very limited time off each week. They would have difficulty seeking care for their elders during standard operating hours in most doctors' offices, especially if faced with the added burden of needing childcare for their own young ones.

Language Barriers

Language issues can also complicate diagnosis and treatment when an elderly patient speaks no English and interpreters are not available. Sometimes newcomer children have learned some English and are used to interpret in health care settings for their older relatives, but the kids lack the English vocabulary necessary to help providers make appropriate diagnoses. In their home country, the seniors were usually highly respected and valued for their knowledge, but feel helpless upon arrival in America as they depend on their children for assistance with interpretation and other issues. Language barriers can also mean that patients' questions are not adequately communicated or misunderstood, and that doctors' instructions might be misunderstood. In other cases, elderly minorities may be particularly stoic and unlikely to divulge their aches, pains, and symptoms.

Cultural Barriers and Conceptions of Health

Different cultures might also have different ideas about what "health" is. For most Americans, being "healthy" is the state in which we feel good enough to maintain our day-to-day activities; a lack of health can be anything that prevents us from functioning in a normal matter. Immigrant and refugee seniors might have very different ideas about what it means to be "healthy." Being "healthy" might simply mean a lack of disease, but they may not consider other conditions that keep them from performing optimally worth going to a doctor. Or, one kind of problem might not mean one lacks health, while other problems

do. A person might be considered unhealthy, even though able to function in terms of family responsibilities, work, and social obligations.

Similarly, ethnic minority and newcomer populations have very different ideas about what constitutes "healthy" behaviors or what factors cause certain diseases. These beliefs vary dramatically by cultural community, and can be more profound among the elderly. For example, standard American dietary recommendations promote consumption of certain foods such as dairy products or some produce to maintain long-term health. In other cultures, these same foods might be uncommon or only consumed when they are in season.

Senior minorities can also have different ideas about the role of health care professionals. People from countries that lack resources to provide preventive and primary care might consider resorting to doctors only in extreme cases, and many minority seniors may never have visited a physician. Differences in what is considered "health" and "wellness" can also prevent the U.S. health care system from working well for aging minorities. For example, a senior who has a chronic disease but is still able to function by working and attending to family matters might consider himself "well" and fail to seek out medical attention that established residents would consider mandatory. There might also be critical differences in assumptions about how to treat or prevent the condition, and cultural differences can increase the likelihood of a missed or inappropriate diagnosis. The results can be costly if health problems are not handled appropriately and become critical, requiring a visit to the emergency room. Many immigrants from non-western cultures in the United States also have highly developed systems of traditional medicine and healers on which they rely for their main care. Minority seniors may be especially likely to value their own traditional health care practices over that of "modern" western medicine

Culture is also likely to be a barrier to care when minority elders cannot be seen by providers familiar with their unique ethnic background or sensitive to their needs. Many public health interventions, for instance,

are developed primarily for white, middle-class populations, and are not culturally sensitive to the specific health practices, needs, and beliefs of older minorities. In other cases, diverse seniors may only want to see "white" American doctors, believing that they are better trained than providers from their own culture.

An Intimidating Health Care System

The often impersonal, institutional system of delivering health care common in the United States does not always work well with minority and newcomer populations, and particularly seniors. Many people from non-western cultures place their primary emphasis on holistic healing and interpersonal relations, rather than on external, institutional disease treatment for curing specific diseases. The American health care system can be intimidating to newcomers and the elderly, and it assumes a level of trust in hospitals, clinics and doctors that not all patients have. Most minority seniors would prefer to have one meaningful relationship with a general health care provider, rather than be sent off to see many different confusing specialists. As with most seniors, most of the minority elders will also have great difficulty in understanding the payment and insurance mechanisms to cover their medical costs.

Experience has shown that minorities, newcomers, and seniors are much more likely to use health care programs that reach out to them in a more personal manner. Formal advertising of the availability of special programs for these populations often does not work as well as personal referrals and word-of-mouth marketing. Making these contacts may take time and patience and might involve identifying and working with leaders in the minority communities to give outreach programs a degree of legitimacy.

Lack of Medical Records

Unlike American-born minorities, immigrants and refugees often arrive in this country with limited or no health records. Without this background information, it is difficult—if not impossible—for providers to make an appropriate medical diagnosis, or even prescribe the best medicine. Lack of medical records can be a very frustrating aspect of working with newcomers for health care professionals. For doctors, there is no history or previous diagnoses to inform a current diagnosis or recommend an appropriate course of action. For community health providers, nurses, and others, it is impossible to tell if newcomer seniors are allergic to any medications, or if they are vaccinated against certain diseases. Elderly immigrants sometimes do not know their exact year of birth, or may never have seen a doctor or dentist prior to arriving in the United States.

Cultural Competency and Health: General Guidelines when Working with Diverse Seniors

"It is much more important to know what kind of person has a disease, than what kind of disease a person has." – Sir William Osler

Culturally Competent Health Care

Providing culturally competent health care means that a provider or organization is sensitive to the cultural differences between patients, understands the influence of these differences on their health status, and can modify programs from a practical standpoint to meet the specific needs of diverse clients. Culturally competent health care is necessary, because many public health studies around the world consistently indicate that culture is a significant, common barrier to care for minority and immigrant patients. Cultural barriers may be quite obvious or more subtle. For instance, a Latino immigrant senior patient may be less likely to visit a local clinic if he knows that the providers there do not speak Spanish, his only language. Likewise, a Somali refugee elder may be reluctant to be seen by a male American physician, because it is disrespectful for her to disrobe in front of a man. Health providers and their agencies, therefore, must be sensitive to the cultural nuances that affect the health status of their elderly minority patients.

Cultural Communication Styles

Humans communicate in a variety of ways, both through verbal and non-verbal methods. In general, people in a specific culture tend to communicate in a similar manner. For example, cultural communication styles can be placed along a spectrum. Although any one individual from a certain culture may actually communicate in a very different way, there are still general tendencies that are seen when describing the way cultures communicate.

For example, the cultures along one end of a continuum tend to communicate in an expressive manner. They usually openly display

more passion, gestures, and emotion in their communication, and may speak more loudly than quieter cultures. They may also stand more closely to one another while speaking, or may touch each other more frequently as a sign of warmth. Language may be very direct and open. Their eye contact with each other also tends to be more direct. On the other hand, there are cultures on the opposite end of the spectrum that are more reserved. Their communication is more proper, formal, and refined, and may follow specific cultural protocols. Their voice levels are usually lower, and body spacing further than in other cultures. Direct eye contact may be avoided, and frequency of touch may be less than in other cultures. It may not be proper to ask direct or pointed questions.

In general, groups such as African Americans, Latinos, and Jews tend to fall into the more openly expressive category of communication along the spectrum. Native Americans and Asian Americans tend to fall along the end of the spectrum that is more reserved in communication. White culture in the United States is usually somewhere in the middle of the spectrum...more reserved than African Americans, for instance, but more open than Asian cultures. To the best of their ability, health providers should try to emulate the cultural communication style of their patients. For instance, if patients come from quieter, more reserved cultures, providers must learn to understand and follow the proper protocols of respect in that society. On the other hand, minority patients from more expressive cultures typically expect closer, warmer, and more trusting relationships with their providers.

The Cultural Competency Continuum

Most people have had relatively little meaningful exposure to people of other backgrounds, and therefore have a need to learn how to become more culturally competent. Learning these skills, though, can take years of immersion in a particular culture, if done correctly. Furthermore, a provider can be culturally competent with one particular ethnicity of patients, but may lack experience with other minority populations. Ultimately, becoming competent in this field requires a deep knowledge of the cultural nuances of various groups and an understanding of the unique demographic and socioeconomic

factors affecting those populations. Being genuinely friendly, compassionate, respectful, and humble can also go a long way toward making one more culturally competent, even if unfamiliar with the particular characteristics of a specific group.

Health providers should honestly assess their own opinions on how they feel about people from other cultures, as well as how their health agencies view patients of minority backgrounds. This honest assessment is necessary as a starting point, so that clinicians and health facilities alike can consciously improve their ability to work with diverse clientele. Researchers have found that cultural competency skills actually exist along a spectrum of human behaviors. This spectrum can be divided into six different levels that range from minimal appreciation of other cultures to maximum appreciation. They include the categories below.

- **Cultural Destructiveness:** Refers to people who have no interest in being "culturally competent," and actually support the violent destruction or elimination of people from other backgrounds. Examples of people in this category would be members of hate groups or political parties that support ethnic cleansing, genocide, and other forms of racial violence.

- **Cultural Incapacity:** Refers to people who have virtually no ability to relate to those from other cultures. Although they do not support violence or destructiveness of other races, they are much more comfortable living in homogeneous communities with almost no interaction with other backgrounds of people. Examples of systemic cultural incapacity would be segregation in the 1950s in the southern region of the United States, and Apartheid in South Africa before it was dismantled.

- **Cultural Blindness:** Refers to people who have very limited exposure to other cultures, but are certainly willing to learn about them. Many people in this category feel that their own particular culture is best, and have some difficulty understanding why others in the world do not think or behave the same way. Most people around the world fall into this category.

- **Cultural Pre-Competence:** Refers to people who are beginning to understand that every culture has good and bad aspects, and one culture is not necessarily better than another. People in this category usually have a very basic understanding of some of the cultural nuances of a particular population.

- **Cultural Competence:** Refers to people who are comfortable interacting with people from another culture, and are able to do so fairly effectively. They have a good working understanding of the history, socioeconomic background, language, and other factors affecting a particular culture.

- **Cultural Proficiency:** Refers to people who are extremely competent in their ability to work with people of diverse backgrounds. They have a very strong knowledge of a particular culture, which is often gained by being born to parents from two different ethnicities or spending large amounts of time heavily immersed in a culture. People in this category can operate extremely effectively in their own culture as well as that of another group, and are usually not viewed as "outsiders" in that culture.

Scale of Cultural Competency

Cultural Proficiency
(Bicultural and Bilingual. Can easily interact with people of different cultures.)

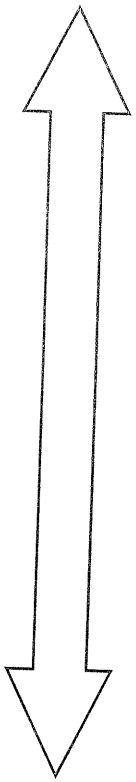
Cultural Competency
(Deep respect and appreciation for another culture. Can interact adequately.)

Cultural Pre-competency
(Beginning to understand and respect other cultures.)

Cultural Blindness
(Unaware of cultural differences. Tends to think that own culture is universal and absolute.)

Cultural Incapacity
(Significant dislike and deliberate separation from other cultures.)

Cultural Destructiveness
(Wants elimination and destruction of other cultures.)



Source: Cross, T.L., B.J. Bazron, K.W. Dennis, and M.R. Isaacs. "The Cultural Competence Continuum." Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely and Emotionally Disturbed. Washington, D.C.: Child and Adolescent Service System Program (CASSP), Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. 1989.

Becoming More Culturally Competent with Minority Seniors: Tips for Providers

Providers who are truly committed to patients should always strive to be as culturally competent as possible with their senior minority clients. However, providers should also remember that culture and age are only two of the many factors that influence the health status of a patient. Gender, income, literacy, educational background, lifestyle, individual personality, and many other issues are equally important to assess when trying to gain a complete understanding of a patient. However, in general, health providers can follow certain fundamental practices when trying to become more culturally sensitive with seniors, regardless of what ethnic group they may be serving. They include the following:

- Be aware of, and sensitive to, one's own cultural values and beliefs as a provider, and recognize how they influence attitudes and behaviors.
- Be aware of, and sensitive to, the cultural values and beliefs of patients, and how they may influence client attitudes and behaviors.
- Be aware of the historical events that have affected particular ethnic groups, and understand how oppression, discrimination, and stereotyping currently affect people differently both professionally and personally.
- Be aware of specific knowledge and information about the particular cultural groups that are being served, such as the role of seniors, the importance of traditional health practices, and attitudes towards health.

- Determine what the general style of communication is most common within a particular culture, and have the providers try to emulate it so that senior patients feel more comfortable. For instance, some cultures value a more direct, open style of communication, while others tend to be more verbally passive and indirect. Cultures that are more passive may not openly share as much health information, so it may be necessary to probe gently with open-ended questions to ascertain a patient's condition.

- Try to be aware of specific cultural "taboos" that apply to a particular ethnic group of patients. For instance, most Jews and Muslims should not be encouraged to follow diets that include pork.

- If senior patients do not speak English as their native language, providers should make an effort to learn at least a few introductory phrases used by them in their culture. This simple act can go a long way to establishing a friendly and trusting rapport between providers and elderly patients. Some of the best words to learn to say in a foreign language are hello, goodbye, how are you, thank you, and please.

- Take the time to gently ask questions of clients and listen actively. The elderly patient should be treated in a holistic manner, and not as a disease or case. Providers should also learn about the culturally specific risk factors, signs, symptoms, barriers to prevention, and methods of treatment that relate to medical conditions affecting minority elders.

- Remember to speak clearly, slowly, and loudly when necessary with minority senior patients. Check for understanding of information by the patients and validate their knowledge of the health issues discussed. Avoid using highly technical or specialized medical words. Explain all information in simple language.

Cultural Competency and Health

- Investigate the traditional role of confidentiality in the culture of the senior patient, and understand that some families may not want elderly patients to know many depressing, complicated details about their illnesses, particularly if they are terminal.

- Most non-western cultures place great emphasis and value on aging. Therefore, treat older minorities with respect and deference for their traditional role in society, and avoid patronizing or intimidating behavior.

- Recognize that it may not be culturally acceptable to look directly into the eyes or face of the senior. Proper body spacing for that particular culture should also be practiced with the senior client out of respect.

- Although literacy rates may sometimes be low, many minority seniors enjoy reading health education material if it is in their native language and large font.

- Recognize that diversity within cultures and individuals is often greater than the diversity between cultures.

- Learn more about various cultural communities through a) interacting informally with individuals of a different culture; b) actively listening to the stories of senior patients when talking with them, even if they are not health related; c) discussing with individuals of a similar cultural background about how culture impacts social experiences; d) participating in cultural diversity workshops and cross-cultural community events; e) reading articles and books on cultural dynamics; and f) consulting with cultural advisors in your community as situations arise.

- Be humble, genuine, and willing to learn. Don't be afraid to make, and apologize for, any "cultural blunders" with senior minorities. Most individuals around the world, no matter what their ethnic background or age may be, will respond positively to sincere, kind, and respectful behavior from others, regardless of whether a particular "taboo" was broken.

Making Health Organizations More Supportive for Minority Senior Patients

Health facilities as organizational units can also adopt a variety of deliberate strategies to become more culturally effective with minority and immigrant seniors. They include the following:

- Health agencies should work together with other organizations in their local community to help provide a welcoming environment for refugees and immigrants. Hospitals and clinics can join senior centers, schools, social service agencies, houses of worship, city councils, and the like in sponsoring town hall meetings, diversity information sessions, and other such services to help prepare local residents for any impending arrival of significant numbers of refugees and immigrants to a community. This welcoming environment should also include outreach services for existing minority populations as well in the community, and should not ignore the special needs of the elderly.

- In order to reduce linguistic barriers to care, health programs should be conducted in the native language of the minority senior clients that are being targeted for service. Interpreters that are native speakers of the foreign language are usually preferable over those that just speak it as a second language.

- In order to reduce cultural barriers to care for seniors, facilities should be staffed with at least some personnel who are members of the same ethnic minority groups as the patients. These multicultural staff members should be older, rather than younger, if possible. These diverse workers should be integrated throughout the entire agency as integral staff, and not function merely as translators.

- As often as possible, health care services should be delivered on-site where minority and immigrant seniors live, work, play, worship, shop, and celebrate. Most minority groups in the United States significantly underutilize formal healthcare services. Programs that can be delivered on-site tend to be much more effective. Consider conducting screenings and preventive education programs, for example, in senior centers, immigrant housing units, church lobbies, laundromats, ethnic markets, and festival sites for increased access.

- Health care services should be provided, at least part-time, during non-traditional hours. Medical offices that are only open Monday through Friday, 9:00 am – 5:00 pm, are likely to miss serving large numbers of minority clients. Consider having flexible scheduling on weekends and evenings for seniors.

- Management should make sure that all health facilities are handicap accessible.

- Agencies should provide extra time for patient visits with seniors, particularly those who are minorities. Many of these people come from non-western backgrounds that place greater emphasis on face-to-face interaction, and do not appreciate being rushed through a medical visit.

- Many non-western cultures place less emphasis on a strict sense of time in comparison to mainstream American culture. Appointments and scheduling, therefore, may need to be flexible for refugee and immigrant seniors who may not necessarily be willing or able to show up at an exact time on a precise day for care. Many of these clients will also present with multiple conditions as well, and will require more than a standard 10-minute visit for care.

- Agencies should provide extra assistance to refugee, immigrant, and minority seniors that may have limited understanding of the complexities of receiving healthcare in the United States. Many newcomers, in particular, come from countries with excellent national healthcare systems, and they are not used to having to pay for services, utilize insurance, or fill out claim and assistance forms.

- If the senior clients are very diverse, healthcare facility signs should be posted in multiple languages and in large font. Written health education material and payment forms should also be available in the native languages of the clients. When distributing written material with illustrations, it is important to have any photographs or drawings culturally specific also.

- All staff should participate in periodic diversity trainings. Remember that most elderly patients from non-western cultures place a great deal of emphasis on the word-of-mouth reputation of a healthcare organization. They will care less about fancy marketing brochures than about what other minorities say about a particular doctor, hospital, or agency. Make sure that all workers, even front office staff, are trained in how to work effectively with minority and senior clients.

- Minority and immigrant members should be recruited to serve actively on hospital boards, non-profit advisory councils, and other external decision-making entities. If they cannot be active on such boards, cultural interpreters from the local should community periodically review programs, written material, and policies to make sure that they are culture and age specific.

- Health agencies should draw upon the immense amount of data, studies, brochures, materials, and other sources of information on minority, immigrant, and refugee services that already exist from public health organizations in large urban and border states, as well as federal and international sources like the United Nations. Many agencies in these areas have been actively addressing minority, immigrant, and refugee health issues for decades, and have a wealth of experience and resources to share.

Working with Interpreters

Many health providers today are finding that they must increasingly work with interpreters in order to provide their services to immigrants, refugees and some minorities. This situation is even more common with diverse senior patients, who are even less likely than younger minorities to speak English fluently. Working with interpreters is a skill that must be learned and practiced. All too often, for example, a clinician may explain lengthy, complicated directions on how to take medication, only to find that the interpreter summarized the comments into just a few words. At the same time, many minority seniors want to have detailed discussions with their providers, but find that the clinicians are not using the interpreters effectively to solicit this information from them. Increasingly, then, health facilities should budget for the employment of interpreters and train their staff to work effectively with them. The following are general guidelines for utilizing interpreters in a culturally competent manner with seniors:

- Never speak more than a sentence or two before stopping to let an interpreter interpret a statement. Avoid the very common mistake of explaining a large amount of information in English, and then waiting for the translator to interpret. Usually this will result in a large amount of missed information.

- Remember to speak to the senior patient, not the interpreter. The patient should be the focus of attention. The interpreter merely acts as the voice of the provider in a second language. Maintain eye and body contact with the patient rather than with the interpreter.

- Validate the information that the elderly patients are receiving from the translator. Ask the patients to explain back any information that has been shared. Ask frequent questions to confirm understanding.

- Use expression and passion in a discussion where appropriate in a health education talk with patients, even if they do not understand the words. Encourage the interpreter to also use the same expression in her presentation.

- Regardless of the interpreter's presence, try to make at least some "small talk" with senior patients, particularly at the beginning and end of each visit. Be respectful and deferential. Most will understand hello, thank you, etc. in English. Likewise, learn a few basic friendly phrases or words to share with clients in their native languages. Smiles, respectful behavior and a friendly attitude by providers will carry over in any language.

- In general, speak slowly and carefully in English when working with interpreters. Use simple English and avoid fancy medical terminology and other types of speech that can easily be confusing for elderly clients and interpreters alike.

- Repeat key words, phrases and medical instructions frequently to ensure that patients understand them. If patients do not understand, try to explain the information in a simpler, more practical way.

- When teaching patients with limited English proficiency, rely heavily on demonstrations, visual aids and culturally appropriate models to teach them. If using models, it is best to use real items instead of replicas to teach them. Incorporate the patients into the demonstrations.

- When working with larger numbers of patients in an audience format, allow them adequate time to translate health information for each other. Always ask simple questions to validate their knowledge.

- Where possible, avoid using young children or other family members to interpret. Confidential health information is less likely to be shared by the patient to the provider in these cases. Likewise, these informal interpreters may not protect the confidentiality of the patient among other extended family members and friends in the ethnic community.

Working with Low-Literacy Seniors

Many refugee, immigrant and even minority populations in the United States will have limited written skills in English. This is particularly true among diverse elderly, who may have had fewer opportunities for formal education in English when they were young. Depending on their backgrounds, these diverse seniors may also be unable to read and write in their native language. This will greatly affect their ability to access health care and to use it effectively. Indeed, literacy is one of the strongest, most direct predictors of health status and poverty. For that reason, some of the most effective public health programs, for example, actually incorporate literacy and economic development together with health, in order to provide comprehensive solutions to their well-being. As providers are increasingly working with these low-literacy senior populations, they should follow the general guidelines below:

- Maintain a respectful, non-judgmental and confidential approach when working with low-literacy patients. Although some may come from cultures where low-literacy is the norm, this will often carry a negative stigma in the United States. Health organizations dealing with many immigrant elderly patients may want to advertise the availability of literacy and English Language classes in the local community for their clients.

- Utilize the patient's native language, in an oral context, when conducting health visits. Avoid relying heavily on written brochures, pamphlets and hand-outs, even if they are in the native language of the patients.

- Incorporate ample opportunities for hands-on, interactive health education in non-traditional means with low-literacy seniors. This can include using tools and methods such as real props, visual aids, art therapy, stories, songs, dance, skits, murals, demonstrations, simulations, role-playing, games, poetry, weaving, quilting, storytelling and the like. Many of these "unusual" methods of teaching a health topic are actually very normal in many non-western cultures, and are quite culturally appropriate for many groups.

- Make sure that patients validate back any information that is presented to them by providers. For instance, a doctor may ask the client to repeat the prescription instructions he has just given, and a health educator may ask a senior refugee to demonstrate the technique she has just learned for injecting herself with insulin.

- Provide all information in a clear, logical, step-by-step manner for senior clients.

- Make sure that all verbal material like foreign-language public service announcements, radio shows, television spots and the like have been pre-tested by members of the specific ethnic and age group being targeted.

- Do not assume that low-literacy seniors will automatically understand all visual information provided to them. Many of these clients are also "visually illiterate," and have difficulty interpreting the meaning of pictures, posters, illustrated brochures and the like. These materials should be used as a last resort, and should always be pre-tested before incorporating them into a health education program.

Understanding Traditional Health Beliefs among Minority Seniors

Many minority seniors utilize a variety of traditional health practices as their primary form of care, and they consider "modern" western medicine to be a secondary, although often powerful, alternative. This situation is not surprising, as the World Health Organization estimates that up to 80 percent of the world uses herbal medicine and other forms of traditional healing as their primary healthcare modality. Most of these traditional health practices have been utilized effectively for hundreds and even thousands of years among many cultures. These healing systems are quite different from those used by Western medicine as many Americans know it. It is important to remember when working with seniors of different cultures that they may or may not have a completely different set of health beliefs, practices and attitudes than those of providers in the dominant culture.

In general, there are five categories of healing that differ from standard Western medicine. Most traditional health practices seen among other cultures fall into one or more of these five categories, as defined by the U.S. National Institute on Complimentary and Alternative Medicine:

Alternative Medical Systems: Complete systems of theory and practice, like Ayurvedic Medicine from India, Traditional Chinese Medicine from East Asia, homeopathic medicine, and naturopathic medicine.

Biological Therapies: Natural products used to heal illness, treat disease, and maintain wellness, such as herbal remedies and foods.

Mind/Body/Spirit Practices: Practices such as meditation, prayer, spiritual rituals, art therapy, group drumming, music, and others.

Manipulative and Body Based Methods: Movement of one or more body parts through massage, chiropractic treatments, and other methods.

Energy Therapies: Cleansing and balancing the energy fields that run through and around the human body through techniques such as acupuncture, reiki, or therapeutic touch.

There are fundamental differences between Western medicine and traditional healing. Although traditional health practices and beliefs vary greatly by culture and subculture, they generally are very holistic in that they strongly combine physical health with mental, emotional, spiritual, environmental and other levels of well-being. They mirror the intuitive, relational high-context cultures from which many of them originated. While Western medicine excels at getting rid of symptoms that have manifested in the physical body, traditional healing typically excels at addressing the root causes of poor health. Like the white, low-context cultures from which it was born, modern Western medicine is linear, logical, and Newtonian in its perspective. In this thinking, disease is separate from the body; caused by a specific virus, lifestyle behavior, or defective gene; treatments are intrusive; and the patient is ultimately responsible for his or her own health.

Most cultures around the world, even in Europe, traditionally have had a very long history of understanding health and practicing healing in a very holistic way. The Chinese and Indians, for example, have extremely advanced written manuals on herbal medicine, manipulation of the human energy field and other related topics that are thousands of years old. Today, modern medicine is confirming scientifically what many of these practitioners have known for generations. Many Europeans also practiced traditional forms of healing for centuries, even though much of this knowledge is now lost in the West, particularly in the United States, with the medicalization of health so common in the 20th century.

In many traditional health systems, the human body, as well as that of all natural things, is thought to be surrounded and permeated by an energy field or spirit that is connected to the life force of the universe. These energy fields vibrate in and around beings, and highly sensitive people like medicine men and women healers are believed to be able to see, hear, sense, and feel them. Poor physical health is usually

considered to first be the result of an energy field imbalance in a non-physical layer, which weakens the body and allows disease to set in. Healers of various forms using different modalities will manipulate this energy field, cleanse it, unblock it and rebalance it in order to bring wellness to the patient. In their traditional view, health is not the absence of disease, but is viewed as complete, full balance within all of these elements. All things in the universe, both living and non-living, are usually considered to be one, and are highly dependent on each other to maintain a balanced and well state. The human body must therefore be well balanced to be properly aligned with all other elements of the universe. It is interesting to note that this "traditional" understanding of health actually correlates strongly with many of Einstein's modern theories on energy, matter, and light.

The traditional health practices around the world used by minority seniors are far too numerous to discuss in a guidebook such as this, and are usually culturally specific. Fundamentally, providers who will be working extensively with a particular immigrant or minority group should take the time to listen to their older patients carefully, ask many open-ended questions about these issues, and do further research into the traditional health practices typically utilized by that population. In general, the following information is helpful to understand when involved with older minorities:

- Take time to know the culturally specific risk factors, signs, symptoms, barriers to care and preferred methods of treatment for diseases affecting a particular ethnic group. Public health studies consistently show that this information varies dramatically by race and ethnicity, and will likely have an influence on the health of elders in that culture.

- Recognize that there are a variety of people who perform traditional healing services in many cultures around the world. At a minimum, they include people such as shamans, medicine men, curanderos, wise women, bonesetters, lay midwives, psychics, energy healers and others. Unlike in Western medicine, most of the people are not specialists. They approach health from a very integrated and holistic perspective, and may be confused by the wide variety of specialists in America. Ask seniors to determine if they are utilizing other alternative healers for care.

- Learn about the traditional health practices and beliefs in the culture of the patients, as well as understand the rationale for usage. More and more, modern scientific medicine is confirming that the basis for many of these treatments is sound.

- Health practices can generally be categorized into three categories: positive, neutral and negative. Encourage those practices with positive or neutral effects on patients, and utilize them together with Western medicine when appropriate.

- Always be respectful of senior minorities no matter what personal beliefs may be held by providers. Ask many open-ended questions with sincere interest, in order to learn more about patient beliefs and practices.

Recruiting Minority Seniors as Lay Health Workers

One of the most effective ways to provide health services to minority seniors is to recruit other minorities, especially those that are older, as peer educators. Health agencies can use a number of strategies that have been recognized as "best practices" in order to increase the recruitment of diverse elders as volunteers, as indicated below:

Cultural Competency and Health

- Understand the role of seniors within a particular culture, and utilize those traditions as the basis for a volunteer program. For instance, Native Americans and Asian Americans have long valued elders for their wisdom, and they look to these respected seniors for their knowledge. Minority seniors can replicate these traditional roles today when they serve as peer health educators.

- Recruit seniors through face-to-face contacts with personal associates. Most minority seniors are far more likely to respond to a request to serve as a volunteer if they are asked individually to do so by significant others; they are less likely, however, to respond to a plea for service from an impersonal recruitment advertisement in a newspaper.

- Recognize that most non-western cultures place extreme value on the importance of the extended family. Minority seniors, especially women, play an important social role in these familial networks. They often are very busy visiting and taking care of many relatives, and more likely than whites to care for their own elders at home. Therefore, they may not have the time or energy to participate in "formal" volunteer and service programs in comparison to whites who often have smaller families and fewer social obligations. Programs that recognize and build upon the tremendous amount of "informal" service already provided by minority seniors to their peers may be more effective and better received.

- Understand that many minority seniors have even greater transportation barriers to serving as volunteers than elderly whites do. Allow diverse elders to serve as volunteers locally on-site within their own neighborhoods, housing units, churches, and the like in order to minimize some of these barriers.

- Financial barriers are also significant problems when recruiting senior minorities to serve as health and related volunteers. Budgeting for the provision of small salaries, stipends, t-shirts, coupons, gifts, and other incentives is necessary in any program that attempts to recruit senior minorities as volunteers.

- Recruit senior minority volunteers for health programs from facilities such as senior centers, neighborhood associations, churches, and other community sites. Ethnic radio stations, newspapers, and television shows can be effective in reaching larger numbers of senior minorities to inform that about volunteer opportunities.

- Provide ample opportunities to recognize and reward, where culturally appropriate, senior minority volunteers who are active as lay health workers.

The Cultural Communities

The guidelines provided in the previous section are designed to be general recommendations for providers and their organizations when working with older immigrant, refugee, and minority populations. If followed carefully, they will greatly improve a clinician's ability to work more effectively with minority senior patients. However, in order to truly improve cultural competency, providers must gain a further understanding of the specific characteristics that are common in particular ethnic groups.

The information provided in this section will introduce some of the fundamentals of working with specific populations, and will discuss the cultural characteristics of some of the most significant minority groups in the United States. This information is to be used only as a general guide and as a starting point for providers trying to learn about the basic culture from which a senior may be. All people are ultimately individuals, and this information is not meant to stereotype any group. Remember, as stated previously, age and culture are not the only factors that influence patient behavior and health status. In an effort to be culturally competent, providers should not ignore other fundamental factors like gender, lifestyle, education level, and individual personality traits in their patients that are equally important.

Finally, the information provided in this section is meant to be only an introduction to a particular cultural group. Ultimately, providers must be willing to immerse themselves in working with people of diverse backgrounds over a regular period of time if they truly wish to improve their cultural competency.

Hispanic Populations

Overview:

- Latinos now represent the largest minority population in the United States, surpassing even African Americans, according to Census 2000 figures. In fact, the U.S. Census Bureau indicates that the Latino population grew by nearly 5% to 37 million residents between April 2000 and July 2001 alone, or twice as quickly as the African American population which grew at only 1.5 percent or the general U.S. population at 1.2 percent during that same time period. In California, there are now more Hispanic babies born than whites. This demographic change is occurring throughout the country, particularly in urban areas and border states. However, rural states have actually seen the greatest increases in Hispanic population growth by town in the United States, where some communities have increased their percentage of Latinos by 700% or even 1,200% over the past decade.

- Providers should recognize the tremendous diversity within Latino culture. Hispanics can come from many different countries, including Mexico, Cuba, Puerto Rico, Spain, Argentina, Venezuela, and many others. They represent one of the world's largest groups, as they represent most of the Western hemisphere, other than the United States and Canada, and also include parts of far western Europe. Providers should avoid putting all Latinos into one group, as their cultural practices and dialects can be quite unique.

Language and Religion:

- Most Hispanics speak Spanish as their primary language, although dialects vary by country and ethnic group. Also, upper class and lower class Hispanics from many regions will often speak some what different forms of Spanish.

- "Latino" usually refers to someone from Latin America, in the Western hemisphere. "Hispanic" usually refers to people that speak Spanish. The United States government considers Hispanics to usually be racially white, although of Spanish-speaking origin. Both terms, Hispanic and Latino, are often used by people from this ethnic group.

- Most Latinos practice some form of Christianity, with the majority being Catholic. Many Catholic parishes have now instituted special Spanish-language masses for their new Latino parishioners. Some Latinos may also combine Catholicism with elements of traditional indigenous spirituality from their native culture.

Family and Social Structure:

- Latinos are well known for their extremely strong tradition of family and extended family. Cousins, for example, are as valued as siblings, while aunts and uncles can serve as second parents. They tend to have tremendous family support, and fairly strong identity of their roles within family by age and gender.

- Although it varies greatly by region, most Latino cultures place great emphasis on pride, self-respect, and family honor. This is particularly true among males. Latinos place great value on their children, and tend to be very loving towards them.

Older Adults:

- Age is highly respected, and elders are appreciated for their knowledge and value to the family. Elderly Latinos should always be treated with great respect.

- Elderly Latinos tend to be somewhat reserved upon first contact. It may be helpful to initially "break the ice" with a native word or phrase before getting started with a program. Additionally, it is often important to clearly explain the purpose of the program, presentation, or visit, reviewing the information regularly to be sure that clear communication occurs.

Communication Style:

- In general, Latinos are an expressive, warm, and hospitable group. They tend to have closer body spacing and eye contact with others. They will also often use more humor, expression, touching, and emotion in their communications than do white Americans. Health providers should try to emulate this warmer style of communication so as to work more effectively with them.

- Face-to-face interactions and family connections are valued in this culture. Health facilities that feature fancy written marketing materials and the latest medical technology will often be less successful than those smaller facilities that feature warm, outgoing staff and caring personnel. Many referrals are made by word-of-mouth, particularly in immigrant communities.

Barriers to Care and Common Health Conditions:

- Money, language, and transportation are usually cited as the major barriers to care for Latinos. A large percent of the newcomers do not have health insurance, and lack adequate personal finances to pay out-of-pocket for medical care. Spanish language interpreters are also difficult to find. Because they often work at two or more jobs, many Latinos will have difficulty using health facilities if they are only open from 9:00 am to 5:00 pm when they are working. Most are not located close to where they live, and transportation for them is usually very limited.

- Diabetes, occupational injuries, dental care, and acculturation stress are but some of the more common conditions that Latino newcomer patients experience in the United States. Although this is changing, many Latinos who come to the United States as economic migrants are younger males who are working to help support their families back home. As such, male health concerns and work injuries can be common issues to address, as are maternal and child wellness issues. Increasingly, Hispanic immigrants are bringing their families and parents with them to the United States.

Bereavement:

- Bereavement practices will vary among Hispanics by the country and culture of origin. If the Latino patient is Catholic a priest should be notified if the patient has died or is in very serious condition. The priest will offer special prayers for healing, as well as perform "last rites" on a dying patient. Many parishes have priests that speak Spanish and are charged with Latino outreach.

- Large gatherings of extended family and friends are common at many funerals, with grief openly displayed. Cremation is generally not common among this group. In many Latino cultures, the souls of the dead are remembered and honored regularly through religious and community celebrations, such as "Day of the Dead" parades and offerings in Mexico each November 1.

Traditional Health Practices:

- Many individuals, particularly seniors or those of more rural indigenous backgrounds, will practice various traditional medicine methods such as herbal healing and energy cleansing rituals. Curanderos are traditional healers in Mexican culture. Many Latinos, particularly those that are older, will want to combine their traditional health practices with Western medicine, and are quite adept at making herbal infusions at home through common plants and herbs. Prayer and religion can be particularly valued as well.

African Americans

Overview:

- African Americans have experienced a unique history as a minority population in the United States, and this experience has profoundly affected their socioeconomic and health status. African Americans were the only major ethnic group that came to the Western Hemisphere against their will. They comprise one of the largest forced migrations of humans in history. In most cases, they were taken from their homes or were prisoners of African wars; separated from their families; spent time in slave dungeons in West Africa; transported in cramped quarters on ships across the Atlantic where many of them died; and then sold to plantation and business owners in the New World.

- African Americans were generally forced to convert from their traditional religions, kept uneducated, and were treated as property for decades in the United States. It was only about 140 years ago in parts of America that slavery was still legal. It was only about 30 years ago that Blacks in many areas of this country, particularly the south, were completely segregated from whites by law in housing, education, and jobs.

- The historically negative relationship between the dominant population in the United States and the minority African American group has had significant impact on the health status of blacks in the country and their use of services. From a public health standpoint, it is no coincidence that African Americans and Native Americans, the two minority groups that have had the worst historical relationships with the majority population, continue to have the lowest health status in the country.

Language and Religion:

- Because their families have been in the United States for centuries, most African Americans speak English as their native language. A number of subtle black dialects exist, though, in the country that are unique to urban inner cities or rural Southern communities.

- Most African Americans practice some form of Christianity in the United States. Many, particularly those who migrated from the South, are Baptist. The percentage of Black Muslims has also been increasing in the United States, particularly among younger males.

Family and Social Structures:

- The family is the foundation of African American society. The family usually revolves around the mother, her elders and siblings, and her children. Fathers may not necessarily live with the family, particularly if they are lower income and the children were born out of wedlock. Families, in general, tend to be large and caring. Black women are especially recognized for their strength and nurturing tendencies.

- Although African Americans as a group have lower income levels than most other minority populations in the United States, the African American middle class is expanding rapidly in the country. Black women, in particular, have made great strides and many have become financially successful, although young black males continue to lag behind as a group.

- Many predominantly black communities are organized into neighborhood associations, which are often associated with a particular local church. These neighborhood associations are often active socially and politically in the community. Health providers and organizations should take the time to meet the leaders of these neighborhood associations, talk to their residents, and incorporate them into outreach programming. Many health services for blacks will be utilized heavily if they are provided on site in church basements, schools, neighborhood centers, and the like.

Older Adults:

- Older adults in the African American community are highly respected members of the family, and often heavily influence decisions made within the extended family. Older adults may serve as the primary caretaker for their grandchildren. Providers should recognize this extra "caretaker" responsibility, and be aware that there may be questions and medical issues to be addressed as a result.

- Most African Americans are much more likely than whites to want to take care of ill relatives and friends at home, rather than send them to formal providers or nursing homes.

Communication Style:

- In general, African Americans are more openly expressive than European Americans. They will often display more direct eye contact, closer body spacing, and a higher level of physical touch than many whites. Verbally, they may be more likely than whites to share their opinions openly or ask questions directly. They may also display a higher level of verbal emotion and expression than European Americans. When conducting health education programs, adjust to these cultural nuances and use interactive activities that allow ample opportunity for discussion, problem solving, and hands-on learning.

Barriers to Care and Common Health Conditions:

- Cost is generally the greatest barrier to care for African Americans in the United States.

- Some public health studies have also shown that blacks, as a whole, are less trusting of the American medical system and its providers, who are primarily white. This mistrust is a very important cultural barrier to care, and should not be underestimated. Many African Americans, even those that are highly successful and educated, feel that the historical legacy of slavery, institutional racism, legal segregation, unethical scientific experiments, racial profiling, and other human rights abuses over the past several centuries

has significantly damaged black-white relationships in the United States, and will require additional time and effort to reconcile. As such, many African American patients question the methods and motives used by white providers and health organizations that provide them with care, and blacks will often be particularly sensitive and insulted by poor treatment from white providers.

- Providers should recognize the implications that the legacy of slavery and discrimination has had on the health status of African Americans. Because it has only been in the last few decades that legal discrimination has been less common, a number of factors combine to put African Americans at very high risk for poor health. As a group, their health status is among the worst in the nation, with significantly higher morbidity and mortality rates for almost all diseases and injuries. Some of these figures are due to genetic factors, but most are a result of higher poverty and unemployment levels, lower education and literacy levels, institutional racism, more single-parent families, limited financial and cultural access to health care, and lifestyle factors. Blatant as well as more subtle forms of discrimination likely contribute to higher levels of stress among African Americans, which can negatively affect their health status as it relates to hypertension, low birth weight, headaches, and other conditions.

- Blacks are disproportionately represented among those on federal or state medical assistance programs, as well as among the unemployed and underemployed.

- African Americans are much less likely to access health care in a timely manner across the United States. They often enter the system when their medical conditions are more complicated and pronounced. Early intervention programs are best provided on an outreach basis in schools, neighborhoods, churches, and other locations where African Americans already are, rather than waiting for them to come to clinics for care.

- Common health concerns include hypertension, diabetes, breast cancer, unintentional and intentional injuries, and others based upon demographics. They experience much higher morbidity and mortality rates for many diseases when compared to the population as a whole in the United States.

Bereavement:

- Bereavement practices will vary somewhat among African Americans, dependent on the form of Christianity the patients practice. In general, many African Americans are deeply spiritual, and place great emphasis on their Christian values. The patient's minister or other religious leader should usually be notified in the case of serious illness or death.

- Large numbers of extended family and friends, particularly women, will likely visit patients that are ill or have died. Visitors may be visibly upset about the condition of the patient. In some cases where the communication between health providers and family members has been poor, visitors may be suspicious about what caused the death or illness of the patient.

- Cremation is less common among African Americans than it is among whites.

Traditional Health Practices:

- Public health studies clearly show that African Americans as a whole often have different health beliefs and attitudes about various medical conditions than do whites or other ethnic populations. Providers should take the time to really listen to their minority patients and try to understand why they may feel a certain way about a condition.

- In general, African Americans have been shown to have a higher external locus of control than European Americans. In other words, while whites may feel that they can control many things in their own lives, blacks are more likely to feel that factors other than their own behaviors are the cause of various life events. Providers will need to help their African American clients develop a sense of empowerment and personal involvement with their own health.

- African American cultures, as well as that of many other non-Europeans, generally believe in a higher sense of fate and destiny as they relate to health and other issues.

- Faith and spirituality play an extremely important role in the lives of most African Americans, and are significant sources of strength in times of illness and poor health.

- Because many African Americans have been shown to have a general distrust of white physicians and of the medical community in general in the United States, providers should actively focus on developing trusting, warm, and respectful relationships with their African American patients.

- Africans, when they were first brought to the United States several centuries ago, carried with them a wealth of knowledge regarding traditional healing through herbs, rituals, and spirituality. Much of this direct knowledge from West Africa was eventually lost throughout the years, although many continue to value alternative, more natural treatments to care.

Native American Populations

Overview:

- Native Americans are among the most diverse of any minority population in the United States. The United States government recognizes more than 500 separate tribes or nations in the country. Most of these tribes have unique and highly distinctive languages, cultures, and practices. Native Americans are the only indigenous population in the United States. Unfortunately, most Americans are unfamiliar with their long, rich, and proud history, and have had little interaction with Native Americans.

- Native Americans can be found throughout the entire United States today. Some European and African American immigrants have family histories that featured intermarriage with Native Americans. Most Native Americans live in urban areas today, as well as on reservations and settlements. Different tribes will have different "blood quantum" rules that determine certain benefits for which individuals may be eligible, depending on the how closely they are related to a tribe.

- Like most indigenous populations around the world, Native Americans throughout their history have experienced ethnic cleansing, broken treaties, forced displacement, wars, excessive mortality from imported illnesses, legal discrimination, and human rights abuses. Today, although their situation is improving, Native Americans continue to experience some of the highest death and illness rates in the country of any group, and have the shortest lifespan.

- It is difficult to generalize when working with Native Americans, so health providers should become familiar with the cultural practices of the tribe that their patients represent.

- Providers should learn about the unique history of the tribal group with which they are working. History texts in the United States are often written from a white or American point of view, and many Natives will understandably have a different viewpoint of key historical events.

Language and Religion:

- Most Native Americans today speak English as their primary language, although various indigenous phrases and words are often worked into everyday speech. Some elders will still know their native language. Sadly, many young Native Americans today do not know the language of their ancestors, and must relearn it in special cultural classes in school. Many Native American languages historically had no written form, although the Cherokee, some of the Northeast tribes, and others did.

- There is significant diversity among Native Americans, even within a tribe. Some may be "pure-blooded", while others have family ancestries of intermarriage with whites, Latinos, blacks, or other ethnic groups. From a religious standpoint, many will practice some form of Christianity or other religion, while others follow Native American spirituality. Others will mix both in a unique manner.

- Native American spirituality is not considered to be a religion that is "practiced" by indigenous peoples, but rather is a way of approaching life in a sacred and holistic manner.

Family and Social Structure:

- Most Native Americans place great emphasis on family, and genuinely love large numbers of children. In fact, the word in Lakota for children is "sacred beings". The family, rather than the individual, is the basis of Native society. The extended family is extremely important, and ultimately extends into the tribe. Aunts and uncles often serve as second parents. Depending on the tribe and population, the mother may have multiple fathers of her children, and may not necessarily live with a spouse. Most elders have input and help raise all the children in the community.

- Not all tribes are patriarchal; in fact, a large number are matriarchal. Western providers should not stereotype and assume that women have a low status in their society. Indeed, most Native cultures place great emphasis on individuality and equality, and the important role that individuals play in contributing to the group.

- Tribal group consensus can be extremely important before undertaking new initiatives or projects. Health providers wishing to establish programs on reservations, for example, usually will need to meet with multiple parties and ultimately gain tribal council approval before operating, which can take lengthy amounts of time.

- There tends to be a strong responsibility among Native American culture to bring honor to one's family, tribe, ancestors, and community. It is important not to shame the family through individual actions.

Older Adults:

- Native Americans usually place great value on elders and the practical knowledge they possess. It is important to recognize this and always treat the elders with genuine and sincere respect.

- Native American tradition has been historically passed down verbally in the form of storytelling. Recognizing this tradition, and developing presentations, outreach activities, and conversations accordingly, will have a greater impact on the transfer of information, than a lecture style of communication.

- As a result of historical events, many middle-age Native Americans today face oppression and a sense of displacement in society. As a result, it is common that older adults in this group will serve as the "caretakers" of their grandchildren. It is important to recognize this and be aware that there may be questions and medical issues to be addressed as a result of this extra responsibility.

Communication Style:

- From a communications standpoint, Native American culture tends to be more reserved, thoughtful, and subtle in the direct expression of feelings and thoughts. Saving face and avoiding conflict can be important in many of the tribal cultures. Ask open-ended questions, and allow Native patients adequate time to respond.

- Like many non-western cultures, Native Americans generally place less emphasis on time. Non-native medical providers should expect that not all appointments will be kept, and that their patients may not call to cancel or reschedule. Flexible, open scheduling is probably better with this population if possible.

- Most Native American cultures value face-to-face informal education and interaction over written, formal information. Storytelling, particularly with younger Native audiences, can be a valuable health education tool.

Barriers to Care and Common Health Conditions:

- Many Native Americans have difficulty accessing medical care in the United States for a variety of reasons. Because many are impoverished, they have limited financial means to purchase services, unless they are provided free or at low-cost by organizations operated by the Indian Health Services or individual tribes. Transportation and geographic barriers are also significant, particularly if they live on large, sparsely populated reservations with few medical providers. Culturally, many Native Americans value their traditional healing practices and do not always feel comfortable seeking care from hospitals or white providers.

- Native Americans suffer very disproportionately from many diseases and conditions in the United States, particularly diabetes, alcoholism, accidents, and intentional injuries.

- Providers will need to allow adequate time to establish a close, trusting relationship with Native American patients. Before conducting business, it is important to take time to get to know the clients as people, rather than just patients. When working on a reservation or with a clearly defined group of Native Americans, it is also helpful to be invited into the group by one or more of them. It tends to be somewhat difficult to just "break into" this culture, because of the importance of trust and personal relationships.

Bereavement:

- The bereavement practices of Native Americans are as diverse as their tribes, individual ethnicities, and religions. It is therefore extremely hard to generalize for this group. Providers should make an effort to learn as much about the Native patient while he or she is still well enough to communicate, so as to avoid any cultural misunderstandings during severe illness or death.

- In general, large numbers of extended family members and friends can be expected to come visit the ill or deceased patient. If the patient or family is fairly traditional, a variety of ritual healing and purification ceremonies may be conducted with the patient. Many of these ceremonies will be communally performed. Often, powerful herbs such as sage are burned as a method of ceremonial purification and harmonizing.

- Open expressions of grief and sadness may be somewhat reserved in this population.

- The spirits of the dead in most Native cultures are honored regularly for generations. Most consider death to be merely the beginning of another journey into the next world. The patient's loved ones often have particular dietary, spiritual, and behavioral practices which they must follow for set periods of time while grieving for the dead. Even if the patient is Christian, many will interweave elements of Native spirituality into the funeral, such as placing sacred herbs or prayer ribbons near the grave.

Traditional Health Practices:

- Indigenous populations around the world are known for their strong sense of connection to the earth and the universe, and their corresponding respect for all living and non-living things. They tend to understand in a very holistic manner the place of humans in the broader scheme of life. People are traditionally viewed as not being any more or less important than any other living thing, and should be responsible caretakers of the self, the family, the tribe, and the earth. Before "sustainable development" was ever coined as a term in western culture, Native Americans were emphasizing the importance of not doing anything harmful to the environment that could affect multiple generations of people into the future.

- Native Americans have a well-developed traditional health system that is very holistic, combining physical, mental, emotional, and spiritual well-being. Physical problems are understood as usually being caused ultimately by emotional, mental, or spiritual imbalances. So, harmony and a sense of balance in all things, including mind, body, spirit, and the environment, are important for wellness. As such, Native American health beliefs tend to be more circular and indirect, in comparison to the more linear "cause-and-effect" view of Western medicine. Native American healing cannot be separated from spirituality. This spirituality is different from religion, and emphasizes the interconnectedness, sacredness, and balance of all things.

- Many Native Americans will combine western medicine with traditional medicine practices, like using herbal remedies, participating in a healing ceremony with a medicine man, performing ritual purification and sweating ceremonies, and other practices. They recognize that Western medicine may be powerful for treating disease symptoms in the body, but generally feel that Native American healing is ultimately best for the soul. Western providers should try to learn as much as they can from the local healers that work with the Native clients.

East and Southeast Asians

Overview:

- East and Southeast Asia is home to some of the world's oldest and most highly defined cultures, many of which have existed intact for thousands of years. Large numbers of immigrants from Asia began arriving in the U.S. in the 1800's as economic migrants, where they first populated ethnic communities on the West Coast in cities such as San Francisco. They provided inexpensive labor for the U.S., and helped build the railroad across this country in conjunction with Irish immigrants. Today, Asian minority communities can be found in all major cities within the U.S. They are generally among the least integrated of many minority groups, preferring often to live in ethnic communities with others from their culture. During World War II, Asian Americans experienced intense levels of discrimination in the United States. Japanese Americans, for instance, were forced to live in internment camps in Southern California and other areas for fear that they might assist the enemy.

- A strong level of diversity exists among Asian/Pacific Islanders. They consist of distinct cultures, such as those from China, Japan, Korea, Vietnam, Cambodia, Laos, Tahiti, the Philippines, Fiji, Thailand, and many other countries with radically different histories and languages. Many Asian Americans are either Vietnamese, Laotian, or Hmong refugees who have been in the country since fleeing the war in Indochina in the 1970s. Health programs must be culturally specific for each group.

Language and Religion:

- There is no one language that is spoken by all Asian Americans. Younger Asian Americans, as well as those that have been in the United States for several generations, will usually speak English. However, many will still know the language of their original homeland, or phrases from it. This could be Vietnamese, Korean, Japanese, or others. Some Asian immigrants, such as those from Laos, may know French or other European languages of the colonial powers that formerly colonized their countries. In some cases such as Chinese, a specific dialect such as Cantonese or Mandarin must be used to communicate with these patients. Most Asian Americans are highly literate.

- The religion of Asian Americans varies dramatically by ethnicity and culture. Many today have adopted some form of Christianity. Others still practice the religions that were common in the native countries, such as Buddhism.

Family and Social Structure:

- Many Asian minorities, particularly in larger communities, live in distinct ethnic neighborhoods. They tend to be distrustful of outsiders, preferring to rely on their own for assistance. Interventions are best conducted through train-the-trainer models and other programs using native providers.

- Asian Americans tend to have an extremely strong cultural value placed on the extended family. Each person, such as a parent or child, has a distinct and well-defined role in the family. Programs should emphasize the relevance to family roles, rather than on the individual.

- While gender preferences in children may favor boys in many Asian cultures, young children are genuinely adored. Women are afforded high levels of respect from a familial standpoint. Many Southeast Asian and Pacific cultures place great emphasis on the power of women, with females often running small businesses.

Older Adults:

- Elders are absolutely revered and valued for their age and wisdom.

- In Southeast Asian cultures especially, education is held in very high esteem and the majority of elders have completed at least a high school level of education, including some English language training. As a result, aging health programs are supported well by this group because they are seen as a form of continuing education.

- Often times, especially with older adults, direct eye contact and a firm handshake can create a sense of confrontation. For this reason, it may be more welcoming to greet an elder with a native word or phrase, or a simple bow. Additionally, Southeast Asian elders are normally addressed by their title (i.e. Mr., Mrs., Dr.,) and not by their first name.

Communication Style:

- Most Asian cultures tend to be fairly reserved and thoughtful when speaking. They generally place high value on the importance of respect and "saving face". They take great pains not to embarrass or put others in awkward positions. Honor and politeness should be emphasized at all times in interactions. Direct eye contact, close body spacing, and casual touching are usually not so common in Asian cultures, as a highly defined sense of formality exists in all relations. They tend to be less willing to openly express their opinions or feelings, particularly if they are negative.

Barriers to Care and Common Health Conditions:

- In ethnic neighborhoods, language and culture can present significant barriers to care for Asian Americans. Health programs should always be culturally appropriate for the specific target population. Many Asian immigrants are not comfortable using western medical care, and prefer to be seen by healers from their own culture.

- Today, Asian Americans have made extreme strides in their standard of living, and generally have an excellent reputation for hard work and educational achievement. Their health status as a group is usually among the very best in the country, often higher than the European American majority, because of genetic factors and positive lifestyle practices. Life expectancies are usually longer, and mortality rates are lower than those for most other cultural groups in America. However, with each generation born in America, fewer differences in health status exist.

Bereavement:

- Bereavement practices will vary significantly by culture, ethnicity, and religion among Asian Americans. If they are Christian, a minister, priest, or other appropriate religious leader should be contacted in cases of serious illness or death.

- Buddhist patients believe that the soul passes through many reincarnations until it is liberated from worldly problems and enters nirvana. As such, death is simply a natural state through which all people pass multiple times. Depending on specific cultural traditions, Buddhists may hold a funeral within several days to a week after death, often with several prayer ceremonies and memorials conducted at home, a funeral parlor, and a temple by a monk or priest prior to burial. Many Buddhists will favor cremation over burial.

- Large numbers of extended family and friends will likely visit the ill or deceased patient.

- In general, Asian Americans will be less openly expressive about their grief and sadness in the event of a death.

- Asian Americans usually confer great reverence and honor to the departed spirits of ancestors, and regularly honor and remember them through ceremonies and offerings.

Traditional Health Practices:

- Asian traditional healing systems are among the oldest and most complex in the world. Many of these systems have been well documented for thousands of years in standardized texts. In general, they tend to emphasize health from a holistic standpoint. Rather than treating a disease symptom, like in the West, they usually emphasize maintaining balance, harmony, and interconnectedness of the body, mind, and spirit. Many exercise programs in the United States today, like yoga and Tai-Chi, are actually ancient Asian healing systems.

- Most Asian cultures have well-defined usages for many herbal remedies as well. Multiple forms of energy healing, like acupuncture and qi-gong, are used in many Asian cultures, and work on rebalancing the electromagnetic field surrounding living beings. In their health belief system, this rebalancing is necessary to remove blockages of energy that can ultimately cause illnesses and disease

Russians and Other Groups from the Former Soviet Union

Overview:

- A number of immigrants from Russia and other republics that formerly comprised the Soviet Union live in the United States. Many of them are economic migrants. While they may once all have been part of the former U.S.S.R., they are nonetheless fairly diverse in a number of areas. Providers should not assume that they are all "Russian", as a number of them are actually from the Ukraine, Latvia, Belorussia, or other republics.

Language and Religion:

- Most of the immigrants from the former Soviet Union will speak Russian, although they may also know the specific languages of the republics where they used to live, like Ukrainian. Health programming is best done in their native language.

- Religion will vary by ethnic group. Some Russians are quite secular, having been raised in the former Soviet Union where organized religion was discouraged. Others will practice some form of Christianity, and may be Orthodox, while others are Muslim.

Family and Social Structure:

- In general, immigrants from Eastern Europe place great value on education, art, music, and fine culture. Although they may be working today in the United States in meat-packing plants and other blue-collar jobs, many were professionals back in their home countries. They, therefore, will usually be fairly literate, although perhaps not in English. They will usually resent being treated as "backwards" or "uneducated" immigrants.

- These Eastern European families usually have strong extended family ties, even though the number of children may be relatively small in comparison to other immigrant groups. It is not unusual for Russian families to pool their money together to achieve a better lifestyle. Parents may take on extra work to help support their children's education. Health programming that incorporates the entire family can be especially valuable.

Older Adults:

- In the Russian culture, there is a sense of naturalism about the end of life. At a young age, the idea is established, that living a naturally healthy life will help a person to live the best life. For this reason, if a person is diagnosed with a terminal illness, it is often the decision of the entire family whether or not to tell the dying person of their illness, helping to keep the end-of-life as peaceful as possible.

- Older adults are held in high esteem and are highly respected. They are always greeted formally with titles of "Mr." or "Mrs." They may also be greeted with the title of "Aunt" or "Uncle" even when no blood relationship is present.

Communication Style:

- Russians usually are highly verbal and fairly direct in their communications with other people. Most are extremely literate, well educated, and very knowledgeable about culture, economics, world history, and current affairs. They tend to enjoy intellectual conversations, and may expect the health provider to discuss these issues with them.

Barriers to Care and Common Health Conditions:

- Cost, language, and transportation are the most significant barriers to care for immigrants from the former Soviet Union. Many work at jobs that do not provide health insurance, and few medical organizations have Russian translators. Others find it difficult to attend health clinics that are only open Monday through Friday during the daytime, since many new immigrants are working several jobs and have limited free time for off-site services.

- Cultural barriers to accessing care also exist among Russian immigrants. Many typically will not seek formal medical care, except in more complicated cases. They will typically use some form of self-treatment before ultimately seeking out a physician for care if they continue to be ill. Russians usually take an active role in maintaining their own health. Mothers are particularly involved in caring for their children's illnesses with alternative therapies. Many Russian immigrant women, particularly those that studied education in universities back home, will have had significant training in primary health skills as part of their curriculum.

- In general, smoking and alcohol consumption rates tend to be fairly high among Eastern European immigrants, and are an integral part of their culture. Many Russians, particularly men, are able to consume relatively large amounts of alcohol gracefully, without obviously appearing to be intoxicated.

- The former Soviet Union had a comprehensive, free national health care system for all residents, and elements of this system continue today in the independent republics. Many of the Eastern European newcomers to the United States will have little understanding of American concepts of private party insurance, fee-for-service care, and other elements. Many will need assistance navigating the health care system in their new community, and will often want to seek out Russian speaking physicians if they are available.

- Mental illnesses generally carried a strong negative stigma in the former Soviet Union, where these conditions were often treated by forced institutionalization under KGB supervision. They were often not even discussed among families with members suffering from various conditions. Many of the Eastern European immigrants will therefore be reluctant, still, to openly admit to feelings of depression, anxiety, acculturation stress, and other mental health challenges that are very normal among newcomer populations. Providers should be aware that these conditions may exist in their patients, and may need to approach this subject tactfully and with full confidentiality.

Bereavement:

- For those Russian immigrants who are Orthodox, most believe that death is a necessary consequence of life, and that they will achieve eternal life in heaven if they have lived appropriately.

- Orthodox religious leaders typically hold a special vigil over the deceased, called panikhida. This special contemplative time includes prayers, hymns (tropar'), chants, frequent repetition of the name of the deceased, and readings from the Gospel.

- Large numbers of family members and friends will likely visit the seriously ill and deceased. They may join in special prayers for the dead, where they ask for mercy on the soul of the deceased patient.

- Burial of the body is far more common than cremation. However, cremation is not prohibited. Many Russian immigrants will opt to be cremated in the United States, so that their ashes can ultimately be transported back home to Russia.

Traditional Health Practices:

- Eastern Europeans from the former Soviet Union have a long history of using traditional herbal remedies for care, which they often did in conjunction with their standard western medical treatments. Many elderly Russians continue to have a strong interest in utilizing herbal teas, alcoholic tinctures, and other methods of treating disease and promoting health. While Americans may consider this "alternative" medicine, providers should remember that these forms of traditional care were greatly respected and used by generations of Eastern Europeans.

- Most Russians actively practice some form of self-care, unrelated to what they are doing under the order of American physicians. For example, many younger immigrants from Russian commonly use homeopathic remedies to treat themselves. Also, many of these immigrants will bring medical kits with them from Russia that contain a variety of drugs to treat general ailments such as headaches, indigestion, bacterial infections, and the like. Most of these medicines are available over the counter in Russia, but would require prescriptions in the United States. Medical providers should always respectfully seek to understand what types of self-treatment may be practiced by their Russian clients.

- The main goal of health care in the former Soviet Union was usually finding the root causes of a particular disease or condition. Many Eastern European immigrants to the United States feel that American doctors, on the other hand, place too much emphasis on treating the disease, rather than trying to understand its causes from a more holistic standpoint. Most Russian patients will want to have active discussions with their providers about what caused their ailments.

Bosnians Refugees from the Former Yugoslavia

Overview:

- Many immigrants from the former Yugoslavia, particularly Bosnia, now reside in the United States. Many of them came in the mid-1990s as war refugees, and were granted legal permission by the United States government to resettle throughout the country. Many of the Bosnians, known as "secondary migrants", first resettled in areas like Utica, New York, before eventually moving to areas in the Midwest and beyond. Many are drawn by jobs in the meat-packing and agricultural processing industries.

- Health providers should understand that Bosnians, unlike many other immigrants, are generally classified legally as true refugees. This means that they were forced to flee their homeland due to ethnic conflict, and did not come voluntarily to the United States like economic migrants. Many would prefer to be back in Bosnia if the political situation was different, and they generally resent people who think they came to America looking for work.

- Bosnia is quite well developed and cosmopolitan. These new-comers will resent providers that speak down to them and imply that the Bosnians came from a "backward" country.

Language and Religion:

- Bosnia was one of the six republics that made up for the former Yugoslavia, and was the most ethnically diverse. Most of the Bosnians speak Bosnian, which is similar to Serbo-Croatian.

- Most Bosnians are Muslim. Although they are Muslim, most are fairly secular in their practices. Providers should be familiar with Muslim practices, though. However, they should not assume, for instance, that Bosnian women wear veils and long dresses. Most Bosnians do not eat pork, celebrate Christmas, or attend churches.

- Most Bosnians are very well educated and highly literate. Not all will know English, though, upon arrival in the United States, and will still prefer educational programs in their native language.

- Many Bosnians were professionals back in their home country. In fact, most were doctors, nurses, teachers, and business leaders. They will greatly resent being spoken down to by American health workers. Many would like to resume their professions in the United States, particularly as medical providers, and should be utilized in refugee programming.

Older Adults:

- Bosnians place a great deal of value on extended family ties. Many have now been successful in bringing additional family members over to the United States, like grandparents. Grown children are usually excellent caretakers of their elderly parents, and do not like to put them into nursing homes. Likewise, young children will usually give great respect to their elders. Public health programming should target the entire family unit, rather than just the individual.

- Working with a translator may be important when communicating with the older adult Bosnian population as many have recently come to the United States and are still in the process of learning the English language.

Communication Style:

- Most Bosnians value a warm, open, direct, and respectful form of communication with others. Bosnians are also well known for their sense of humor and positive outlook on life.

Barriers to Care and Common Health Conditions:

- Because they are classified as refugees, most Bosnians qualify for a number of special federal and state benefits in the health, business, and human service sectors. They are generally legal residents in the United States. While they may financially be able to access health care here, not all health organizations have Bosnian translators available or personnel trained in how to work with refugee populations.

- Because they are true war refugees, many Bosnians have experienced extremely difficult circumstances prior to arrival in the United States. Many lost their homes and livelihoods, and most have close family members and friends that died in the war. Some were deeply traumatized by ethnic cleansing, war injuries, torture, group rape, and other human rights abuses.

- Significant mental health challenges such as depression, anxiety, and post-traumatic stress are common human reactions to uncommon circumstances. Health providers should expect to see higher rates of these conditions in Bosnian refugees than in the general population of immigrants. However, mental health conditions often carry a negative stigma with them in Bosnian culture, and so many are reluctant to discuss them with providers.

- Mental health providers should be trained in the complexities of dealing with war refugees. Clinicians should not push a trauma victim to share feelings or experiences, until he or she is ready. Providers can only provide gentle, ample, and supportive opportunities for them to do so.

- Bosnians generally have high rates of smoking and drinking alcohol, as they are integral cultural practices. Like their Russian immigrant counterparts, they may not be familiar with American laws prohibiting the purchase of alcohol by children for their parents, and they may have some difficulty getting used to the anti-smoking mentality in the United States. Second-hand smoke and prenatal smoking are often issues that need public health intervention as well.

- Large numbers of extended family members and friends will likely come to visit the seriously ill or deceased patient. They will often gather to offer special prayers of compassion and forgiveness for the deceased.

- Bosnians typically will prefer to be buried in special cemeteries set aside for Muslims.

- Most Bosnians, who are Muslims, believe that life on earth is to be spent preparing for another world after death.

- In general, Bosnians do not embalm. The body is usually washed and purified in a ritual manner, and then covered in a simple cloth. The deceased is then buried in the ground directly, upon completion of the funeral. The burial usually takes place fairly quickly after death. Direct burial in the ground is required by "shari'ah", or Islamic law.

Traditional Health Practices:

- Herbal infusions, alcohol-based tinctures, and other forms of traditional medicine were commonly used in Bosnia for generations, and are still found to some extent in Bosnian ethnic markets. Many Bosnians will use these remedies simultaneously with Western medicine.

Somalis, Sudanese and Other East African Immigrants

Overview:

- Africa is the continent most affected by poor health and civil strife in the world, and significantly lags behind in many public health indicators. Increasingly, Africans are fleeing violent ethnic conflict, severe poverty, and political oppression as refugees, and are being granted asylum in countries like the United States. In recent years, there has been an influx of East African refugees, primarily from Somalia and the Sudan.

- Most of the Somalis and Sudanese came from impoverished rural settings. They are knowledgeable about farming in rugged, difficult conditions. However, many do not immediately have the skills necessary to work in an industrialized country, and usually require some form of vocational training before taking jobs in the United States.

Language and Religion:

- These two countries, like all of Africa, are far more diverse than the United States, so generalizations are difficult to make. However, most of the Sudanese speak Nuer and possibly some fundamental Arabic. The Somalis typically speak Somali, which had no written script until 1972.

- Most of the Somalis are devout Muslims, so providers should follow general guidelines for working with people from this religion.

- Sudan is one of the most diverse countries in the world, and its refugees come from many backgrounds. In general, though, most of the Sudanese refugees in come from the south of the country, and are Christian. Many have been persecuted in civil war by Muslims in the north. Most of the southerners are either Christian or practice some form of indigenous spirituality.

Family and Social Structure:

- The family is the basis of East African society. The families are extremely large, with many children and extended relatives. They will also try to remain living in close proximity to each other as they get older. Children are loved and greatly valued, so birth control efforts are often not successful. Maternal and child health is a priority public health focus with these newcomers.

- Many immigrants from East Africa have different concepts of time than that in the West. It is not uncommon for them to miss exact medical appointments, and come at completely different times. They also will usually not call to cancel. Rather than force them to fit into rigid, standardized 10-minute visits in the United States, a more open, flexible schedule of medical appointments would probably be more effective.

- Many Somalis and Sudanese will not know exactly how old they are, for a variety of reasons. Birth records were not always kept like in the West, and a person's birthday is more likely to be associated with a particular seasonal event than with an exact day and year. Also, upon immigration, many officials just estimated the age of each of the new arrivals, so they may not be accurate.

Older Adults:

- A mutual respect between elders and young people is common in the Southern Sudanese culture. Young people respect their elders and elders respect the young people. It is common that if a conflict arises, traditional counseling, or a group of elders from the family assist in problem solving, which includes sitting down and talking about the situation.

- As a result of the large family network, East African elderly are usually taken care of by their own families in their homes.

- Somali elders are highly respected in their culture. They are usually addressed as "Aunt" or "Uncle," even if they are strangers.

Communication Style:

- Most will dress fairly modestly, particularly the women who often wear loose, long dresses and headwraps. Interaction between males and females is generally quite segregated, and should be respected. Male providers should generally not shake hands with females. Where possible, male providers should see male clients, and female clinicians should see female clients. Eye and physical contact between men and women is usually avoided in public out of respect, and should not be misread by clinicians as avoidance.

- East African women and children are much more likely to display emotions than are men. Providers will need to be tactful and respectful when probing for health problems that affect males. Maintaining dignity and respect with each other is important.

- East Africans usually give a great deal of respect to elders and to people in positions of power, like physicians. They will usually be fairly passive and not ask a lot of questions, even if they do not understand something, because it is believed to be disrespectful. They may also be reluctant to ask for help.

- Somalia and the Sudan have among the lowest literacy rates in the world, particularly for women. Health providers should focus on conducting programs that are primarily oral, and avoid heavy utilization of written information in any language. Verbal programs should be conducted in the native languages of these two populations.

- Body spacing among East Africans is typically closer than that among Americans, although looking directly into someone's eyes may be considered disrespectful. East African culture is highly verbal, with many discourses and proverbs. Requiring these newcomers to complete large amounts of written forms can be frightening and overwhelming.

- If visiting the homes of East Africans, avoiding sitting with the soles of your feet pointing to them. It can be considered disrespectful. Also, do not call them to come with your index finger, such as when they are in your clinic lobby, as that is reserved for communication with animals.

Barriers to Care and Common Health Conditions:

- Many Somalis and Sudanese are classified as refugees by the United States, and are legal residents. As such, they are entitled to a number of health, human service, and economic forms of government assistance for a limited time. Language and transportation, then, are the most significant barriers to care for this group if they have financial access to health.

- Somalia and the Sudan are two of the world's poorest, most violent countries. Mortality and morbidity rates are extremely high for many infectious diseases. Lifespans are among the shortest in the world due to violence and illness, with many people back home not living past age 45 years.

- Many of the Somalis and Sudanese arriving in the United States have undergone profound levels of hardship and human rights abuses. Many have witnessed or personally experienced war injuries, starvation, rape, and torture. Most had very poor access to medical care in their home countries, and thus typically present with multiple significant physical, mental, and dental health concerns in the United States.

- As with Bosnian and other refugees, East African refugees should be monitored for post traumatic stress, which could manifest itself through excessive fear and anxiety, sleeplessness, forgetfulness, flashbacks, and unexplained physical problems like diarrhea, heart palpitations, general aches, and susceptibility to infections.

- Many East African refugees have had few medical checkups in their home countries. They often will have undiagnosed cases of diabetes, parasites, high blood pressure, depression, and the like.

- Providers should be aware that many of these newcomers routinely share medications and prescriptions with each other. Also, they will often stop taking Western pills once their symptoms stop, even though they might not be through with the full course of medicines. Clinicians should conduct proper health education programs with them on these topics.

- In general, East African women value breastfeeding, and it may be common for them to nurse their children for two years or more, while also feeding them solid foods. This practice is recommended by the World Health Organization, and should not be discouraged by American providers or baby formula marketers. They are also quite adept at nursing their children discreetly in public, and have a rich knowledge of how to overcome nursing difficulties that often stump American women. Providers should encourage the women to maintain their healthy lactation habits, and avoid trying to emulate American women who nurse far less.

- Male circumcision and female genital cutting of youth is common in some East African cultures, particularly those that practice Islam. Providers should become more aware of how to address this topic in a sensitive manner by reading the extensive body of literature that exists on it. Clinicians may sometimes see patients who have experienced various forms of circumcision, and may need to check for infections, tearing, or other difficulties.

- Many East Africans consider Americans to be highly wasteful and indulgent, as indicated by the high percentage of people in this country who are overweight. However, for Africans in Africa, being heavy is usually a sign of wealth and success, and being underweight is a sign of poverty and poor health.

Bereavement:

- Bereavement practices will vary significantly by East African culture and religion. Many Christians will follow similar practices as other Christians in the United States.

- Many Sudanese refugees view death as the will of God or spirits. Burial ceremonies are usually meant to appease the spirits so that additional deaths do not occur.

- Many Sudanese will mourn for a period of several months after a death.

- For Moslem East Africans, burial usually takes place fairly quickly after death. Cremation is usually not practiced. The body is blessed and ritually cleaned in a mosque by an Imam, or Muslim religious leader. The body is often carried to a grave in a funeral procession. The official mourning period may last between three to seven days.

- Large numbers of extended family and friends will typically visit ill patients and the deceased.

Traditional Health Practices:

- Pork is avoided in their diet. The right hand is considered "clean", and is used for eating and handshaking; the left hand is "unclean" and used for toileting and the like.

- Sudanese that practice traditional spirituality typically believe in a variety of supernatural beings and spirits of animals. During illness, it is not uncommon for the Nuer, for example, to try to determine what evil spirit or bad energy has caused a condition, and then try to rectify it through an offering or an animal sacrifice. The "evil eye" is also a common belief among this group, whereby a bad person can send negative energy to another and cause misfortune or poor health.

- Traditional medicines have been used for centuries by East Africans like the Somalis and Sudanese, and vary widely by geography and culture. They are far too numerous to discuss, but providers should be aware that their patients will likely be interested in using a variety of these herbal and plant remedies if available, as a supplement to Western medicine.

The Amish

Overview:

- The Amish are one of the oldest and most unique minority populations in the United States, with many of them first arriving in this country from the region around Switzerland several hundred years ago. The Amish practice a traditional form of Christian fundamentalism that has changed little upon settlement in the United States. They are well known for their preference to remain apart, by and large, from mainstream American society so that they may practice their traditional lifestyles. Pennsylvania, Ohio, Iowa, Wisconsin, the Dakotas, Kansas, and other rural areas are among the states with the greatest populations of Amish in the U.S.

- The old-order Amish generally shun most use of modern technology, as they believe it draws people away from a more natural, simpler lifestyle that is closer to God. Therefore, health education programs should not incorporate telephones, driving, electrical equipment, computers, or other such technology with the Amish.

Language and Religion:

- The Amish are usually not native speakers of English, but rather speak an old form of German called Pennsylvania Dutch. Health workers will want to use an Amish translator for their work, unless the clients are familiar enough with English.

- The Old Order Amish generally follow a very strict interpretation of the Bible, and are devout Christians. Programs should not be conducted on Sundays or religious holy days with them. They will usually not celebrate non-religious holidays like the Fourth of July. Also, human or God-like traits should not be assigned to learning props, such as dolls or animal toys.

Family and Social Structure:

- The Amish are a rural people, with very large families. Most marry young, and do not use birth control. It is not uncommon for Amish women to have 15 or more children. The Amish generally intermarry only with other Amish, so most are related in some way to other Amish.

- Gender roles are usually strong in Amish culture, with men serving as the head of household and being responsible for heavy farming and building duties, while women and children tend to the home and family garden.

Older Adults:

- The Amish will usually take care of their own elders until they die, and keep them active in the family unit. Many will build an addition to their homes so that their aging parents can live with them. Children are expected to be disciplined, and must obey and honor their elders.

Communication Style:

- The Amish, in general, are a very stoic, decent, honest, hard working, devout, and respectful group of people. They tend to treat others with these positive traits, and expect the same in return. Health educators should maintain appropriate body space when working with them, and should avoid excessive physical contact with them.

- The Amish typically do not let people to take pictures of them. In general, maintain a respectful distance and minimize touching, particularly between males and females.

- Health educators should dress very modestly when working with Amish in order to respect their traditional values. Women should wear long skirts or dresses, with their arms, legs, and chests covered to a large extent. Muted colors are usually most appropriate.

- The Amish typically study in one-room schoolhouses, with all ages and both genders together through eighth grade. After that, they usually return to their farms as an agrarian people. Students will usually be highly disciplined and respectful to health educators, although potentially shy and passive. They generally prefer not to mix boys and girls together on teams. Literacy rates among the Amish will usually be fairly low, so health educators should rely more on face-to-face and visual learning.

Barriers to Care and Common Health Conditions:

- Culture is a significant barrier to care for the Amish. Most Amish willingly isolate themselves from mainstream American society, in an effort to maintain their culture. As such, they do not typically use western medicine unless it is absolutely necessary or if an illness is in an advanced state.

- The Amish do not have medical insurance. They pay for their care in cash, and not with credit. Large medical bills are usually covered communally through Amish financial cooperatives. As the Amish are rural dwellers, most also do not live near any health facilities and require transportation for medical care.

- The Amish generally avoid going to the doctor unless it is absolutely necessary. For instance, most will not get prenatal care until the very end of a term, and most give birth at home after the first child.

- Maternal and child health, infectious diseases, farm safety, and buggy accidents are among the most common health conditions they face. They typically are quite fit, with almost no obesity.

Bereavement:

- The Amish are devout Christians. They generally believe that life on earth must be lived well and oriented to God, so as to enter heaven upon death.

- The Amish usually do not embalm their dead. Instead, they typically bury them shortly after death directly into the ground.

- Amish cemeteries, in keeping with their lifestyle, are plain and simple, and lack ornate decorations and detailed descriptions of the dead common in many American cemeteries.

- In general, the Amish will be fairly reserved in their expression of grief and mourning. They tend to view death as simply a natural process that will ultimately bring them closer to God.

- The Amish will usually work closely as a community to help the single head of household after the death of a spouse. Many will come together to help widows, in particular, with plowing, harvesting, and other difficult farm duties.

Traditional Health Practices:

- A strong religious belief in fate is common, so health educators should make appropriate adjustments in their presentations to recognize this external locus of control value.

- The Amish typically value the use of natural remedies like herbal medicines as their first choice of care, and generally do not want to take modern Western medicines or use vaccinations unless necessary. Many are reluctant to follow the medical advice of physicians, and prefer less invasive and more natural methods of treatment. Most Amish have a great interest in herbal medicines, and many women make their own remedies for their families.

Jewish and Hassidic Jewish Populations

Overview:

- Judaism is one of the world's oldest religions, and was the first major one to recognize one god (monotheism), rather than pantheism (multiple gods). Judaism has been practiced for thousands of years. It eventually gave rise to Christianity 2,000 years ago, and then Islam.

- Jews as an ethnic group originated in the Middle East several thousand years ago, but throughout history have experienced a number of waves of dispersion across Europe, Asia, and Africa due to political upheavals, war, and ethnic cleansing.

Language and Religion:

- The native language of Jews in Israel today is Hebrew. However, because Jews can be found in many countries throughout the world, they will usually speak the native language of that state. Most Jews in the United States speak English as their first language. Many of the ultra conservative Jews are originally from New York, so they speak English. However, others are from Israel and speak Hebrew. No matter where they are from, though, most ultra-orthodox Jews will know some Hebrew, as it is their sacred language.

- Jews are one of the smallest but most active minority populations in the United States. Jews are extremely diverse among themselves. Those of European origin are called Ashkenazi Jews, while those of Middle Eastern or non-European origin are called Sephardic Jews.

- Jews may be secular (non-religious) or religious. Those that are religious may be reform (not very traditional), conservative, orthodox (very traditional), or ultra-orthodx (hassidic)

- Jews greatly resent, in general, any efforts to convert them to Christianity. Most are keenly aware of historical events such as the Crusades, the Inquisition, the Holocaust, and anti-Semitism, which caused large numbers of Jews to be killed by Christians or forced to convert. In Judaism, a person born to a Jewish mother is believed to be a Jew. Most people are therefore born into Judaism, rather than convert to it.

- Health workers should be aware of different Jewish calendar issues. Programs should not be operated on the Jewish Sabbath, which begins Friday at sundown and ends Saturday at sundown. Also, do not operate programs during Jewish holidays, such as Passover in the spring; Rosh ha Shana (New Year's day in the fall); or Yom Kippur (a full day of complete fasting in the fall). Jews are not Christians, and therefore do not celebrate Christmas and Easter. Sunday is a working day in Jewish communities. Most Jewish holidays begin at sunset one day, and end at sunset one or more days later.

Older Adults:

- Jews tend to place a great deal of value on elders, as well as on the generations that came before them. Children will often be named after a close family elder. Family and religious historic traditions are often shared from seniors to the young through stories and during holidays.

Family and Social Structure:

- Most Hassidic, ultra-orthodox Jews marry young and have very large families.

- Among very conservative Jews, male and female roles are well defined. The men tend to be the heads of household and wage earners, while the women are in charge of the family and home. Many of the Hassidic women also are active volunteers for their community.

- Health providers should respect the well-defined gender roles among ultra-orthodox Jews. Men should not hug, shake hands, pat the back, or otherwise touch women out of respect. Physical contact between the sexes is usually reserved only for spouses or younger children. Many Hassidic men, when passing women in a hall or on the road, will typically look down or cover their eyes so as not to infer sexual interest in the females. Ultra-orthodox Jewish men may not hide their unwillingness to interact with secular female health professionals.

- Many of the ultra-orthodox Hassidic Jewish children study in religious schools. In general, their literacy rates are high. They use technology like computers, cars, and phones.

- Conservative Hassidic Jews will usually wear very modest, dark clothes. Women usually wear long, beautiful dresses or skirts and dark stockings, with their arms fully covered by sleeves. Hats or wigs are used to cover their hair. Religious Jewish men will wear a kipa or yarmulke, which is a skullcap or small covering for the back of the head. This will usually never be removed in public. Health professionals that work regularly with Hassidics should take care to dress modestly as well and respect these traditions.

Communication Style:

- Israelis and Jews in general are extremely warm, passionate, and outgoing people with a sharp sense of humor. Where possible, health educators should also use this same communication style. The Jews also appreciate language that is frank and direct. They are a highly verbal culture that values analytical sparring, so health educators should be aware that it is often difficult to lecture passively to this type of an audience. Question-and-answer sessions and open discussions are probably more effective.

- Body spacing is usually fairly close in this culture, and physical contact to show affection is common among many Israelis. However, among the more conservative Hassidic Jews, men and women are generally much more likely to avoid inappropriate contact with each other. Where possible, women health providers should work with Hassidic Jewish women clients, and vice versa for men.

- Israelis, like other Middle Eastern populations, place a profound emphasis on respect and hospitality. Health workers will usually need to take the time to discuss other personal issues with this population, before getting down to business with the clients.

Barriers to Care and Common Health Conditions:

- Jewish populations in the United States usually do not have significant financial barriers to care. Most American-born Jews that are not ultra-orthodox tend to utilize medical care frequently and early. They usually will have insurance, and take an active part in the own care. However, some lower-income Jewish immigrants working in agriculture and manufacturing sectors may not have adequate health insurance. They also may not know English and do not have enough providers that speak Hebrew. If they are ultra-religious, they may not feel comfortable utilizing care in secular or Christian-based hospitals that are common.

- Among many conservative Jews, health concerns tend to focus on maternal and child topics, the prevention of chronic diseases like cancer, obesity, women's health, and occupational injuries.

Bereavement:

- Most Jews believe that death will ultimately lead to resurrection in a future world.

- Jews usually do not embalm their deceased. Instead, the dead are typically buried within 24 hours of their death, after ritual purification and dressing in a plain linen shroud. The body is usually watched over from the time of death until burial.

- Jews will usually recite the Kaddish, a special prayer in honor of the dead. They will "sit shiva" for seven days, which means that they will curtail most daily activities and mourn out of respect for the dead. During shiva, they will often wear black and will cover mirrors and sit on low stools. A special candle will usually be lit to honor the dead. The full mourning period lasts one year, at which time a special "yahrtzeit" memorial ceremony is offered. Hassidic Jews honor an 11-month mourning period. Jews usually honor the anniversary of the death of a loved one for many years into the future.

- Many Jews, particularly those of Sephardic background, will be highly expressive and visibly distraught when a loved one dies or is seriously ill. To remain stoic and silent, as is more common in dominant American culture, would imply lack of true feelings for the deceased.

Traditional Health Practices:

- Jewish people, even if they are not religious, generally follow some level of Kosher dietary laws. These laws emphasize the use of food that is clean and easy to digest, and were first explained by Moses in the Jewish Torah, or the book Christians call the Old Testament. Health providers and hospitals, therefore, should be thoroughly familiar with Jewish dietary laws before attempting to discuss nutrition issues or meet their dietary needs. Most Jews will not eat pork, and usually do not mix milk and meat products together in the same meal. Israelis, in general, eat far more fresh produce than most Americans do.

- Many Jews, particularly those that are Hassidic, have very strong fate and destiny values. They often will not directly speak words such as "cancer", over the concern that it might predestine them to have bad luck with the disease.

- Most Jews greatly value Western medical care and will access it frequently if financial and geographic barriers do not exist.

- Most Jews will usually take an active role in maintaining their own health, and will frequently give advice to others on how to do the same. Many will also question their provider thoroughly about a particular treatment or medical process, and will expect detailed information.

Muslim Populations

Overview:

- Islam is one of the world's three great monotheistic religions, along with Judaism and Christianity. People that practice Islam are called Muslims. They share a belief with Christians and Jews in the Old Testament, but also follow the Muslim holy book, the Koran, and the teachings of the prophet Mohammad. They believe in the same god as Christians and Jews, and he is referred to as Allah. Jesus is recognized as a prophet and holy man, but not as a Messiah as in Christianity.

- The Islamic faith came out of Middle Eastern traditions, like Christianity and Judaism, and is one of the fastest growing religions on earth. Many Muslims live in America, particularly in larger black urban areas. However, Muslims can be found in the Bosnian and Somali refugee communities, as well as in communities with Arab immigrant student populations.

Language and Religion:

- The language spoken by Muslims will vary, depending on ethnicity. For instance, among Muslim university students, Arabic will be common. However, Bosnian refugees speak Bosnian. African American Muslims will usually speak English as their native language.

- Muslims can range from being secular to very devout. For instance, most Bosnians do not follow a strict interpretation of the faith, like gender segregation, modest dress codes, or regular worship at a mosque. However, the Somalis are much more religious, and will typically wear loose, long clothing, and have well-defined roles for men and women.

- Devout Muslims worship at a mosque, not a church or synagogue. They do not celebrate Christmas, Easter, or other religious holidays that Christians practice. Friday is their holy day of rest and worship, not Sunday like Christians. They will generally greatly resent any efforts to convert them to Christianity, as they have a keen understanding of historical persecution of Muslims by Christians during the Crusades and other events.

- Devout Muslims will usually pray five times a day, from the early morning through the evening. They will pray in the direction of Mecca, the holy city in Saudi Arabia, from wherever they are in the world. If Muslim patients are staying in a hospital, workers should be able to tell them what direction Saudi Arabia would be for them, so that the patients can pray to Mecca.

- Most Muslims practice a month of fasting from sunup to sundown, called Ramadan. Its timing varies from year to year. No food, water, or smoking is allowed during this time. Devout Muslims do not drink alcohol at any time of the year.

Family and Social Structure:

- Devout Muslims usually have well-defined, traditional roles for men and women. With religious clients, the sex of the provider should match the sex of the patient. Exposure of body parts of the Muslim patient should be kept to a minimum. Most will not like to be disrobed next to other family members as well, unless they are of the same sex. Clinicians should also not touch the patient's head or hair, unless necessary for an exam.

- Muslims usually value large families, and greatly adore children. Birth control is not usually desired in devout families, because of the value placed on children.

Older Adults:

- Muslim families have an obligation to take care of their elders, without institutionalization. Muslim women are greatly respected and revered for their role as mothers and keepers of the home.

- It is important to take into account ethnic origin when planning and implementing a program or offering healthcare advice for Muslims. While males and females have distinct roles within the religion, there are also cultural and age expectations that should be observed.

Communication Style:

- A general communication style is difficult to describe for Muslims, as it will vary by ethnicity, not religion. As noted, Muslims may be as diverse as Somali refugees, Arab university students, African American Muslims, or Bosnian refugees. In general, though, Muslims value a communication style that is respectful and honorable to others.

Barriers to Care and Common Health Conditions:

- Hospitalized Muslims will usually have large numbers of family visiting at all hours, which should be accommodated if possible. The family members will often recite the Koran near the patient, which they would like to do discreetly. It would usually be inappropriate for them to pray in the chapel room of many hospitals, because they often have Christian crucifixes posted.

Bereavement:

- Most Muslims believe that life on earth is to be spent preparing for another world after death.

- In general, Muslims do not embalm. The body is usually washed and purified in a ritual manner, and then covered in a simple "kafan" cloth. The deceased is then buried in the ground directly, upon completion of the funeral. The burial usually takes place fairly quickly after death. Direct burial in the ground is required by "shari'ah", or Islamic law.

- Death is viewed as being predestined by God, and is just the beginning of eternal life. As such, some very religious Muslims may be quite stoic and calm in their mourning. The outward expression of grief through wailing and banging the chest is forbidden. Grieving is usually allowed for just three days.

- Large numbers of extended family and friends will usually visit seriously ill or deceased patients. Mourners will join together to offer "janazah" prayers for heavenly compassion and forgiveness for the deceased. An additional janazah prayer will often be said upon burial.

- Upon death in a hospital, providers should try to turn the face of the patient so that it faces Mecca.

- Most Muslims will prefer to be buried in cemeteries set aside for followers of Islam.

Traditional Health Practices:

- Traditional health practices of Muslims will primarily vary by ethnicity, rather than by religion. For further information, please refer to specific cultural information regarding Bosnians, Somalis, and others.

- Abortion is not allowed in the Muslim religion. Circumcision is performed on all boys, although the timing can vary from birth until puberty. Premarital sex and adultery are forbidden in Islam.

- Most Muslims do not eat pork products or other foods that are deemed unclean and unhygienic. Meat products will only be eaten if they are "halal", or have been slaughtered according to strict practices. (This is somewhat similar to the "kosher" dietary rules in Judaism). Hospital food and diets should be modified to meet their needs. They typically will share food, and are often taught not to eat to capacity. Some food, therefore, may remain untouched. Devout Muslims will also not eat any food product made with lard or animal fat, like some ice cream, gelatin, and fried foods. They also do not drink alcohol.

- Muslims generally consider the right hand to be "clean", and it is used for eating, shaking hands, and touching others. The left hand is considered "unclean", and reserved for toileting and other such practices. Providers should minimize touching Muslim patients with their left hands.

- Ritual cleanliness of the body and home is usually extremely important to Muslims, particularly during times of prayer.

- After birth, many Muslim parents will take the placenta and dispose of it for burial, in accordance with Islamic tradition. Fetuses after the age of 120 days are considered viable babies, and would require burial by Muslims.

Resources and Referrals

National Resources about Immigrant, Refugee, and Minority Health

National Consumer Protection Technical Resource Center for Senior Medicare Patrol
Tel: 877-808-2468

National Institutes of Health
National Center on Minority Health and Health Disparities
6707 Democracy Blvd., Suite 800
MSC-5465
Bethesda, Maryland 20892-5465
Tel: 301-402-1366
Fax: 301-480-4049
www.ncmhd.nih.gov

Office of Minority Health
P.O. Box 37337
Washington, D.C. 20013-7337
Toll Free: 800-444-6472
Tel: 301-230-7199
Fax: 301-230-7198
www.omhrc.gov/omhhome.htm

Centers for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30333
(800) 311-3435

Closing the Health Gap
800-444-6472
email HealthGap@omhrc.gov
www.healthgap.omhrc.gov

United States Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
Phone (800) 368-1019
TDD (800) 537-7697
Email: ocrmail@hhs.gov
www.hhs.gov/ocr/mission.html
www.medicare.gov

DiversityRx
rcchc@aol.com
www.diversityrx.org/HTML/DIVRX.htm

Indian Health Services
The Reyes Building
801 Thompson Avenue, Ste. 400
Rockville, MD 20852-1627
http://www.ihs.gov/

Asian & Pacific Islander American Health Forum
942 Market Street, Suite 200
San Francisco, CA 94102
Tel: (415) 954-9988
Fax: (415) 954-9999
E-Mail: hforum@apiahf.org
www.apiahf.org/

The National Alliance for Hispanic Health
1501 Sixteenth Street, NW
Washington, DC 20036
Tel: (202) 387-5000
E-mail: alliance@hispanichealth.org
www.hispanichealth.org/

Refugee Health and Immigrant Health
Email: Charles_Kemp@baylor.edu
www3.baylor.edu/~Charles_Kemp/refugees.htm

United Nations High Commissioner for Refugees
Case Postale 2500
CH-1211 Genève 2 Dépôt
Suisse.
+41 22 739 8111
www.unhcr.ch/cgi-bin/texis/vtx/home

International Organization for Migration
17 route des Morillons
C.P. 71
CH-1211 Geneva 19
Switzerland
Tel: +41 22 7179111
Fax: +41 22 798 61 50
Email general: hq@iom.int
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1604 N. Country Club Road
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National Hispanic Council on Aging
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www.nhcoa.org/index.htm

National Asian Pacific Center on Aging
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The National Caucus and Center on Black Aged, Inc.
1220 L Street, NW, Suite 800
Washington, CD 20005
Tel: (202) 637-8400
www.ncba-aged.org/index.html

Jewish Home & Aging Services
The Art of Jewish Caregiving
6710 W. Maple Road
W. Bloomfield, MI 48322
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University of Northern Iowa

The Iowa Project EXPORT Center of Excellence on Health Disparities

The Iowa Project EXPORT Center of Excellence on Health Disparities provides statewide academic leadership in research, training, planning, education, and outreach on health disparity issues affecting minority, immigrant, refugee, and rural populations. It is part of a series of several dozen such model centers around the country that have been initiated and funded by the National Institutes of Health, Office of Minority Health and Health Disparities, in recent years as part of the federal government's priority on reducing health disparities. The Iowa EXPORT Center links components of three award-winning, model programs at the University of Northern Iowa into an umbrella organization that helps agencies throughout the state meet the challenge of promoting health equity for all. The three member organizations at the University of Northern Iowa are a) The Global Health Corps, a service-learning organization that trains health students and working professionals to conduct culturally appropriate health programs with diverse and underserved populations around the world; b) The Center for Social and Behavioral Research, which conducts multiple large-scale studies for government, non-profit, and private agencies on public health and related issues; and c) The New Iowans Program (see next section). For more information about the services provided by the Center that relate to minority and aging issues, please contact www.iowahealthdisparities.org.

New Iowans Program

The University of Northern Iowa's New Iowans Program (NIP) guides and prepares Iowa communities and businesses as they accommodate immigrant and refugee newcomers living and working in the state and region. NIP provides tailored consultation for community leadership, conducts research relating to issues facing newcomers and communities, develops innovative training programs for business and industry, and educates Iowans concerning the needs, challenges and opportunities of their new immigrant neighbors, co-workers and employees. All NIP programming incorporates a strong appreciation for the critical role newcomers play in ensuring the long-term social and economic vitality of Iowa's businesses and communities. Visit our website at www.newiowans.com.

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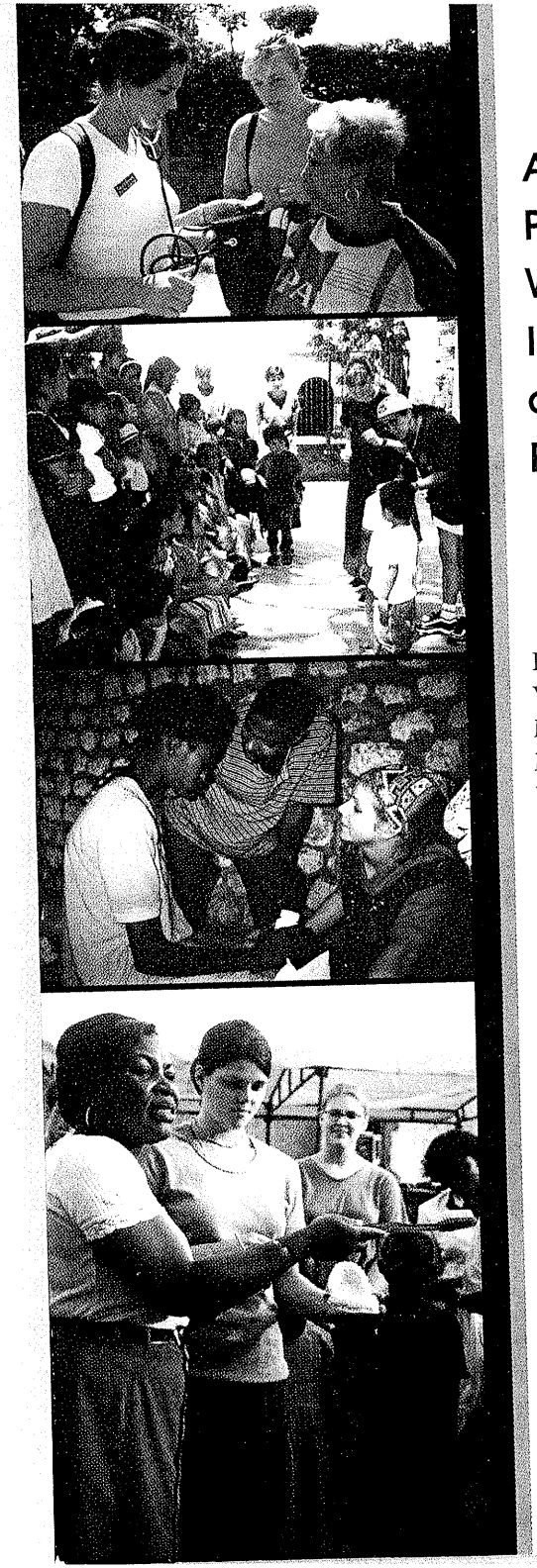

A Health Provider's Pocket Guide to Working with Immigrant, Refugee and Minority Populations in Iowa

First Edition 2003

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About this Guide

This pocket guide is a practical resource for health care providers who work with Iowa's growing immigrant and refugee populations, as well as other long-time minority groups in the state. Minority populations in Iowa, as well as in the United States as a whole, typically experience unique cultural, social and economic barriers that can significantly affect their health status. Minority and newcomer populations pose a number of rewards and challenges for Iowa communities, employers, schools and health care providers. This book was developed in response to growing demand among physicians, nurses, educators and community health workers for information and practical advice on how to work with newcomer and minority populations. The information provided in the guide comes from a number of different sources, including the background of the authors who have extensive field and academic experience addressing the health and other needs of immigrant, refugee and minority populations. Other sources include the body of professional health literature and the knowledge of many providers who have shared their experiences with us. Most importantly, clients and professionals that represent each of the minority populations addressed in this guidebook have provided extensive input.

This guide responds to several questions:

1) What are the cultural backgrounds of Iowa's racial minority and newcomer populations?
2) How do the cultural, religious and socioeconomic backgrounds of these minority populations impact their perspectives on health and the health care system? How do people from different cultures define "health"?
3) What should health care providers know about these minorities and newcomers that will help them provide the best possible care?

This guide will address some general characteristics about the experience of being a minority, immigrant or refugee. In addition to introducing readers to such key concepts as culture, the guide will discuss important issues such as the difference between immigrants and refugees, as well as religion. The guide will also discuss some of the challenges these newcomers bring to Iowa's health care providers.

Of course, minorities, immigrants, and refugees also represent a very diverse set of nationalities, ethnicities and cultures. Therefore, the guide will also address some of the key differences between them and how these cultural and ethnic experiences impact their ideas about health, the American health care system and how to access it. Therefore, the guide also provides valuable information about the best ways to approach health issues for individual ethnic groups. To help readers develop a better understanding of these cultures, the guide also provides case studies.

Part I:

The Immigrant, Refugee and Minority Experience in Iowa

The land that today is Iowa was originally home to a number of indigenous tribes of the northern plains, such as the Sac and Fox. By the mid-1880s, European American expansion was increasing west, beyond the Mississippi River, driven by pioneer families who ultimately dominated the demographics of the state. The state of Iowa, therefore, has been a land of immigrants since its establishment. Indeed, without immigration, Iowa as we know it today would simply not exist. However, at the same time, Iowa continues to have a number of long-standing minority populations as residents. For example, there is the indigenous Meskwaki in Tama, multi-generation Hispanic families in Muscatine and many African-Americans in Waterloo. Southeast Asian refugees began arriving in Iowa in sizeable numbers in the 1970s, and refugees from around the world continue to come today for a variety of reasons. Most immigrants come for work and better opportunities for themselves and their families. Many refugees also come because Iowa provides an opportunity to flee their war-ravaged homelands and start a new life.

In the 1990s, Iowa began to experience a dramatic increase in the number of immigrant newcomers, particularly Latino immigrants. Indeed, in the 2000 Census, Latinos were Iowa's largest minority group, numbering almost 83,000 (20,000 more than African-Americans).

Approximately 25 percent of the population of the United States today consists of minorities. By the year 2050, demographers predict that this figure will increase to 50 percent, with no single group representing a majority population anymore. This general trend is already occurring in many larger states, with even small rural states like Iowa following the pattern. Indeed, the percentage of minorities in Iowa is expected to continue to grow significantly in future years. This will occur for a number of reasons, including higher birth rates for most minority groups, low birth rates for whites, an aging white population and an exodus of young working people from Iowa. The state will no doubt also continue to receive new immigrants and refugees. In many communities—and for many employers—the arrival and accommodation of immigrant and refugee newcomers, as well as the ability to work with existing minorities, is critical to their long-term social and economic health. The growth in these populations will also present challenges and opportunities to health care providers.

To lay a foundation for the practical advice and information provided in this guide, it will be helpful to first discuss some basic information about the minority and newcomer experience. Later, we will provide more specific information about the health needs of individual cultures. To begin, here are some key concepts and definitions.

Culture

Culture is a word that is used by many people to mean a variety of things. We often read or hear about "workplace culture" or the "culture of an organization." In any human community, culture can be thought of as the "software" in people's brains that determines their behavior, attitudes, distinguishing right from wrong, faith in God, dress, food and other habits of daily life. Culture is a set of similar ideas shared by a group of people about appropriate behavior and values. People who share these basic ideas tend to act generally the same, eat and dress the same way, and in many respects, think the same way about life. People usually don't think about their own culture unless they are confronted with another culture. But one way to think about one's own culture is by asking this simple question: "What are the things I do in my normal life that seem so natural that I forget them?" These things make up culture.

Culture is passed from generation to generation, remaining stable over time and shared by everyone in a community. Just the same, culture is also flexible. Cultures share ideas and values with one another, just as people do. A community can thus change its values and behaviors to better meet a changing environment, or because it is exposed to new and better ways of doing things.

Ethnicity and "Race"

Ethnicity is closely related to culture, but it is a more precise term that has to do with how people develop a sense of identity as individuals and members of groups. Like culture, ethnicity is flexible, often changing for different situations and through life. It is also closely related to language, where people live, their families and the people they call friends. Language and ethnicity are not always exact matches. For example, not all Spanish-speaking Americans call themselves "Hispanic" or "Latino." Indeed, many Mexican immigrants prefer the term "Mexicano" to either "Latino" or "Hispanic."

Ethnicity is a much more accurate term than "race," a word that is often used to describe physical differences among people in terms of skin color, hair or facial features. Race and ethnicity are very different things. Most social scientists do not believe that significant physical differences exist among humans. Rather, race is a cultural concept, not a scientific one. Physical differences themselves are meaningless unless people attach meanings to them.

Ethnicity does not rely on the physical characteristics of people. A person with black skin might identify him- or herself as Somali or Sudanese and would dislike being called an "African-American." Likewise, not all people with light colored skin like to be called "white," perhaps preferring to think of themselves as Italian or Jewish or Irish. The danger in relying on race to categorize people is that it contributes to stereotypes. There is always a great deal of ethnic diversity among people who otherwise share physical characteristics. Thinking in terms of ethnicity is more appropriate because it reflects how people understand their own identity, rather than using their appearance to impose an artificial identity on them.

Language

People use language to communicate with one another. Language may be verbal, written or visual. Language helps people understand who they are because language can help explain concepts like health, emotions, religion, etc. Most Iowans share verbal English and can read and write English as well. English serves a practical function in jobs and families, as well as in health care settings, for most minority populations in the state. Refugees and immigrants use languages, too, although the languages they bring with them are often different from English. Even though Iowans may not understand or speak the language of newcomers, it is important to keep in mind that regardless of which specific language is spoken, people use language for essentially the same reasons.

Religion

Religion includes beliefs and behaviors that relate to spiritual and moral issues. For example, in the Judeo-Christian tradition, religion does three things:
It confirms the existence of God and helps us understand God's nature.

- It provides important stories and documents about the historic deeds of God's power such as those found in the Bible, in miracles and in the deeds of saints.
- It provides rituals (such as prayer and worship) intended to ask God to intervene on our behalf, including in matters of health and well-being.

Rituals are the formal events that are performed in sacred and publib places like churched and at set times. Rituals also include sequences of words and actions, such as a communion service, that are learned before the ritual takes place and repeated every time. Also, rituals are social events during which people acknowledge they accept common ideals that transcend their status as individuals.

Of course, the nature of these cultural understandings, stories and rituals varies from culture to culture. Even though God's nature is the same all over the world, human beings understand it in terms of the language, values and behaviors of their own communities. Religious stories might tell the same underlying message, but with plots, characters and settings that change to match the life in each culture. All people ask for God's protection and help, but every culture's religious rituals will reflect its own places, times and social customs.

Refugees, Immigrants, and Minorities: Differences that Matter

Understandably, people often cannot distinguish between minorities, refugees and immigrants, but the difference is important for economic, social and legal reasons. Minority populations, for purposes of this guidebook, refer to those groups of individuals that are distinct racially and ethnically from the dominant European American majority. This would include groups, for instance, such as African Americans, Asian Americans, Native Americans and Hispanics. These populations are very distinct from each other, and have different histories. For example, the Meskwakis who live in Iowa are one of more than 500 unique Native American tribes. They are indigenous to the region, and are most definitely not newcomers, although they clearly are ethnic minorities and American citizens. On the other hand, many of the African Americans in Iowa arrived in the early part of the 20th century from southern states to work in agricultural processing plants. While they are ethnic and racial minorities, they are American citizens. Many can trace their family histories in the United States back to the 1700s when they were brought as slaves to the New World. Indeed, African Americans generally have family histories in the United States much longer than those of many whites from Western Europe who arrived much more recently within the past century to the United States. Most minorities in the United States, therefore, are actually American citizens and have been in the country for many generations, even though they are not of European, white descent. They are often quite different from newly arrived immigrants or refugees. For example, an African American woman from Waterloo, Iowa, would most likely have far more in common culturally with her white neighbors, than she probably would with a newly arrived refugee mother from the African country of Somalia.

Most immigrants and refugees in the state of Iowa are ethnic minorities, too, although they usually have arrived much more recently in the state. Likewise, all refugees in Iowa are immigrants here, but not all immigrants are refugees. Important legal distinctions exist between these two special types of minorities. Refugees were forced to leave their home countries because of war, environmental disasters, political persecution and/or religious or ethnic

intolerance. They are officially recognized by the United Nations as being individuals who cannot return to their homeland because of well-founded fear of persecution. They come to the United States or other asylum country with a special immigration status that gives them automatic admission into the country and eases their reunification with family members. Refugee status in the United States also provides them with a "green card" or work authorization permit. In addition, short-term financial assistance is funded by the U.S. Department of Health and Human Services through private and state agencies like the Iowa Bureau of Refugee Services. Refugees are "invited" to live in the United States to start a new life.

Immigrants generally come to the U.S. for one of two reasons: they are joining family members who already live in this country or they are "economic immigrants" seeking work and a better life for themselves and their families.

Immigrants and refugees have a good deal in common. For example, they come to Iowa seeking the things that established residents like about living here. Iowa provides job opportunities, schooling for children, safe communities and inexpensive housing. For both populations, coming to the U.S. and Iowa also presents similar challenges. For example, they experience new cultures and languages. They are often ethnic minorities who might face open racism or other forms of hostility, regardless of their immigration status. For immigrants and refugees who do not speak English, living in Iowa communities—and dealing with the American health care system—can cause a tremendous amount of stress. So many activities that English-speaking parents take for granted can be daunting for newcomers. Simple things like following written instructions or filling out health related forms can lead to a great deal of anxiety.

Challenges for Health Care Providers and Minority Clients

Serving the health care needs of minorities, immigrants and refugees can present a number of special challenges for health care providers. Health status varies dramatically by ethnic group in the United States. In general, minorities are disproportionately affected in comparison to the white majority population by chronic illnesses, infectious diseases, mental health challenges, accidents, intentional injuries and other conditions. Interestingly, only a small portion of this disparity is considered to be a result of genetic differences that cannot be changed. More typically, broad differences in income, education, living conditions, lifestyle practices, insurance coverage, family support systems and other socioeconomic factors have far greater impact on the health status of minorities than do inherent biological differences.

Access to Care

Access to care is the greatest barrier to good health for minorities and newcomers in the United States. Cost and transportation are particularly difficult challenges to address for minorities in Iowa and the rest of the United States. There are approximately 42 million Americans who do not have medical insurance, and minorities are disproportionately represented among the uninsured. Millions of others are under-insured or represent the working poor. Immigrants who are in the United States without the proper legal documentation are particularly likely to be uninsured. Indeed, in Iowa, new reports indicate that 50 percent or more of the Latino population may not have medical insurance.

However, money is not the only barrier to care for minorities. Geographic restraints are also significant. Health services are not always located conveniently in ethnic neighborhoods where minority and immigrant populations often live, and they may not have easy car or bus transportation to medical facilities in white areas. Likewise, health services that are offered only 9 a.m. to 5 p.m., Monday through

Friday, off-site in a building staffed by all white providers would typically not be well utilized by many minorities. Many immigrant workers in meat packing plants, for instance, work double shifts with only one day off per week. They would have difficulty seeking care when needed during standard operating hours for most doctors' offices, especially if faced with the added burden of either bringing their children with them or finding suitable childcare. Cultural access is also a common barrier to care when the minority patient cannot be seen by providers familiar with their unique ethnic background or sensitive to their needs. In general, because of significant barriers to care, minority patients will often seek treatment for health problems later than the majority white population, and are more likely to present with multiple, more advanced conditions.

The Lack of Medical Records

Unlike American-born minorities, immigrants and refugees often arrive in this country with limited or no health records. Without this background information, it is difficult—if not impossible—for providers to make an appropriate medical diagnosis, or even prescribe the best medicine. Lack of medical records can be a very frustrating aspect of working with newcomers for health care professionals. For doctors, there is no history or previous diagnoses to inform a current diagnosis or recommend an appropriate course of action. For community health providers, nurses and others, it is impossible to tell if newcomers are allergic to any medications, or if school children have already received immunizations (perhaps even multiple times).

Different Health Patterns

Immigrants and refugees can have medical needs that an established community might never have experienced before. Sometimes they bring health problems with them from their home regions, or they might develop the so-called "diseases of the poor" during their travels. Some of these

"diseases of the poor" are common even in American-born minority communities, like scabies or high infant mortality. There are also diseases associated with mobile populations, such as tuberculosis, and certain parasites or viruses. In mobile populations, sexually transmitted diseases can be common, and among newcomers, prenatal care might have been limited.

Language

Language issues can also complicate diagnosis when a patient speaks no English and translators are not available. Sometimes newcomer children have learned some English and are used to translate in health care settings, but lack the English vocabulary necessary to help healthcare providers make appropriate diagnoses. The lack of appropriate translation can also mean that patients' questions are not adequately communicated or misunderstood, and that doctors' instructions might be misunderstood. Many health education programs are developed primarily for white, middle-class populations and are not culturally sensitive to the specific health practices, needs and beliefs of minorities.

Conceptions of "Health"

Different cultures might also have different ideas about what "health" is. For most Americans, being "healthy" is the state in which we feel good enough to maintain our day-to-day activities; a lack of health can be anything that prevents us from functioning in a normal matter. Immigrants and refugees might have very different ideas about what it means to be "healthy." Being "healthy" might simply mean a lack of disease, but they may not consider other conditions that keep them from performing optimally worth going to a doctor. Or, one kind of problem might not mean one lacks health, while other problems do. A person might be considered unhealthy, even though able to function in terms of family responsibilities, work and social obligations.

Similarly, ethnic minority and newcomer populations have very different ideas about what constitutes "healthy" behaviors or what factors cause certain diseases. These beliefs vary dramatically by cultural community. For example, standard American dietary recommendations promote consumption of certain foods, dairy products and fresh vegetables for instance, to maintain long-term health. In other cultures, these same foods might be uncommon or only consumed when they are in season.

People can also have different ideas about the role of health care professionals. Most Americans understand the importance of preventive and primary health care and the need to establish long-term relationships with a physician. People from countries that lack resources to provide preventive and primary care might consider resorting to doctors only in extreme cases. Many non-western cultures in Iowa and the United States have highly developed systems of traditional medicine and healers on which they rely for their main care.

An Intimidating Health Care System

The often impersonal, institutional system of delivering health care common in the United States does not always work well with minority and newcomer populations. This is particularly true for non-western cultures that are highly focused on the family and interpersonal relationships for healing, and are not used to external, institutional health care that focuses on curing specific diseases, rather than promoting the holistic well-being of the patient. The American health care system is often intimidating to newcomers, and it assumes a level of trust in hospitals, clinics and doctors that not all newcomers have.

Experience has shown that newcomers are much more likely to use health care programs that reach out to them in a more personal manner. Advertising the availability of special programs for newcomers often does not work as well as making personal contact. Making these contacts may take time and patience and might involve identifying and working with leaders in newcomer communities to give outreach programs a degree of legitimacy.

Differences in what is considered "health" and "wellness" can also prevent the U.S. health care system from working well for newcomers. For example, the person who has a chronic disease but is still able to function by working and attending to family matters might consider himself "well" and fail to seek out medical attention that established residents would consider mandatory. There might also be critical differences in assumptions about how to treat or prevent the condition, and cultural differences can increase the likelihood of a missed or inappropriate diagnosis. The results can be costly if health problems are not handled appropriately and become critical, requiring a visit to the emergency room.

PART II:

Cultural Competency and Health: General Guidelines

"It is much more important to know what kind of person has a disease, than what kind of disease a person has."
Sir William Osler

Culturally Competent Health Care

Providing culturally competent health care means that a provider or organization is sensitive to the cultural differences between patients, understands the influence of these differences on their health status, and can modify programs from a practical standpoint to meet the specific needs of diverse clients. Culturally competent health care is necessary, because many public health studies around the world consistently indicate that culture is a significant, common barrier to care for minority and immigrant patients. Cultural barriers may be quite obvious or more subtle. For instance, a Latino immigrant patient may be less likely to visit a local clinic if he knows that the providers there do not speak Spanish, his only language. On the other hand, a pregnant Somali refugee mother may be reluctant to be seen by a male Iowan physician for prenatal care, because she is more used to being supported by female lay midwives during labor, and does not consider pregnancy to be a medical condition requiring treatment. Health providers and their agencies, therefore, must be sensitive to the cultural nuances that affect the health status of their minority patient populations.

The Spectrum of Cultural Competency

Most people have had relatively little meaningful exposure to people of other backgrounds, and therefore have a need to learn how to become more culturally competent. Learning these skills, though, can take years of immersion in a particular culture, if done correctly. Furthermore, a provider can be culturally competent with one particular ethnicity of patients, but may lack experience with other minority populations. Ultimately, becoming competent in this field requires a deep knowledge of the cultural nuances of various groups and an understanding of the unique demographic and socioeconomic factors affecting those populations. Being genuinely friendly, compassionate, respectful and humble can also go a long way toward making one more culturally competent, even if unfamiliar with the particular characteristics of a specific group.

Health providers should honestly assess their own opinions on how they feel about people from other cultures, as well as how their health agencies view patients of minority backgrounds. This honest assessment is necessary as a starting point, so that clinicians and health facilities alike can consciously improve their ability to work with diverse clientele. Researchers have found that cultural competency skills actually exist along a spectrum of human behaviors. This spectrum can be divided into six different levels that range from minimal appreciation of other cultures to maximum appreciation. They include the categories below.

Cultural Destructiveness: Refers to people who have no interest in being "culturally competent," and actually support the violent destruction or elimination of people from other backgrounds. Examples of people in this category would be members of hate groups or political parties that support ethnic cleansing, genocide and other forms of racial violence.

Cultural Incapacity: Refers to people who have virtually no ability to relate to those from other cultures. Although they do not support violence or destructiveness of other races, they are much more comfortable living in homogeneous communities with almost no interaction with other backgrounds of people. Examples of systemic cultural incapacity would be segregation in the 1950s in the southern region of the United States, and apartheid in South Africa before it was dismantled.

Cultural Blindness: Refers to people who have very limited exposure to other cultures, but are certainly willing to learn about them. Many people in this category feel that their own particular culture is best, and have some difficulty understanding why others in the world do not think or behave the same way. Most people around the world fall into this category.

Cultural Pre-Competence: Refers to people who are beginning to understand that every culture has good and bad aspects, and one culture is not necessarily better than another. People in this category usually have a very basic understanding of some of the cultural nuances of a particular population.

Cultural Competence: Refers to people who are comfortable interacting with people from another culture, and are able to do so fairly effectively. They have a good working understanding of the history, socio-economic background, language and other factors affecting a particular culture.

Cultural Proficiency: Refers to people who are extremely competent in their ability to work with people of diverse backgrounds. They have a very strong knowledge of a particular culture, which is often gained by being born to parents from two different ethnicities or spending large amounts of time heavily immersed in a culture. People in this category can operate extremely effectively in their own culture as well as that of another group, and are usually not viewed as "outsiders" in that culture.

SCALE OF CULTURAL COMPETENCY

Cultural Proficiency
(Bicultural and bilingual. Can easily interact with people of different cultures.)

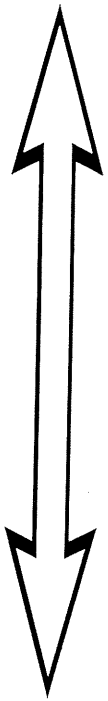
Cultural Competency
(Deep respect and appreciation for another culture. Can interact adequately.)

Cultural Pre-competency
(Beginning to understand and respect other cultures.)

Cultural Blindness
(Unaware of cultural differences. Tends to think that own culture is universal and absolute.)

Cultural Incapacity
(Significant dislike and deliberate separation from other cultures.)

Cultural Destructiveness
(Wants elimination and destruction of other cultures.)



Source: Cross, T.L., B.J. Bazron, K.W. Dennis, and M.R. Isaccs. "The Cultural Competence Continuum." *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* Washington, D.C.: Child and Adolescent Service System Program (CASSP), Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, 1989; p.13.

Becoming More Culturally Competent: Tips for Providers

Providers who are truly committed to their patients should always strive to be as culturally competent as possible with their minority clients. However, providers should also remember that culture is only one of the many factors that influence the health status of a patient. Age, gender, income, literacy, educational background, lifestyle, individual personality and many other issues are equally important to assess when trying to gain a complete understanding of a patient. However, in general, health providers can follow certain fundamental practices when trying to become more culturally sensitive, regardless of what ethnic group they may be serving. They include the following:

- Be aware of, and sensitive to, your own cultural values and beliefs as a provider, and recognize how they influence attitudes and behaviors.
- Be aware of, and sensitive to, the cultural values and beliefs of patients, and how they may influence client attitudes and behaviors.
- Be aware of the historical events that have affected particular ethnic groups, and understand how oppression, discrimination and stereotyping currently affect people differently both professionally and personally.
- Be aware of specific knowledge and information about the particular cultural groups you are serving, especially when it comes to their traditional health practices, attitudes and perceptions about various conditions.
- Determine what general style of communication is most common within a particular culture, and try to emulate it so that your patients relate better to you. For instance, some cultures value a more direct, open style of communication, while others tend to be more verbally passive and indirect. Cultures that are more passive may not openly share as much health information with you, so you may need to probe gently with open-ended questions to ascertain a patient's condition.
- Try to be aware of specific cultural "taboos" that apply to a particular ethnic group with which you may be working. For instance, most Jews and Muslims should not be encouraged to follow diets that include pork.
- If you work with patients that do not speak English as their native language, make an effort to learn at least a few introductory phrases used by them in their culture. This simple act can go a long way to establishing a friendly and trusting rapport between a provider and patient. Some of the best words to learn to say in a foreign language are hello, goodbye, how are you, thank you and please.
- Take the time to ask a lot of questions of your clients and listen actively. Try to treat the entire patient in a holistic manner, rather than just focusing on a particular disease. Learn about the culturally specific risk factors, signs, symptoms, barriers to prevention and methods of treatment that relate to medical conditions affecting minority patients.
- Recognize that diversity within cultures and individuals is often greater than the diversity between cultures.
- Learn more about various cultural communities through a) interacting informally with individuals of a different culture; b) actively listening to their stories when talking with them, even if they are not health related; c) discussing with individuals of a similar cultural background about how your culture impacts your experiences in society; d) participating in cultural diversity workshops and cross-cultural community events; e) reading articles and books on cultural dynamics; and f) consulting with cultural advisors in your community as situations arise.
- Be humble, genuine and willing to learn. Know that you will often make mistakes. Don't be afraid to apologize and ask why you may have offended someone. Most individuals around the world, no matter what their ethnic background may be, will respond positively to sincere, kind and respectful behavior from others, regardless of whether a particular "cultural taboo" was broken.

Making Health Organizations More Supportive for Minority Patients

Just as there are multiple strategies that individual health providers can undertake, health organizations can also adopt a variety of deliberate strategies to become more culturally effective with minority and immigrant patients. They include the following:

- Health agencies should work together with other organizations in their local community to help provide a welcoming environment for refugees and immigrants. Hospitals and clinics can join schools, law enforcement, social service agencies, houses of worship, city councils and the like in sponsoring town hall meetings, diversity information sessions and other such services to help prepare local residents for any impending arrival of significant numbers of refugees and immigrants to a community. This welcoming environment should also include outreach services for existing minority populations as well in the community.
- In order to reduce linguistic barriers to care, health programs should be conducted in the native language of the minority clients that are being targeted for service. Translators that are native speakers of the foreign language are usually preferable over those that just speak it as a second language.
- In order to reduce cultural barriers to care, try to staff your facility with at least some personnel who are members of the same ethnic minority groups as the patients. These multicultural staff members should be spread throughout your agency as integral workers, and not function merely as translators. They should be represented throughout the front office staff, support services and healthcare provider departments in your agency.
- As often as possible, deliver health care services on-site where minority and immigrant populations live, work, study, play, worship, shop and celebrate. Most minority groups in Iowa and the United States significantly underutilize healthcare services. Programs that can be delivered on-site tend to be much more effective. Consider conducting screenings, vaccinations and preventive education programs, for example, in schools, immigrant trailer parks, church lobbies, laundromats, ethnic markets and festival sites for increased access.
- Provide healthcare services at non-traditional hours. Many minority and immigrant patients are lower-income, and work at multiple jobs. Medical offices that are only open Monday through Friday, 9 a.m. – 5 p.m., are likely to miss serving large numbers of minority clients. Consider having flexible scheduling on weekends and nights.
- Allow extra time for patient visits when working with many minority and immigrant clients. Many of these people come from non-western backgrounds that place greater emphasis on face-to-face interaction and do not appreciate being rushed through a medical visit. Many of these clients will present with multiple conditions as well, and will require more than a standard 10-minute visit for care.
- Many non-western cultures place less emphasis on a strict sense of time, in comparison to mainstream American culture. Appointments and scheduling may need to be flexible when dealing with refugee and immigrant patients in particular, who may not necessarily be willing or able to show up at an exact time on a precise day for care.
- Recruit minority and immigrant members to serve actively on hospital boards, non-profit advisory councils and other external decision-making entities. If they cannot be active on such boards, at least have cultural interpreters in the local community periodically review programs, written material and policies developed by the health agency for minority-friendliness.
- Provide extra assistance to refugee, immigrant and some minority patients who may have limited understanding of the complexities of receiving healthcare in the United States. Many newcomers, in particular, come from countries with excellent national healthcare systems, and

they are not used to having to pay for services, utilize insurance or fill out claim and aid forms.

- If your clients are very diverse, make sure that signs in your hospital or healthcare facility are posted in multiple languages. Also have available written health education material and payment forms that are in the native languages of your clients. When distributing written material with illustrations, it is important to have any photographs or drawings culturally specific as well.
- Have all staff in your facility participate in periodic diversity trainings and refresher courses. Remember that most patients from non-western cultures place a great deal of emphasis on the word-of-mouth reputation of your healthcare organization. They will care less about fancy marketing brochures than they will about what other minorities say about a particular doctor, hospital or agency. Make sure that all staff, even your front office workers, is trained in how to work effectively with immigrant and minority clients, in order to make their experience more positive.
- Health agencies in Iowa should draw upon the immense amount of data, studies, brochures, materials and other sources of information on minority, immigrant and refugee services that already exist from public health organizations in large urban and border states, as well as federal and international sources. Too often, provider agencies in small rural states feel overwhelmed by minority health issues and often think they must create culturally appropriate programs on their own. Many other states and countries have been actively addressing minority, immigrant and refugee health issues for decades and have a wealth of experience and resources to share. (Please refer to Part IV of this manual for further links.)

Public Health Planning for Newcomer Populations

Local public health agencies are often charged with trying to plan short- and long-range services for communities in their district who may be facing sudden influxes of large numbers of refugees and immigrants. This situation often happens if a new meat packing plant has moved into a community, for example. Many health agencies in small rural states like Iowa often feel drained and overwhelmed in trying to determine what their health priorities should be for these newcomers. However, extensive public health research around the world indicates that these medical concerns are fairly predictable and follow general patterns. Public health planners should be aware of the health priorities for intervention that are typically needed by newcomer populations and their host communities:

Upon first arrival in a new community, public health interventions are as follows:

- Conduct a rapid public health assessment as soon as possible to determine the general demographics of the newcomer population. This should include getting a general estimate of the total number of new arrivals, as well as the general breakdown of people by age groups such as infants, young children, youth, teens, young adults, middle age adults and seniors. This information will also need to be split by gender. The overall health condition of the population should also be assessed through any incoming medical records or rapid health assessments of their overall condition in order to determine what existing medical conditions are most prevalent. Of course, it is also important to know the socioeconomic background of the newcomers, such as their general literacy level, reason for arrival, economic history in former country, etc.
- Control any infectious diseases such as tuberculosis that may be brought in by newcomer populations that are arriving directly from refugee camps or poor countries. This is necessary for the immediate health of the newcomers, as well as to protect the well-being of the host community.
- Triage your population of newcomers into high, medium and low priority for health interventions. Usually, pregnant

and lactating women, young children, the handicapped and the elderly are considered at highest risk initially.

- Work collaboratively with other agencies to ensure adequately meeting the immediate needs of newcomers in areas such as housing and food. Local health departments should already have been working closely with the city council, churches, schools, law enforcement and other organizations to address some of these needs and help prepare the community prior to the arrival of the newcomers.
- As time progresses and the immediate needs of newcomers have been met, public health activities shift to the following:
- Conduct public health interventions to address any negative lifestyle practices that will contribute to future chronic diseases. For instar ce, many immigrants arrive in the United States with dietary and exercise patterns that are better than those of local residents. These positive practices should be promoted and maintained. All too often, as immigrants acculturate, they become more sedentary, eat more processed food and decrease their consumption of fresh produce in the United States. Diabetes is one of the most common chronic diseases that develops in immigrant populations as they acculturate. At the same time, many arrive with smoking rates that are much higher than those found in the general population, so tobacco reduction programs would be appropriate in that case.
- Implement programs to reduce unintentional injuries and promote safety. Many newcomers work in lower paying, dangerous jobs with high rates of accidents. Others may not be aware of American laws requiring car seats for children or smoke detectors in apartments, and will need educational programs and consumer health training.
- Provide coordinated, culturally appropriate mental health programs and early intervention projects. Most immigrant populations experience some level of mental health challenges. These health problems will vary greatly by individual, age and gender, as well as by the reasons that caused the immigration to occur. For instance, voluntary economic migrants usually suffer from depression less than refugees, who were involuntarily forced to migrate due to political persecution or war. Also, many of the elderly have more difficulty than younger people in acculturating. Many immigrant parents often experience stress dealing with their children, as traditional social roles change dramatically with acculturation. Likewise, many newcomer men come from cultures where male verbalization of feelings may not be acceptable, or mental health conditions carry a negative stigma. In general, it is normal for many newcomers to experience some levels of anxiety, depression, acculturation stress, and even post-traumatic stress disorder for at least some time. Some conditions can remain for years if not addressed properly. Family reunification is often the single most important factor that can improve mental health status.
- Implement dental health assessments and treatment programs. Although many newcomers come from countries that had excellent national health care systems, most had relatively little access to good dental care. Newcomers will need dental health assessments and access to primary dental care. Providers should expect to see significant numbers of fairly complicated cases and untreated conditions.

Working Effectively with Translators

Many health providers today in Iowa are finding that they must increasingly work with translators in order to provide their services to immigrants, refugees and some minority populations. Even if providers are unfamiliar with a specific ethnic minority population, they still must be at least minimally competent at working with interpreters. This is a skill that must be learned and practiced. All too often, for example, a clinician may explain lengthy, complicated directions on how to take medication, only to find that the translator summarized the comments into just a few words. At the same time, many minority patients want to have detailed discussions with their providers about their conditions, but find that the clinicians are not using the interpreters effectively to

solicit this information from them. Increasingly, then, health facilities in Iowa should employ translators and train their staff to work effectively with them. The following are general guidelines for utilizing interpreters in a culturally competent manner:

- Never speak more than a sentence or two before stopping to let the translator interpret your statement. Avoid the very common mistake of explaining a large amount of information in English, and then waiting for the translator to interpret. Usually this will result in a large amount of missed information.
- Remember to speak to the patient, not the translator. The patient should be the focus of your attention. The translator merely acts as your voice in the second language. Maintain eye and body contact, if appropriate, with the patient rather than with the interpreter.
- Validate the information that your patients are receiving from the translator. Ask the patients to explain back to you, through the translator, whatever information has been shared. Ask frequent questions to confirm understanding.
- Do not forget to use expression and passion in your presentation if appropriate in a health education talk with patients, even if they do not understand your words. Encourage the translator to also use the same expression in her presentation.
- Regardless of the translator's presence, try to make at least some "small talk" with the patients, particularly at the beginning and end of each visit. Most will understand hello, thank you, etc. in English. Likewise, you should learn a few basic friendly phrases or words to share with your clients in their native languages. Smiles, respectful behavior and a friendly attitude by providers will carry over in any language.
- In general, speak slowly and carefully in English when working with translators. Use simple, plain English, avoid slang, fancy medical terminology and other types of speech that can easily be confusing for clients and interpreters alike.

- Repeat key words, phrases and medical instructions frequently to ensure that the patients understand them. If patients do not understand, try to explain the information in a simpler, more practical way. Do not speak more loudly as if they are deaf or stupid; they are not. More than likely, the fault is with the provider who may not be explaining things carefully.
- When teaching patients that are not native speakers of English, rely heavily on demonstrations, visual aids and culturally appropriate models to teach them. If using models, it is best to use real items instead of replicas to teach them. Incorporate the patients into any demonstrations you may be conducting.
- When working with larger numbers of patients in an audience format, allow them adequate time to translate health information for each other. Always ask simple questions to validate their knowledge.
- Where possible, avoid using young children or other family members to translate. Confidential health information is less likely to be shared by the patient to the provider in these cases. Likewise, these informal translators may not protect the confidentiality of the patient among other extended family members and friends in the ethnic community.

Working with Low-Literacy Clients

Many refugee, immigrant and even minority populations in the United States and Iowa will have limited written skills in English. Depending on their backgrounds, they may also be unable to read and write in their native language. This will greatly affect their ability to access health care and to use it effectively. Indeed, literacy is one of the strongest, most direct predictors of health status and poverty. For that reason, some of the most effective public health programs for immigrants, for example, actually incorporate literacy and economic development together with health, in order to provide comprehensive solutions to their well-being. As

providers are increasingly working with these low-literacy populations, they should follow the general guidelines below. Health workers should remember that even though some of their patients may not be literate, it does not mean that they cannot learn how to improve their health status.

- Maintain a respectful, non-judgmental and confidential approach when working with low-literacy patients. Although some may come from cultures where low-literacy is the norm, this will often carry a negative stigma in the United States. Health organizations dealing with many immigrant patients may want to advertise the availability of literacy and English language classes in the local community for their clients.
- Utilize the patient's native language, in an oral context, when conducting health visits. Avoid relying heavily on written brochures, pamphlets and hand-outs, even if they are in the native language of the patients.
- Incorporate ample opportunities for hands-on, interactive health education in non-traditional means with low-literacy patients. This can include using tools and methods such as real props, visual aids, art therapy, songs, dance, skits, murals, demonstrations, simulations, role-playing, games, poetry, weaving, quilting, storytelling and the like. Many of these "unusual" methods of teaching a health topic are actually very normal in many non-western cultures, and are quite culturally appropriate for many groups, depending on other factors like age and gender.
- Make sure that patients validate back any information that is presented to them by a provider. For instance, a doctor may ask the client to repeat the prescription instructions he has just given, and a health educator may ask a senior refugee to demonstrate the technique she has just learned for injecting herself with insulin.
- Provide all information in a clear, logical, step-by-step manner for clients.
- Make sure that all verbal material like foreign-language public service announcements, radio shows, television spots and the like have been pre-tested by members of the specific ethnic group you are targeting. Many have not been translated by native speakers and often contain glaring mistakes.
- Do not assume that low-literacy patients will automatically understand all visual information provided to them. Many of these clients are also "visually illiterate," and have difficulty interpreting the meaning of pictures, posters, illustrated brochures and the like. These materials should be used as a last resort, and should always be pre-tested before incorporating them into a health education program.

Understanding Traditional Health Practices

The World Health Organization estimates that up to 80 percent of the world uses herbal medicine and other forms of traditional healing as their primary form of healthcare.

Most of these traditional health practices have been utilized effectively for hundreds, and even thousands, of years among many cultures. These healing systems are quite different from those used by Western medicine as many Americans know it. It is important to remember when working with people of different cultures that they may or may not have a completely different set of health beliefs, practices and attitudes than those of providers in the dominant culture.

Traditional health practices around the world are far too numerous to discuss in a guidebook such as this, and are usually culturally specific. Providers who will be working extensively with a particular immigrant or minority group should take the time to listen to their patients carefully, ask many open-ended questions about these issues, and do further research into the traditional health practices typically utilized by that population. In general, the following information is helpful to understand when trying to work cross-culturally and be respectful of traditional health systems:

- When working with minority populations, make sure that you take the time to know the culturally specific risk fac-

tors, signs, symptoms, barriers to care and preferred methods of treatment for that particular group. Public health studies consistently show that this information varies dramatically by race and ethnicity.

- Recognize that most cultures around the world, even in Europe, have had a very long history of understanding health and practicing healing in a very holistic way. The Chinese and Indians, for example, have extremely advanced written manuals on herbal medicine, manipulation of the human energy field and other related topics that are thousands of years old. Today, modern medicine is confirming scientifically what many of these practitioners have known for generations. Many Europeans also practiced traditional forms of healing for centuries, even though much of this knowledge is now lost in the West, particularly in the United States, with the medicalization of health so common in the 20th century.
- There are a variety of people who perform traditional healing services in many cultures around the world. At a minimum, they include people such as shamans, medicine men, wise women, bonesetters, lay midwives, psychics, energy healers and others. Unlike in Western medicine, most of the people are not specialists, but rather approach health from a very integrated and holistic perspective.
- Although traditional medicine practices and beliefs vary greatly by culture and subculture, in general they have a number of things in common. They are usually very holistic in that they strongly combine physical health with mental, emotional, spiritual, environmental and other levels of well-being. Western medicine is Newtonian in its perspective, in that disease is separate from the body and treatments are intrusive. In many traditional practices, however, the human body, as well as that of all natural things, is believed to be surrounded by an energy field that is connected to the life force of the universe. These energy fields vibrate in an aura, and can be felt and even seen by highly sensitive people like medicine men and women healers. Poor physical health is usually considered to first be the result of an energy field imbalance in a non-physical layer, which weakens the body and allows disease to set in. Healers of various forms using different modalities will manipulate this energy field, cleanse it, unblock it and rebalance it in order to bring wellness to the patient. In the traditional view, health is not the absence of disease, but is viewed as complete, full balance within all of these elements. All things in the universe, both living and non-living, are usually considered to be one, and are highly dependent on each other to maintain a balanced and well state. The human body must therefore be well balanced and healthy in order to be properly aligned with all other elements of the universe. It is interesting to note that this "traditional" understanding of health actually correlates strongly with many of Einstein's modern theories on energy, matter and light.
- There are many different modalities of traditional healing that are used by practitioners in many cultures. These can range anywhere from herbal treatments and homeopathic remedies to rebalancing the human energy field and intuitive medicine. Acupuncture and yoga are two well-known forms of energy field manipulation in the West that have been borrowed from Eastern countries. While Western medicine excels at getting rid of symptoms that have manifested in the physical body, traditional healing typically excels at addressing the root causes of poor health, which may have been caused by emotional or psychological distress.
- No matter what traditional practices are utilized in a culture, a good health worker should always try to learn about them and their rationale for usage. More and more, modern scientific medicine is confirming that the basis for many of these treatments is sound. Health practices can generally be categorized into three categories: positive, neutral and negative. Those practices that have positive or neutral effects on patients should be encouraged and

utilized together with Western medicine when appropriate. No matter what your personal beliefs are about traditional medicine, be respectful of others and do not ridicule clients.

PART III:
The Cultural Communities

The guidelines provided in the previous section are designed to be general recommendations for providers and their organizations when working with immigrant, refugee and minority populations. If followed carefully, they will greatly improve a clinician's ability to work more effectively with minority patients. However, in order to truly improve cultural competency, providers must gain a further understanding of the specific characteristics that are common in particular ethnic groups.

The information provided in this section will introduce some of the fundamentals of working with specific populations. This information is to be used only as a general guide and as a starting point for providers trying to learn basic cultural competency points. All people are ultimately individuals and this information is not meant to stereotype any group. Remember, as stated previously, culture is only one factor that influences a patient's behavior and health status. In an effort to be culturally competent, providers should not ignore other fundamental factors like gender, age, lifestyle, education level and individual personality traits in their patients that are equally important.

Finally, the information provided in this section is meant to be only an introduction to a particular cultural group. Ultimately, providers must be willing to immerse themselves in working with people of diverse backgrounds over a regular period of time in they truly wish to improve their cultural competency.

LATINO POPULATIONS

Overview:

- Latinos now represent the largest minority population in the United States, surpassing even African Americans, according to Census 2000 figures. In fact, the U.S. Census Bureau indicates that the Latino population grew by nearly 5 percent to 37 million residents between April 2000 and July 2001 alone, or twice as quickly as the African American population which grew at only 1.5 percent or the general U.S. population at 1.2 percent during that same time period. In California, there are now more Hispanic babies born than white babies. This demographic change is occurring throughout the country, particularly in urban areas and border states. However, rural states like Iowa have actually seen the greatest increases in Hispanic population growth by town in the United States, where some communities have increased their percentage of Latinos by 700 percent or even 1,200 percent over the past decade. Most Hispanics in the state are new immigrants, although others have been here for generations.
- Providers should recognize the tremendous diversity within Latino culture. Hispanics can come from many different countries, including Mexico, Cuba, Puerto Rico, Spain, Argentina, Venezuela and many others. They represent one of the world's largest groups, as they represent most of the Western hemisphere, other than the United States and Canada, and also include parts of far western Europe. Providers should avoid lumping all Latinos into one group, as their cultural practices and dialects can be quite unique.

Language and Religion:

- Most Hispanic newcomers speak Spanish as their primary language, although dialects vary by ethnic group. Also, upper class and lower class Hispanics from many regions will often speak somewhat different forms of Spanish.
- "Latino" usually refers to someone from Latin America, in the Western hemisphere. "Hispanic" usually refers to people who speak Spanish. The United States government considers Hispanics to usually be racially white, although of Spanish-speaking origin. Both terms, Hispanic and Latino, are often used by people of this ethnic group.
- Most Latinos in Iowa practice some form of Christianity, with the majority being Catholic. Many Catholic parishes have now instituted special Spanish-language masses for their new Latino parishioners. Some Latinos may also combine Catholicism with elements of traditional indigenous spirituality from their native culture.

Family and Social Structure:

- Latinos are well known for their extremely strong tradition of family and extended family. Cousins, for example, are as valued as siblings, while aunts and uncles can serve as second parents. They tend to have tremendous family support, and fairly strong identity of their roles within family by age and gender.
- Latinos place great value on their children and tend to be very loving towards them. At the same time, age is highly respected and elders are valued for their knowledge and value to the family. Young physicians, for example, should always treat elderly Latino patients with great respect.
- Although it varies greatly by region, most Latino culture places great emphasis on pride, self-respect and family honor. This is particularly true among males.

Communication Style:

- In general, Latinos are an expressive, warm and hospitable group. They tend to have closer body spacing and eye contact with others. They will also often use more humor, expression, touching and emotion in their communications than do white Americans. Health providers should try to emulate this warmer style of communication so as to work more effectively with them.
- Face-to-face interactions and family connections are valued in this culture. Health facilities that feature fancy written

marketing materials and the latest medical technology will often be less successful than those smaller facilities that feature warm, outgoing staff and caring personnel. Many referrals are made by word-of-mouth, particularly in immigrant communities.

Barriers to Care and Common Health Concerns:

- Money, language and transportation are usually cited as the major barriers to care for Latinos in Iowa. A large percent of the newcomers do not have health insurance and lack adequate personal finances to pay out-of-pocket for medical care. Spanish language interpreters are also difficult to find. Because they often work at two or more jobs, many Latinos will have difficulty using health facilities if they are only open from 9 a.m. to 5 p.m. when they are working. Most are not located close to where they live and transportation for them is usually very limited.
- Diabetes, occupational injuries, dental care and acculturation stress are but some of the more common conditions that Latino newcomer patients will exhibit. Although this is changing, many of the Latinos in Iowa are younger males who are working here to support families back in their home countries. As such, male health concerns are a priority in this group, if their families have not accompanied them.

Bereavement:

- Bereavement practices will vary among Hispanics by the country and culture of origin. If the Latino patient is Catholic, as most are in Iowa, a priest should be notified if the patient has died or is in very serious condition. The priest will offer special prayers for healing, as well as perform "last rites" on a dead patient. Many parishes have priests that speak Spanish and are charged with Latino outreach.
- Large gatherings of extended family and friends are common at many funerals, with grief openly displayed.

Cremation is generally not common among this group. In many Latino cultures, the souls of the dead are remembered and honored regularly through religious and community celebrations, such as "Day of the Dead" parades and festivals in Mexico, which usually occur between October 31 and November 2. Children are often given candies in the shape of skeletons, teaching them not to fear the dead.

- Pregnant women are usually prohibited from caring for the dying or attending funerals in some Hispanic cultures.

Traditional Health Practices:

- Learn about and honor the traditional health practices and beliefs of these groups. Many individuals, particularly those of more rural indigenous backgrounds, will practice various traditional medicine methods such as herbal healing and others. Curanderos, for instance, are traditional healers in Mexican culture. Many Latinos, particularly those that are older, will want to combine their traditional health practices with Western medicine.

AFRICAN AMERICANS

Overview:

- African Americans have experienced a unique history as a minority population in the United States, and this experience has profoundly affected their socioeconomic and health status. African Americans were the only major ethnic group that came to the Western Hemisphere against their will. They comprise one of the largest forced migrations of humans in history. In most cases, they were taken from their homes or were prisoners of African wars; separated from their families; spent time in slave dungeons in West Africa; transported in cramped quarters on ships across the Atlantic where many of them died; and then sold to plantation and business owners in the New World.
- African Americans were generally forced to convert from their traditional religions, kept uneducated, and were treated as property for decades in the United States. It was only about 140 years ago in parts of America that slavery was still legal. It was only about 30 years ago that blacks in many areas of this country, particularly the south, were completely segregated from whites by law in housing, education, and jobs.
- The historically negative relationship between the dominant population in the United States and the minority African American group has had significant impact on the health status of blacks in the country and their use of services. From a public health standpoint, it is no coincidence that African Americans and Native Americans, the two minority groups that have had the worst historical relationships with the majority population, continue to have the lowest health status in the country.

Language and Religion:

- Because their families have been in the United States for centuries, most African Americans speak English as their native language. A number of subtle black dialects exist, though, in the country that are unique to urban inner cities or rural Southern communities.

- Most African Americans practice some form of Christianity in the United States. Many, particularly those who migrated to Iowa from the South, are Baptist. The percentage of Black Muslims has also been increasing, though, in the United States and Iowa, particularly among younger males.

Family and Social Structures:

- The family is the foundation of African American society. The family usually revolves around the mother, her elders and siblings, and her children. Fathers may not necessarily live with the family, particularly if they are lower income and the children were born out of wedlock. Families, in general, tend to be large and caring. Black women are especially recognized for their strength and nurturing tendencies.
- Although African Americans as a group have lower income levels than most other minority populations in the United States, the African American middle class is expanding rapidly in the country. Black women, in particular, have made great strides and many have become financially successful, although young black males continue to lag behind as a group.
- Many predominantly black communities throughout Iowa are organized into neighborhood associations, which are often associated with a particular local church. These neighborhood associations are often active socially and politically in the community. Health providers and organizations should take the time to meet the leaders of these neighborhood associations, talk to their residents, and incorporate them into outreach programming. Many health services for blacks will be utilized heavily if they are provided on site in church basements, schools, neighborhood centers and the like.
- Most African Americans are much more likely than whites to want to take care of ill relatives and friends at home, rather than send them to formal providers or nursing homes.

Communication Style:

- In general, many African Americans are more openly expressive than European Americans. They will often display more direct eye contact, closer body spacing and a higher level of physical touch than many whites. Verbally, they may be more likely than whites to share their opinions openly or ask questions directly. They may also display a higher level of verbal emotion and expression than European Americans. When conducting health education programs, adjust to these cultural nuances and use interactive activities that allow ample opportunity for discussion, problem solving and hands-on learning.

Barriers to Care and Common Health Conditions:

- Cost is generally the greatest barrier to care for African Americans in Iowa and the United States.
- Some public health studies have also shown that blacks, as a whole, are less trusting of the American medical system and its providers, who are primarily white. This mistrust is a very important cultural barrier to care, and should not be underestimated. Many African Americans, even those that are highly successful and educated, feel that the historical legacy of slavery, institutional racism, legal segregation, unethical scientific experiments, racial profiling and other human rights abuses over the past several centuries has significantly damaged black-white relationships in the United States, and will require additional time and effort to reconcile. As such, many African American patients question the methods and motives used by white providers and health organizations that provide them with care, and blacks will often be particularly sensitive and insulted by poor treatment from white providers.
- Providers should recognize the implications that the legacy of slavery and discrimination has had on the health status of African Americans. Because it has only been in the last few decades that legal discrimination has been less common, a number of factors combine to put African Americans at very high risk for poor health. As a group, their health status is among the worst in the nation, with significantly higher morbidity and mortality rates for almost all diseases and injuries. Some of these figures are due to genetic factors, but most are a result of higher poverty and unemployment levels, lower education and literacy levels, institutional racism, more single-parent families, limited financial and cultural access to health care and lifestyle factors. Blatant as well as more subtle forms of discrimination likely contribute to higher levels of stress among African Americans, which can negatively affect their health status as it relates to hypertension, low birth weight, headaches and other conditions.
- Blacks are disproportionately represented among those on federal or state medical assistance programs, as well as among the unemployed and underemployed.
- African Americans are much less likely to access health care in a timely manner in Iowa and the United States. They often enter the system when their medical conditions are more complicated and pronounced. Early intervention programs are best provided on an outreach basis in schools, neighborhoods, churches and other locations where African Americans already are, rather than waiting for them to come to clinics for care.
- Common health concerns include hypertension, diabetes, breast cancer, unintentional and intentional injuries and others based upon demographics. They experience much higher morbidity and mortality rates for many diseases when compared to the population as a whole in the United States.

Bereavement:

- Bereavement practices will vary somewhat among African Americans, depending on the form of Christianity the patients practice. In general, many African Americans are deeply spiritual, and place great emphasis on their Christian values. The patient's minister or other religious leader should usually be notified in the case of serious illness or death.

- African Americans typically have a strong belief in the afterlife.
- Large numbers of extended family and friends, particularly women, will likely visit patients that are ill or have died. Visitors may be visibly upset about the condition of the patient. Open displays of emotion are common and acceptable bereavement practices for this culture.
- In some cases where the communication between health providers and family members has been poor, visitors may be suspicious about what caused the death or illness of the patient.
- Cremation is less common among African Americans than it is among whites.

Traditional Health Practices:

- Public health studies clearly show that African Americans as a whole often have different health beliefs and attitudes about various medical conditions than do whites or other ethnic populations. Providers should take the time to really listen to their minority patients and try to understand why they may feel a certain way about a condition.
- In general, African Americans have been shown to have a higher external locus of control than European Americans. In other words, while whites may feel that they personally can control many things in their own lives, blacks are more likely to feel that factors other than their own behaviors are the cause of various life events. Providers will need to help their African American clients develop a sense of empowerment and personal involvement with their own health.
- African American cultures, as well as that of many other non-Europeans, generally believe in a higher sense of fate and destiny as they relate to health and other issues.
- Faith and spirituality play an extremely important role in the lives of most African Americans, and are significant sources of strength in times of illness and poor health.
- Because many African Americans have been shown to have a general distrust of white physicians and of the medical community in general in the United States, providers should actively focus on developing trusting, warm and respectful relationships with their African American patients.
- Africans, when they were first brought to the United States several centuries ago, carried with them a wealth of knowledge regarding traditional healing through herbs, rituals and spirituality. Much of this direct knowledge from West Africa was eventually lost throughout the years, although many continue to value alternative, more natural treatments to care.

NATIVE AMERICAN POPULATIONS

Overview:

- Native Americans are among the most diverse of any minority population in the United States. The United States government recognizes more than 500 separate tribes or nations in the country. Most of these tribes have unique and highly distinctive languages, cultures and practices. Native Americans are the only indigenous population in the United States. Unfortunately, most Americans are unfamiliar with their long, rich and proud history, and have had little interaction with Native Americans.
- Native Americans can be found throughout the entire United States today. Some European and African American immigrants have family histories that featured intermarriage with Native Americans. Most Native Americans live in urban areas today, as well as on reservations and settlements. Different tribes will have different "blood quantum" rules that determine certain benefits for which individuals may be eligible, depending on the how closely they are related to a tribe.
- Like most indigenous populations around the world, Native Americans throughout their history have experienced ethnic cleansing, broken treaties, forced displacement, wars, excessive mortality from imported illnesses, legal discrimination and human rights abuses. Today, although their situation is improving, Native Americans continue to experience some of the highest death and illness rates in the country of any group, and have the shortest lifespan.
- It is difficult to generalize when working with Native Americans, so health providers should become familiar with the cultural practices of the tribe that their patients represent. In Iowa, most Native Americans are from the Meskwaki or Sac and Fox tribes.
- Providers should learn about the unique history of the tribal group with which they are working. History texts in the United States are often written from a white or American point of view, and many Native Americans will understandably have a different viewpoint of key historical events.

Language and Religion:

- Most Native Americans today speak English as their primary language, although various indigenous phrases and words are often worked into everyday speech. Some elders will still know their native language, which in Iowa would usually be Meskwaki. Sadly, many young Native Americans today do not know the language of their ancestors, and must relearn it in special cultural classes in school. Many Native American languages historically had no written form, although the Cherokee, some of the Northeast tribes and others did.
- There is significant diversity among Native Americans, even within a tribe. Some may be "pure-blooded," while others have family ancestries of intermarriage with whites, Latinos, blacks or other ethnic groups. From a religious standpoint, many will practice some form of Christianity or other religion, while others follow Native American spirituality. Others will mix both in a unique manner. Native American spirituality is not considered to be a religion that is "practiced" by indigenous peoples, but rather is a way of approaching life in a sacred and holistic manner.

Family and Social Structure:

- Most Native Americans place great emphasis on family, and genuinely love large numbers of children. In fact, the word in Lakota for children is "sacred beings." The family, rather than the individual, is the basis of Native society. The extended family is extremely important, and ultimately extends into the tribe. Aunts and uncles often serve as second parents. Depending on the tribe and population, the mother may have multiple fathers of her children, and may not necessarily live with a spouse. Most elders have input and help raise all the children in the community.

- Not all tribes are patriarchal; in fact, a large number are matriarchal. Western providers should not stereotype and assume that women have a low status in their society. Indeed, most Native cultures place great emphasis on individuality and equality and the important role that individuals play in contributing to the group.
- Tribal group consensus can be extremely important before undertaking new initiatives or projects. Health providers wishing to establish programs on reservations, for example, usually will need to meet with multiple parties and ultimately gain tribal council approval before operating, which can take lengthy amounts of time.
- Native Americans usually place great value on elders and the practical knowledge they possess. Younger providers should always treat the elders with genuine and sincere respect.
- There tends to be a strong responsibility among Native American culture to bring honor to one's family, tribe, ancestors and community. It is important not to shame the family through individual actions.

Communication Style:

- From a communications standpoint, Native American culture tends to be more reserved, thoughtful and subtle in the direct expression of feelings and thoughts. Saving face and avoiding conflict can be important in many of the tribal cultures. Ask open-ended questions and allow Native patients adequate time to respond.
- Like many non-western cultures, Native Americans generally place less emphasis on time. Non-Native medical providers should expect that not all appointments will be kept and that their patients may not call to cancel or reschedule. Flexible, open scheduling is probably better with this population if possible.
- Most Native American cultures value face-to-face informal education and interaction over written, formal information. Storytelling, particularly with younger Native audiences, can be a valuable health education tool.

Barriers to Care and Common Health Conditions:

- Many Native Americans have difficulty accessing medical care in the United States for a variety of reasons. Because many are impoverished, they have limited financial means to purchase services, unless they are provided free or at low-cost by organizations operated by the Indian Health Services or individual tribes. Transportation and geographic barriers are also significant, particularly if they live on large, sparsely populated reservations with few medical providers. Culturally, many Native Americans value their traditional healing practices and do not always feel comfortable seeking care from hospitals or white providers.
- Native Americans suffer very disproportionately from many diseases and conditions in the United States, particularly diabetes, alcoholism, accidents and intentional injuries.
- Providers will need to allow adequate time to establish a close, trusting relationship with Native American patients. Before conducting business, it is important to take time to get to know the clients as people, rather than just patients. When working on a reservation or with a clearly defined group of Native Americans, it is also helpful to be invited into the group by one or more of them. It tends to be somewhat difficult to just "break into" this culture, because of the importance of trust and personal relationships.

Bereavement:

- The bereavement practices of Native Americans are as diverse as their tribes, individual ethnicities and religions. It is therefore extremely hard to generalize for this group. Providers should make an effort to learn as much about the Native patient while he or she is still well enough to communicate, so as to avoid any cultural misunderstandings during severe illness or death.
- In general, large numbers of extended family members and friends can be expected to come visit the ill or deceased patient. If the patient or family is fairly traditional, a variety of ritual healing and purification ceremonies

may be conducted with the patient. Many of these ceremonies will be communally performed. Often, powerful herbs such as sage are burned as a method of ceremonial purification and harmonizing.

- Open expressions of grief and sadness may be somewhat reserved in this population. Indeed, mourning is not usually displayed in the presence of the patient.
- Family meetings at the end of life are helpful to determine the wishes and beliefs of the patient regarding funeral arrangements.
- The spirits of the dead in most Native cultures are honored regularly for generations. Most consider death to be merely the beginning of another journey into the next world. The patient's loved ones often have particular dietary, spiritual and behavioral practices which they must follow for set periods of time while grieving for the dead. Even if the patient is Christian, many will interweave elements of Native spirituality into the funeral, such as placing sacred herbs or prayer ribbons near the grave.

Traditional Health Practices:

- Indigenous populations around the world are known for their strong sense of connection to the earth and the universe, and their corresponding respect for all living and non-living things. They tend to understand in a very holistic manner the place of humans in the broader scheme of life. People are traditionally viewed as not being any more or less important than any other living thing, and should be responsible caretakers of the self, the family, the tribe and the earth. Before "sustainable development" was ever coined as a term in western culture, Native Americans were emphasizing the importance of not doing anything harmful to the environment that could affect multiple generations of people into the future.
- Native Americans have a well-developed traditional health system that is very holistic, combining physical, mental, emotional and spiritual well-being. Physical problems are understood as usually being caused ultimately by emotional, mental or spiritual imbalances. So, harmony and a sense of balance in all things, including mind, body, spirit and the environment, are important for wellness. As such, Native American health beliefs tend to be more circular and indirect, in comparison to the more linear "cause-and-effect" view of Western medicine. Native American healing cannot be separated from spirituality. This spirituality is different from religion, and emphasizes the interconnectedness, sacredness and balance of all things.
- Many Native Americans will combine western medicine with traditional medicine practices, like using herbal remedies, participating in a healing ceremony with a medicine man, performing ritual purification and sweating ceremonies and other practices. They recognize that Western medicine may be powerful for treating disease symptoms in the body, but generally feel that Native American healing is ultimately best for the soul. Western providers should try to learn as much as they can from the local healers that work with the Native clients.

EAST AND SOUTHEAST ASIAN POPULATIONS

Overview:

- East and Southeast Asia is home to some of the world's oldest and most highly defined cultures, many of which have existed intact for thousands of years. Large numbers of immigrants from Asia began arriving in the U.S. in the 1800s as economic migrants, where they first populated ethnic communities on the West Coast in cities such as San Francisco. They provided inexpensive labor for the U.S., and helped build the railroad across this country in conjunction with Irish immigrants. Today, Asian minority communities can be found in all major cities within the U.S. They are generally among the least integrated of many minority groups, preferring often to live in ethnic communities with others from their culture. During World War II, Asian Americans experienced intense levels of discrimination in the United States. Japanese Americans, for instance, were forced to live in internment camps in Southern California and other areas for fear that they were spies.
- A strong level of diversity exists among Asian/Pacific Islanders. They consist of distinct cultures, such as those from China, Japan, Korea, Vietnam, Cambodia, Laos, Tahiti, the Philippines, Fiji, Thailand and many other countries with radically different histories and languages. In Iowa, many Asian Americans are either Vietnamese, Laotian, or Hmong refugees who have been in the country since fleeing the war in Indochina in the 1970s. Health programs must be culturally specific for each group.

Language and Religion:

- There is no one language that is spoken by all Asian Americans. Younger Asian Americans, as well as those that have been in the United States for several generations, will usually speak English. However, many will still know the language of their original homeland, or phrases from it. This could be Vietnamese, Korean, Japanese or others. Some Asian immigrants, such as those from Laos, may know French or other European languages of the colonial powers that formerly colonized their countries. In some cases such as Chinese, a specific dialect such as Cantonese or Mandarin must be used to communicate with these patients. Most Asian Americans are highly literate.
- The religion of Asian Americans varies dramatically by ethnicity and culture. Many today have adopted some form of Christianity. Others still practice the religions that were common in the native countries, such as Buddhism.

Family and Social Structure:

- Many Asian minorities, particularly in larger communities, live in distinct ethnic neighborhoods. They tend to be distrustful of outsiders, preferring to rely on their own for assistance. Interventions are best conducted through train-the-trainer models and other programs using native providers.
- Asian Americans tend to have an extremely strong cultural value placed on the extended family. Each person, such as a parent or child, has a distinct and well-defined role in the family. Programs should emphasize the relevance to family roles rather than on the individual.
- While gender preferences in children may favor boys in many Asian cultures, women are still afforded high levels of respect from a familial standpoint. Many Southeast Asian and Pacific cultures place great emphasis on the power of women, with females often running small businesses.
- Elders are absolutely revered and valued for their age and wisdom, while young children are genuinely adored. Aging and child health programs are supported well by this group.

Communication Style:

- Most Asian cultures tend to be fairly reserved and thoughtful when speaking. They generally place high value on the importance of respect and "saving face." They take great pains not to embarrass or put others in awkward positions. Honor and politeness should be emphasized at all times in interactions. Direct eye contact, close body spacing and casual touching are usually not so common in Asian cultures, as a highly defined sense of formality exists in all relations. They tend to be less willing to openly express their opinions or feelings, particularly if they are negative.

Barriers to Care and Common Health Conditions:

- In ethnic neighborhoods, language and culture can present significant barriers to care for Asian Americans. Health programs should always be culturally appropriate for the specific target population. Many Asian immigrants are not comfortable using western medical care, and prefer to be seen by healers from their own culture.
- Today, Asian Americans have made extreme strides in their standard of living, and generally have an excellent reputation for hard work and educational achievement. Their health status as a group is usually among the very best in the country, often higher than the European American majority, because of genetic factors and positive lifestyle practices. Life expectancies are usually longer, and mortality rates are lower than those for most other cultural groups in America. However, with each generation born in America, fewer differences in health status exist.

Bereavement:

- Families often request that the patient not be told about their terminal illness or impending death.
- Bereavement practices will vary significantly by culture, ethnicity and religion among Asian Americans. If they are Christian, a minister, priest or other appropriate religious leader should be contacted in cases of serious illness or death.

- Buddhist patients believe that the soul passes through many reincarnations until it is liberated from worldly problems and enters nirvana. As such, death is simply a natural state through which all people pass multiple times. Depending on specific cultural traditions, Buddhists may hold a funeral within several days to a week after death, often with several prayer ceremonies and memorials conducted at home, a funeral parlor and a temple by a monk or priest prior to burial. Many Buddhists will favor cremation over burial.
- Large numbers of extended family and friends will likely visit the ill or deceased patient.
- In general, Asian Americans will be less openly expressive about their grief and sadness in the event of a death.
- Asian Americans usually confer great reverence and honor to the departed spirits of ancestors and regularly honor and remember them through ceremonies and offerings.

Traditional Health Practices:

- Asian traditional healing systems are among the oldest and most complex in the world. Many of these systems have been well documented for thousands of years in standardized texts. In general, they tend to emphasize health from a holistic standpoint. Rather than treating a disease symptom, like in the West, they usually emphasize maintaining balance, harmony, and interconnectedness of the body, mind and spirit. Many exercise programs in the United States today, like yoga and Tai Chi, are actually ancient Asian healing systems. Most Asian cultures have well-defined usages for many herbal remedies as well. Multiple forms of energy healing, like acupuncture and qi-gong, are used in many Asian cultures, and work on rebalancing the electromagnetic field surrounding living beings. In their health belief system, this rebalancing is necessary to remove blockages of energy that can ultimately cause illnesses and disease

RUSSIANS AND OTHER IMMIGRANTS FROM THE FORMER SOVIET UNION

Overview:

- A number of immigrants from Russia and other republics that formerly comprised the Soviet Union now live in Iowa. Many of them live in Northeast Iowa, and have recently arrived in the area as economic migrants. While they may once all have been part of the former U.S.S.R., they are nonetheless fairly diverse in a number of areas. Providers should not assume that they are all "Russian," as a number of them are actually from the Ukraine, Latvia, Belorussia or other republics.

Language and Religion:

- Most of the immigrants from the former Soviet Union will speak Russian, although they may also know the specific languages of the republics where they used to live, like Ukrainian. Health programming is best done in their native language.
- Religion will vary by ethnic group. Some Russians are quite secular, having been raised in the former Soviet Union where organized religion was discouraged. Others will practice some form of Christianity, and may be Orthodox.

Family and Social Structure:

- In general, immigrants from Russia place great value on education, art, music and fine culture. Although they may be working today in Iowa in meatpacking plants and other blue-collar jobs, many were professionals back in their home countries. They therefore will usually be fairly literate, although perhaps not in English. They will usually resent being treated by providers as "backwards" or "uneducated" immigrants.
- These Russian families usually have strong extended family ties, even though the number of children may be relatively small in comparison to other immigrant groups. It is not unusual for Russian families to pool their money together to achieve a better lifestyle. Parents may take on extra work to help support their children's education. Health programming that incorporates the entire family can be especially valuable.

Communication Style:

- Russians usually are highly verbal and fairly direct in their communications with other people. Most are extremely literate, well educated and very knowledgeable about culture, economics, world history and current affairs. They tend to enjoy intellectual conversations and may expect the health provider to discuss these issues with them.

Barriers to Care and Common Health Conditions:

- Cost, language and transportation are the most significant barriers to care for immigrants from the former Soviet Union. Many work at jobs that do not provide health insurance and few medical organizations have Russian translators. Others find it difficult to attend health clinics that are only open Monday through Friday during the daytime, since many Russians are working several jobs in meatpacking plants and have limited free time for off-site services.
- Cultural barriers to accessing care also exist among Russian immigrants. Many typically will not seek formal medical care, except in more complicated cases. They will typically use some form of self-treatment, before ultimately seeking out a physician for care if they continue to be ill. Russians usually take an active role in maintaining their own health. Mothers are particularly involved in caring for their children's illnesses with alternative therapies. Many Russian immigrant women, particularly those that studied education in universities back home, will have had significant training in primary health skills as part of their curriculum.
- In general, smoking and alcohol consumption rates tend to be fairly high among Russian immigrants and are an integral part of their culture. Many Russians, particularly

men, are able to consume relatively large amounts of alcohol gracefully, without obviously appearing to be intoxicated.

- The former Soviet Union had a comprehensive, free national health care system for all residents, and elements of this system continue today in the independent republics. Many of the Eastern European newcomers to Iowa will have little understanding of American concepts of private party insurance, fee-for-service care and other elements. Many will need assistance navigating the health care system in their new community, and will often want to seek out Russian speaking physicians if they are available.
- Mental illnesses generally carried a strong negative stigma in the former Soviet Union, where these conditions were often treated by forced institutionalization under KGB supervision. They were often not even discussed among families with members suffering from various conditions. Many of the Eastern European immigrants will therefore be reluctant, still, to openly admit to feelings of depression, anxiety, acculturation stress and other mental health challenges that are very normal among newcomer populations. Providers should be aware that these conditions may exist in their patients and may need to approach this subject tactfully and with full confidentiality.

Bereavement:

- For those Russian immigrants who are Orthodox, most believe that death is a necessary consequence of life, and that they will achieve eternal life in heaven if they have lived appropriately.
- Orthodox religious leaders typically hold a special vigil over the deceased, called panikhida. This special contemplative time includes prayers, hymns (tropar'), chants, frequent repetition of the name of the deceased and readings from the Gospel.
- Large numbers of family members and friends will likely visit the seriously ill and deceased. They may join in special prayers for the dead to ask for mercy on the soul of the deceased patient.

- Burial of the body is far more common than cremation. However, cremation is not prohibited. Many Russian immigrants will opt to be cremated in the United States, so that their ashes can ultimately be transported back home to Russia.

Traditional Health Practices:

- Russians from the former Soviet Union have a long history of using traditional herbal remedies for care, which they often did in conjunction with their standard western medical treatments. Many elderly Russians continue to have a strong interest in utilizing herbal teas, alcoholic tinctures and other methods of treating disease and promoting health. While Americans may consider this "alternative" medicine, providers should remember that these forms of traditional care were greatly respected and used by generations of Russians.
- Most Russians actively practice some form of self-care, unrelated to what they are doing under the order of American physicians. For example, many younger immigrants from Russian commonly use homeopathic remedies to treat themselves. Also, many of these immigrants will bring medical kits with them from Russia that contain a variety of drugs to treat general ailments such as headaches, indigestion, bacterial infections and the like. Most of these medicines are available over the counter in Russia, but would require prescriptions in the United States. Iowan medical providers should always respectfully seek to understand what types of self-treatment may be practiced by their Russian clients.
- The main goal of health care in the former Soviet Union was usually finding the root causes of a particular disease or condition. Many Russian immigrants to the United States feel that American doctors, on the other hand, place too much emphasis on treating the disease, rather than trying to understand its causes from a more holistic standpoint. Most Russian patients will want to have active discussions with their providers about what caused their ailments.

BOSNIANS AND OTHER REFUGEES FROM THE FORMER YUGOSLAVIA

Overview:

- Many immigrants from the former Yugoslavia, particularly Bosnia, now reside in Iowa. Many of them came in the mid-1990s as war refugees, and were granted legal permission by the United States government to resettle throughout the country. Many of the Bosnians here in Iowa are actually "secondary migrants," as they first resettled in other areas like Utica, New York, before eventually moving to Iowa. Most are drawn to the state by jobs in the meatpacking and agricultural processing industries, and by Iowa's peaceful, rural, family-oriented lifestyle.
- Health providers should understand that Bosnians, unlike many other immigrants to Iowa, and generally classified legally as true refugees. This means that they were forced to flee their homeland due to ethnic conflict and did not come voluntarily to the United States like economic migrants. Many would prefer to be back in Bosnia if the political situation was different and they generally resent people who think they came to America looking for work.
- Bosnia is quite well developed and cosmopolitan. These newcomers will resent providers that speak down to them and imply that the Bosnians came from a "backward" country.

Language and Religion:

- Bosnia was one of the six republics that made up the former Yugoslavia and was the most ethnically diverse. Most of the Bosnians in Iowa speak Bosnian, which is similar to Serbo-Croatian.
- Most Bosnians in Iowa are Muslim. Although they are Muslim, most are fairly secular in their practices. Providers should be familiar with Muslim practices, though. However, they should not assume, for instance, that Bosnian women wear veils and long dresses. Most Bosnians do not eat pork, celebrate Christmas or attend churches.

Family and Social Structure:

- Bosnians place a great deal of value on extended family ties. Many have now been successful in bringing additional family members, such as grandparents, to the United States. Grown children are usually excellent caretakers of their elderly parents and do not like to put them into nursing homes. Likewise, young children will usually give great respect to their elders. Public health programming should target the entire family unit rather than just the individual.
- Most Bosnians are very well educated and highly literate. Not all will know English, though, upon arrival in the United States, and will still prefer educational programs in their native language.
- Many Bosnians were professionals back in their home country. In fact, most were doctors, nurses, teachers and business leaders. They will greatly resent being spoken down to by American health workers. Many would like to resume their professions in the United States, particularly as medical providers, and should be utilized in refugee programming.

Communication Style:

- Most Bosnians value a warm, open, direct and respectful form of communication with others. Bosnians are also well known for their sense of humor and positive outlook on life.

Barriers to Care and Common Health Conditions:

- Because they are classified as refugees, most Bosnians qualify for a number of special federal and state benefits in the health, business and human service sectors. They are generally legal residents in Iowa. While they may financially be able to access health care here, not all health organizations have Bosnian translators available or personnel trained in how to work with refugee populations.
- Because they are true war refugees, many Bosnians have

experienced extremely difficult circumstances prior to arrival in the United States. Many lost their homes and livelihoods and most have close family members and friends that died in the war. Some were deeply traumatized by ethnic cleansing, war injuries, torture, group rape and other human rights abuses.

- Significant mental health challenges such as depression, anxiety and post-traumatic stress are common human reactions to uncommon circumstances. Health providers should expect to see higher rates of these conditions in Bosnian refugees than in the general population of immigrants. However, mental health conditions often carry a negative stigma with them in Bosnian culture, and so many are reluctant to discuss them with providers. Mental health providers should be trained in the complexities of dealing with war refugees. Clinicians should not push a trauma victim to share feelings or experiences until he or she is ready. Providers can only provide gentle, ample and supportive opportunities for them to do so.
- Bosnians generally have high rates of smoking and drinking alcohol, as they are integral cultural practices. Newcomers may not be familiar with American laws prohibiting the purchase of alcohol by children for their parents, and they may have some difficulty getting used to the anti-smoking mentality in the United States. Second-hand smoke and prenatal smoking are often issues that need public health intervention as well.

Bereavement:

- Large numbers of extended family members and friends will likely come to visit the seriously ill or deceased patient. They will often gather to offer special prayers of compassion and forgiveness for the deceased.
- Bosnians typically will prefer to be buried in special cemeteries set aside for Muslims.
- Most Bosnians, who are Muslims, believe that life on earth is to be spent preparing for another world after death.

- In general, Bosnians do not embalm. The body is usually washed and purified in a ritual manner and then covered in a simple cloth. The deceased is then buried in the ground directly upon completion of the funeral. The burial usually takes place fairly quickly after death. Direct burial in the ground is required by "shari'ah," or Islamic law.

Traditional Health Practices:

- Herbal infusions, alcohol-based tinctures and other forms of traditional medicine were commonly used in Bosnia for generations and are still found to some extent in Bosnian ethnic markets here in Iowa. Some Bosnians will use these remedies simultaneously with Western medicine.

SOMALIS, SUDANESE, AND OTHER REFUGEES FROM EAST AFRICA

Overview:

- Africa is the continent most affected by poor health and civil strife in the world, and significantly lags behind in many public health indicators. Increasingly, Africans are fleeing violent ethnic conflict, severe poverty and political oppression as refugees, and are being granted asylum in countries like the United States. In recent years, Iowa has seen an influx of East African refugees, primarily from Somalia and the Sudan.
- Most of the Somalis and Sudanese in Iowa came from impoverished rural settings. They are knowledgeable about farming in rugged, difficult conditions. However, many do not immediately have the skills necessary to work in an industrialized country and usually require some form of vocational training before taking jobs in the United States.

Language and Religion:

- Somalia and the Sudan, like all of Africa, are far more diverse than the United States so generalizations are difficult to make. However, most of the Sudanese in Iowa speak Nuer and possibly some fundamental Arabic. The Somalis here typically speak Somali, which had no written script until 1972.
- Most of the Somalis in Iowa are devout Muslims, so providers should follow general guidelines for working with people from this religion. Most will dress fairly modestly, particularly the women who often wear loose, long dresses and headwraps. Interaction between males and females is generally quite segregated and should be respected. Male providers should generally not shake hands with females. Where possible, male providers should see male clients and female clinicians should see female clients. Eye and physical contact between men and women is usually avoided in public out of respect and should not be misread by clinicians as avoidance. Pork is avoided in their diet. The right hand is considered "clean," and is used for eating and handshaking; the left hand is "unclean" and used for toileting and the like.
- Sudan is one of the most diverse countries in the world and its refugees come from many backgrounds. In general, though, most of the Sudanese refugees in Iowa come from the south of the country and are Christian. Many have been persecuted in civil war by Muslims in the north. Most of the southerners are either Christian or practice some form of indigenous spirituality.

Family and Social Structure:

- The family is the basis of East African society. The families are extremely large with many children and extended relatives. They will also try to remain living in close proximity to each other as they get older. Children are loved and greatly valued so birth control efforts are often not successful. Maternal and child health is a priority public health focus with these newcomers. At the same time, East African families are usually committed to taking care of their elderly themselves.
- Many immigrants from East Africa have different concepts of time than in the West. It is not uncommon for them to miss exact medical appointments and come at completely different times. They also will usually not call to cancel. Rather than force them to fit into rigid, standardized 10-minute visits in the United States, a more open, flexible schedule of medical appointments would probably be more effective.
- Many Somalis and Sudanese will not know exactly how old they are, for a variety of reasons. Birth records were not always kept like in the West, and a person's birthday is more likely to be associated with a particular seasonal event than with an exact day and year. Also, upon immigration, many officials just estimated the age of each of the new arrivals, so they may not be accurate.

Communication Style:

- East African women and children are much more likely to display emotions than are men. Providers will need to be tactful and respectful when probing for health problems that affect males. Maintaining dignity and respect with each other is important.
- East Africans usually give a great deal of respect to elders and to people in positions of power, like physicians. They will usually be fairly passive and not ask a lot of questions, even if they do not understand something, because it is believed to be disrespectful. They may also be reluctant to ask for help.
- Somalia and the Sudan have among the lowest literacy rates in the world, particularly for women. Health providers should focus on conducting programs that are primarily oral and avoid heavy utilization of written information in any language. Verbal programs should be conducted in the native languages of these two populations.
- Body spacing among East Africans is typically closer than among Americans, although looking directly into someone's eyes may be considered disrespectful. East African culture is highly verbal with many discourses and proverbs. Requiring these newcomers to complete large amounts of written forms can be frightening and overwhelming.
- If visiting the homes of East Africans, avoiding sitting with the soles of your feet pointing to them. It can be considered disrespectful. Also, do not call them to come with your index finger, such as when they are in your clinic lobby, as that is reserved for communication with animals.

Barriers to Care and Common Health Conditions:

- Many of the Somalis and Sudanese in Iowa are classified as refugees by the United States and are legal residents of the state. As such, they are entitled to a number of health, human service and economic forms of government assistance for a limited time. Language and transportation, then, are the most significant barriers to care for this group if they have financial access to health.

- Somalia and the Sudan are two of the world's poorest, most violent countries. Mortality and morbidity rates are extremely high for many infectious diseases. Lifespans are among the shortest in the world due to violence and illness with many people back home not living past age 45 years.
- Many of the Somalis and Sudanese arriving in Iowa have undergone profound levels of hardship and human rights abuses. Many have witnessed or personally experienced war injuries, starvation, rape and torture. Most had very poor access to medical care in their home countries and thus typically present with multiple significant physical, mental and dental health concerns in the United States.
- As with Bosnian and other refugees, East African refugees should be monitored for post-traumatic stress, which could manifest itself through excessive fear and anxiety, sleeplessness, forgetfulness, flashbacks and unexplained physical problems like diarrhea, heart palpitations, general aches and susceptibility to infections.
- Most East African refugees in Iowa have had few medical checkups in their home countries. They often will have undiagnosed cases of diabetes, parasites, high blood pressure, depression and the like.
- Providers should be aware that many of these newcomers routinely share medications and prescriptions with each other. Also, they will often stop taking Western pills once their symptoms stop, even though they might not be through with the full course of medicines. Clinicians should conduct proper health education programs with them on these topics.
- In general, East African women value breastfeeding and it may be common for them to nurse their children for two years or more, while also feeding them solid foods. This practice is recommended by the World Health Organization and should not be discouraged by American providers or baby formula marketers. They are also quite adept at nursing their children discreetly in public and

have a rich knowledge of how to overcome nursing difficulties that often stump American women. Providers should encourage the women to maintain their healthy lactation habits and avoid trying to emulate American women who nurse far less.

- Male circumcision and female genital cutting of youth is common in some East African cultures, particularly those that practice Islam. Providers should become more aware of how to address this topic in a sensitive manner by reading the extensive body of literature that exists on it. Clinicians may sometimes see patients who have experienced various forms of circumcision and may need to check for infections, tearing or other difficulties.
- Many East Africans consider Americans to be highly wasteful and indulgent, as indicated by the high percentage of people in this country who are overweight. However, for Africans in Africa, being heavy is usually a sign of wealth and success and being underweight is a sign of poverty and poor health.

Bereavement:

- Bereavement practices will vary significantly by East African culture and religion. Many Christians will follow similar practices as other Christians in the United States.
- Many Sudanese refugees view death as the will of God or spirits. Burial ceremonies are usually meant to appease the spirits so that additional deaths do not occur.
- Many Sudanese will mourn for a period of several months after a death.
- For Moslem East Africans, burial usually takes place fairly quickly after death. Cremation is usually not practiced. The body is blessed and ritually cleaned in a mosque by an Imam, or Muslim religious leader. The body is often carried to a grave in a funeral procession. The official mourning period may last between three to seven days.
- Large numbers of extended family and friends will typically visit ill patients and the deceased.

Traditional Health Practices:

- Sudanese that practice traditional spirituality typically believe in a variety of supernatural beings and spirits of animals. During illness, it is not uncommon for the Nuer, for example, to try to determine what evil spirit or bad energy has caused a condition and then try to rectify it through an offering or an animal sacrifice. The "evil eye" is also a common belief among this group, whereby a bad person can send negative energy to another and cause misfortune or poor health.
- Traditional medicines have been used for centuries by East Africans like the Somalis and Sudanese, and vary widely by geography and culture. They are far too numerous to discuss, but providers should be aware that their patients will likely be interested in using a variety of these herbal and plant remedies, if available, as a supplement to Western medicine.

THE AMISH

Overview:

- The Amish are one of the oldest and most unique minority populations in the United States, with many of them first arriving in this country from the region around Switzerland several hundred years ago. The Amish practice a traditional form of Christian fundamentalism that has changed little upon settlement in the United States. They are well known for their preference to remain apart, by and large, from mainstream American society so that they may practice their traditional lifestyles. Iowa is one of a few states in the country that has an active, significant population of Amish in its rural communities.
- The old-order Amish generally shun most use of modern technology, as they believe it draws people away from a more natural, simpler lifestyle that is closer to God. Therefore, health education programs should not incorporate telephones, driving, electrical equipment, computers or other such technology with the Amish.

Language and Religion:

- The Amish are usually not native speakers of English but rather speak an old form of high German. Health educators will want to use an Amish translator for their work unless the clients are familiar enough with English.
- The Old Order Amish generally follow a very strict interpretation of the Bible and are devout Christians. Do not conduct programs on Sundays or religious holy days with them. They will usually not celebrate non-religious holidays like the Fourth of July. Also, do not assign human or God-like traits to learning props, such as dolls or animal toys.

Family and Social Structure:

- The Amish are a rural people with very large families. Most marry young and do not use birth control. It is not uncommon for Amish women to have 15 or more children.

- The Amish generally intermarry only with other Amish so most are related in some way to other Amish.
- Gender roles are usually strong in Amish culture, with men serving as the head of household and being responsible for heavy farming and building duties, while women and children tend to the home and family garden.
- The Amish will usually take care of their own elders and keep them active in the family unit. Many will build an addition to their homes so that their aging parents can live with them. Children are expected to be disciplined and must obey and honor their elders.

Communication Style:

- The Amish, in general, are a very stoic, decent, honest, hard working, devout and respectful group of people. They tend to treat others with these positive traits and expect the same in return. Health educators should maintain appropriate body space when working with them and should avoid excessive physical contact.
- The Amish typically do not like people to take pictures of them. In general, maintain a respectful distance and minimize touching, particularly between males and females.
- Health educators should dress very modestly when working with Amish in order to respect their traditional values. Women should wear long skirts or dresses, with their arms, legs and chests covered to a large extent. Muted colors are usually most appropriate.
- The Amish typically study in one-room schoolhouses in Iowa, with all ages and both genders together through eighth grade. After that, they usually return to their farms as an agrarian people. Students will usually be highly disciplined and respectful to health educators, although potentially shy and passive. They generally prefer not to mix boys and girls together on teams. Literacy rates among the Amish will usually be fairly low so health educators should rely more on face-to-face and visual learning.

Barriers to Care and Common Health Conditions:

- Culture is the greatest barrier to care for the Amish. Most Amish willingly isolate themselves from mainstream American society in an effort to maintain their culture. As such, they do not typically use western medicine unless it is absolutely necessary or if an illness is in an advanced state. The Amish do not have medical insurance. They pay for their care in cash, not with credit. Large medical bills are usually covered communally through Amish financial cooperatives. As the Amish are rural dwellers, most also do not live near any health facilities and require transportation for medical care.
- The Amish generally avoid going to the doctor unless it is absolutely necessary. For instance, most will not get prenatal care until the very end of a term and most give birth at home after the first child.
- Maternal and child health, infectious diseases, farm safety and buggy accidents are among the most common health conditions they face. They typically are quite fit with almost no obesity.

Bereavement:

- The Amish are devout Christians. They generally believe that life on earth must be lived well and oriented to God so as to enter heaven upon death.
- The Amish usually do not embalm their dead. Instead, they typically bury them shortly after death directly into the ground.
- Amish cemeteries, in keeping with their lifestyle, are plain and simple and lack ornate decorations and detailed descriptions of the dead common in many American cemeteries.
- In general, the Amish will be fairly reserved in their expression of grief and mourning. They tend to view death as simply a natural process that will ultimately bring them closer to God.
- The Amish will usually work closely as a community to help the single head of household after the death of a spouse. Many will come together to help widows, in particular, with plowing, harvesting and other difficult farm duties.

Traditional Health Practices:

- A strong religious belief in fate is common, so health educators should make appropriate adjustments in their presentations to recognize this external locus of control value.
- The Amish typically value the use of natural remedies like herbal medicines as their first choice of care, and generally do not want to take modern Western medicines or use vaccinations unless necessary. Many are reluctant to follow the medical advice of physicians, and prefer less invasive and more natural methods of treatment. Most Amish have a great interest in herbal medicines and many women make their own remedies for their families.

JEWISH AND HASSIDIC JEWISH POPULATIONS

Overview:

- Judaism is one of the world's oldest religions and was the first major one to recognize one god (monotheism), rather than pantheism (multiple gods). Judaism has been practiced for thousands of years. It eventually gave rise to Christianity 2,000 years ago, and then Islam.
- Jews as an ethnic group originated in the Middle East several thousand years ago, but throughout history have experienced a number of waves of dispersion across Europe, Asia and Africa due to political upheavals, war and ethnic cleansing.

Language and Religion:

- The native language of Jews in Israel today is Hebrew. However, because Jews can be found in many countries throughout the world, they will usually speak the native language of that state. Most Jews in the United States speak English as their first language. In Postville, Iowa, many of the ultra-conservative Jews are originally from New York, so they speak English. However, others are from Israel and speak Hebrew. No matter where they are from, though, most of the Hassidics in Postville will know Hebrew, as it is their sacred and preferred language. Health workers in Iowa will generally need to work with a Hebrew translator with this population unless the audience is extremely comfortable in English.
- Jews are one of the smallest but most active minority populations in the United States. Jews are extremely diverse among themselves. Those of European origin are called Ashkenazi Jews, while those of Middle Eastern or non-European origin are called Sephardic Jews.
- Jews may be secular (non-religious) or religious. Those that are religious may be reform (not very traditional), conservative or orthodox (very traditional). While reform and conservative Jews may be found throughout Iowa, particularly in its larger cities, one of the most significant concentrations of ultra-orthodox Jews can be found in tiny Postville, Iowa. These ultra-orthodox Jews in Postville are called Hassidic Jews from the Lubavitcher sect.
- Jews greatly resent, in general, any efforts to convert them to Christianity. Most are keenly aware of historical events such as the Crusades, the Inquisition, the Holocaust and anti-Semitism, which caused large numbers of Jews to be killed by Christians or forced to convert. In their faith, a person born to a Jewish mother is believed to be a Jew. Most people are therefore born into Judaism, rather than convert to it.
- Health workers should be aware of different Jewish calendar issues. Do not operate programs on the Jewish Sabbath, which begins Friday at sundown and ends Saturday at sundown. Also, do not operate programs during Jewish holidays, such as Passover in the spring; Rosh ha Shana (New Year's day in the fall); or Yom Kippur (a full day of complete fasting in the fall). Jews are not Christians and therefore do not celebrate Christmas and Easter. Sunday is a working day in Israel, as it is in the Postville kosher meatpacking plant. Most Jewish holidays begin at sunset one day and end at sunset one or more days later.

Family and Social Structure:

- Most Hassidic, ultra-orthodox Jews marry young and have very large families.
- Among conservative Jews, male and female roles are well defined. The men tend to be the heads of household and wage earners while the women are in charge of the family and home. Many of the Hassidic women also are active in volunteer service for their community.
- Health providers should respect the well-defined gender roles among ultra-orthodox Jews. Men should not hug, shake hands, pat the back or otherwise touch women out

of respect. Physical contact between the sexes is usually reserved only for spouses or younger children. Many Hassidic men, when passing women in a hall or on the road, will typically look down or cover their eyes so as not to infer sexual interest in the females. Ultra-orthodox Jewish men may not hide their unwillingness to interact with secular female health professionals.

- Many of the ultra-orthodox Hassidic Jewish children study in religious schools. In general, their literacy rates are high. They use technology like computers, cars and phones.
- Conservative Hassidic Jews will usually wear very modest, dark clothes. Women usually wear long, beautiful dresses or skirts and dark stockings, with their arms fully covered by sleeves. Hats or wigs are used to cover their hair. Religious Jewish men will wear a kipa or yarmulke, which is a skullcap or small covering for the back of the head. This will usually never be removed in public. Health professionals that work regularly with Hassidics should take care to dress modestly as well and respect these traditions.

Communication Style:

- Israelis and Jews in general are extremely warm, passionate and outgoing people with a sharp sense of humor. Where possible, health educators should also use this same communication style. The Jews also appreciate language that is frank and direct. They are a highly verbal culture that values analytical sparring, so health educators should be aware that it is often difficult to lecture passively to this type of an audience. Question-and-answer sessions and open discussions are probably more effective.
- Body spacing is usually fairly close in this culture and physical contact to show affection is common among many Israelis. However, among the more conservative Hassidic Jews, men and women are generally much more likely to avoid inappropriate contact with each other. Where possible, women health providers should work with Hassidic Jewish women clients and vice versa.
- Israelis, like other Middle Eastern populations, place a profound emphasis on respect and hospitality. Health workers will usually need to take the time to discuss other personal issues with this population before getting down to business with the clients.

Barriers to Care and Common Health Conditions:

- Jewish populations in the United States usually do not have significant financial barriers to care. Most American-born Jews that are not ultra-orthodox tend to utilize medical care frequently and early. They usually will have insurance and take an active part in the own care. However, some of the lower-income Jews working in meatpacking plants in Iowa may not have adequate health insurance. They also may not know English and do not have enough providers that speak Hebrew. Because they are ultra-religious they may not feel comfortable utilizing care in secular or Christian-based hospitals that are common in Iowa.
- Among the Hassidic Jews working at meatpacking plants in Iowa, health concerns tend to focus on maternal and child topics, the prevention of chronic diseases like cancer and occupational injuries.

Bereavement:

- Most Jews believe that death will ultimately lead to resurrection in a future world.
- Jews usually do not embalm their deceased. Instead, the dead are typically buried within 24 hours of their death after ritual purification and dressing in a plain linen shroud. The body is usually watched over from the time of death until burial.
- Jews will usually recite the Kaddish, a special prayer in honor of the dead. They will "sit shiva" for seven days, which means that they will curtail most daily activities and mourn out of respect for the dead. During shiva, they will often wear black and will cover mirrors and sit on low stools. A special candle will usually be lit to honor the dead. The full mourning period lasts one year, at which

time a special "yahrtzeit" memorial ceremony is offered. Hassidic Jews honor an 11-month mourning period. Jews usually honor the anniversary of the death of a loved one for many years into the future.

- Many Jews, particularly those of Sephardic background, will be highly expressive and visibly distraught when a loved one dies or is seriously ill. To remain stoic and silent, as is more common in dominant American culture, would imply lack of true feelings for the deceased.

Traditional Health Practices:

- Jewish people, even if they are not religious, generally follow some level of Kosher dietary laws. These laws emphasize the use of food that is clean and easy to digest and were first explained by Moses in the Jewish Torah, or the book Christians call the Old Testament. Health providers and hospitals, therefore, should be thoroughly familiar with Jewish dietary laws before attempting to discuss nutrition issues or meet their dietary needs. Most Jews will not eat pork and usually do not mix milk and meat products together in the same meal. Israelis, in general, eat far more fresh produce than most Americans do.
- Many Jews, particularly those that are Hassidic, have very strong fate and destiny values. They often will not directly speak words such as "cancer," over the concern that it might predestine them to have bad luck with the disease.
- Most Jews greatly value Western medical care and will access it frequently if financial and geographic barriers do not exist.
- Most Jews will usually take an active role in maintaining their own health and will frequently give advice to others on how to do the same. Many will also question their provider thoroughly about a particular treatment or medical process and will expect detailed information.

MUSLIM POPULATIONS

Overview:

- Islam is one of the world's three great monotheistic religions, along with Judaism and Christianity. People that practice Islam are called Muslims. They share a belief with Christians and Jews in the Old Testament, but also follow the Muslim holy book, the Koran, and the teachings of the prophet Mohammad. They believe in the same god as Christians and Jews and he is referred to as Allah. Jesus is recognized as a prophet and holy man but not as a Messiah as in Christianity.
- The Islamic faith came out of Middle Eastern traditions, like Christianity and Judaism, and is one of the fastest growing religions on earth. Many Muslims live in America, particularly in larger urban areas. However, even in Iowa, Muslims can be found in the Bosnian and Somali refugee communities, as well as in communities with Arab immigrant student populations.

Language and Religion:

- The native language spoken by Muslims in Iowa will vary, depending on ethnicity. For instance, among Muslim university students, Arabic will be common. However, Bosnian refugees in the state speak Bosnian. African American Muslims will usually speak English as their native language.
- Muslims can range from being secular to very devout. For instance, most of the Bosnians in Iowa do not follow a strict interpretation of the faith, like gender segregation, modest dress codes or regular worship at a mosque. However, the Somalis are much more religious and will typically wear loose, long clothing and have well-defined roles for men and women.
- Devout Muslims worship at a mosque, not a church or synagogue. They do not celebrate Christmas, Easter or other religious holidays that Christians practice. Friday is their holy day of rest and worship, not Sunday like

Christians. They will generally greatly resent any efforts to convert them to Christianity, as they have a keen understanding of historical persecution of Muslims by Christians during the Crusades and other events.

- Devout Muslims will usually pray five times a day, from the early morning through the evening. They will pray in the direction of Mecca, the holy city in Saudi Arabia, from wherever they are in the world. If Muslim patients are staying in a hospital, workers should be able to tell them what direction Saudi Arabia would be for them, so that the patients can pray to Mecca.
- Most Muslims practice a month of fasting from sunup to sundown, called Ramadan. Its timing varies from year to year. No food, water or smoking is allowed during this time. Devout Muslims do not drink alcohol at any time of the year.

Family and Social Structure:

- Devout Muslims usually have well-defined, traditional roles for men and women. If you have religious clients, the sex of the provider should match the sex of the patient. Exposure of body parts of the Muslim patient should be kept to a minimum. Most will not like to be disrobed next to other family members as well, unless they are of the same sex. Clinicians should also not touch the patient's head or hair, unless necessary for an exam.
- Muslims usually value large families and greatly adore children. Birth control is not usually desired in devout families, because of the value placed on children. At the same time, the family has an obligation to take care of its elders without institutionalization. Muslim women are greatly respected and revered for their role as mothers and keepers of the home.

Communication Style:

- A general communication style is difficult to describe for Muslims in Iowa, as it will vary by ethnicity, not religion. As noted, Muslims in the state may be as diverse as

Somali refugees, Arab university students, African American Muslims or Bosnian refugees. In general, though, Muslims value a communication style that is respectful and honorable to others.

Barriers to Care and Common Health Conditions:

- Hospitalized Muslims will usually have large numbers of family visiting at all hours, which should be accommodated if possible. The family members will often recite the Koran near the patient, which they would like to do discreetly. It would usually be inappropriate for them to pray in the chapel room of many hospitals because they often have Christian crucifixes posted.

Bereavement:

- Most Muslims believe that life on earth is to be spent preparing for another world after death.
- Second-degree male relatives, such as uncles or cousins, should usually be the family contact in the event of a terminal illness prognosis for a patient. This person can then decide if the patient and/or immediate family should be told of the diagnosis.
- In general, Muslims do not embalm. The body is usually washed and purified in a ritual manner and then covered in a simple "kafan" cloth. If possible, only same-sex Muslims should handle the body after death. If this is not possible, non-Muslims should wear gloves so that they do not directly touch the body.
- The deceased is buried in the ground directly upon completion of the funeral. The burial usually takes place fairly quickly after death. Direct burial in the ground is required by "shari'ah," or Islamic law.
- Death is viewed as being predestined by God and is just the beginning of eternal life. As such, some very religious Muslims may be quite stoic and calm in their mourning. The outward expression of grief through wailing and banging the chest is forbidden. Grieving is usually allowed for just three days.

- In general, grief counseling is usually not accepted nor viewed as necessary.
- Large numbers of extended family and friends will usually visit seriously ill or deceased patients. Mourners will join together to offer "janazah" prayers for heavenly compassion and forgiveness for the deceased. An additional janazah prayer will often be said upon burial.
- Upon death in a hospital, providers should try to turn the face of the patient so that it faces Mecca. In the United States, this is west or southwest. Also, the head of the deceased should be elevated above the body.
- Most Muslims will prefer to be buried in cemeteries set aside for followers of Islam.

Traditional Health Practices:

- Traditional health practices of Muslims will primarily vary by ethnicity rather than by religion. For further information, please refer to specific cultural information regarding Bosnians, Somalis and others.
- Abortion is not allowed in the Muslim religion. Circumcision is performed on all boys, although the timing can vary from birth until puberty. Premarital sex and adultery are forbidden in Islam.
- Most Muslims do not eat pork products or other foods that are deemed unclean and unhygienic. Meat products will only be eaten if they are "halal," or have been slaughtered according to strict practices. (This is somewhat similar to the "kosher" dietary rules in Judaism.) Hospital food and diets should be modified to meet their needs. They typically will share food and are often taught not to eat to capacity. Some food, therefore, may remain untouched. Devout Muslims will also not eat any food product made with lard or animal fat, like some ice cream, gelatin and fried foods. They also do not drink alcohol.
- Muslims generally consider the right hand to be "clean," and it is used for eating, shaking hands and touching others. The left hand is considered "unclean," and reserved for toileting and other such practices. Providers should minimize touching Muslim patients with their left hands. Ritual cleanliness of the body and home is usually extremely important to Muslims, particularly during times of prayer.
- After birth, many Muslim parents will take the placenta and dispose of it for burial, in accordance with Islamic tradition. Fetuses after the age of 120 days are considered viable babies and would require burial by Muslims.

PART IV: RESOURCES AND REFERRALS

National Resources about Immigrant, Refugee and Minority Health

Office of Minority Health
P.O. Box 37337
Washington, D.C. 20013-7337
Toll Free: 1-800-444-6472
Phone: 301-230-7199
Fax: 301-230-7198
www.omhrc.gov/omhhome.htm

Centers for Disease Control and Prevention
1600 Clifton Rd.
Atlanta, GA 30333
Toll Free: 1-800-311-3435

University of Washington School of Medicine
The Bioethics Education Project
c/o The Department of Medical History and Ethics
Box 357120
Seattle, WA 98195
Fax: 206-685-7515
http://eduserv.hscer.washington.edu/bioethics/topics/cross.html

Closing the Health Gap
800-444-6472
E-mail: HealthGap@omhrc.gov
www.healthgap.omhrc.gov/

The National Alliance for Hispanic Health
1501 Sixteenth Street, NW
Washington, DC 20036
Phone: 202-387-5000
E-mail: alliance@hispanichealth.org
www.hispanichealth.org/

Pan American Health Organization
Regional Office of the World Health Organization
525 Twenty-third Street, N.W.
Washington, DC 20037
Phone: 202-974-3000
Fax: 202-974-3663
www.paho.org

Indian Health Services
The Reyes Building
801 Thompson Avenue, Ste. 400
Rockville, MD 20852-1627
www.ihs.gov/

Asian & Pacific Islander American Health Forum
942 Market Street, Suite 200
San Francisco, CA 94102
Phone: 415-954-9988
Fax: 415-954-9999
E-mail: hforum@apiahf.org
www.apiahf.org/

Refugee Health and Immigrant Health
E-mail: Charles_Kemp@baylor.edu
www3.baylor.edu/~Charles_Kemp/refugees.htm

DiversityRx
E-mail: rcchc@aol.com
www.diversityrx.org/HTML/DIVRX.htm

The Provider's Guide to Quality and Culture
Management Sciences for Health
165 Allandale Road
Boston, MA 02130
Phone: (617) 524-7799
E-mail: erc@msh.org
http://erc.msh.org/mainpage.cfm?file=5.4.1.htm&module=provider&language=English

United Nations High Commissioner for Refugees
Case Postale 2500
CH-1211 Genève 2 Dépôt
Suisse.
Phone: +41 22 739 8111
www.unhcr.ch/cgi-bin/texis/vtx/home

International Organization for Migration
17 route des Morillons
C.P. 71
CH-1211 Geneva 19
Switzerland
Phone: +41 22 7179111
Fax: +41 22 798 61 50
E-mail general: hq@iom.int
www.iom.int/

Su Familia National Hispanic Family Health Helpline
Phone: 866-783-2645 or 866-SU-FAMILIA
Helpline open Monday-Friday, 9 a.m. to 6 p.m. eastern time

State Resources on Immigrant and Refugee Health

New Iowans Health Outreach Coordinator
Carlos Macias
Community Services Building
321 E. 12th Street
Lucas State Office Building
Des Moines, IA 50319-0075
Phone: 515-281-4094
Fax: 515-242-6384
E-mail: cmacias@idph.state.ia.us

Proteus
Central Administrative Office
175 NW 57th Place
Des Moines, IA 50306-0385
Phone: 1-800-372-6031
Fax: 515-244-4166
http://showcase.netins.net/web/proteus/

Justice for Our Neighbors Clinic (Des Moines)
Alison Brown
Grace United Methodist Church
PO Box 41006
Des Moines, IA 50311
Phone: 515-277-4719

Resources: University of Northern Iowa Programs

UNI Global Health Corps

Dr. Michele Yehieli
220 WRC
University of Northern Iowa
Cedar Falls, IA 50614-0241
Phone: 319-273-6411
Fax: 319-273-6413
www.globalhealthcorps.org

UNI New Iowans Program

Dr. Mark Grey
Dr. Anne Woodrick
James Hoelscher
Department of Sociology, Anthropology and Criminology
University of Northern Iowa
Cedar Falls, IA 50614-0513
Phone: 319-273-3029
Fax: 319-273-3885

Teacher Education Addressing Minority-Language Students

The TEAMS Project
Dr. Deborah Tidwell
Dr. Andrea DePruin-Parecki
College of Education
University of Northern Iowa
Cedar Falls, IA 50614-0612
Phone: 319-273-7422
Fax: 319-273-7420
www.uni.edu/teams

Teaching English to Speakers of Other Languages (TESOL)

Dr. Cheryl Roberts
University of Northern Iowa
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Resources: Other Iowa Immigration and Refugee Resources and Services

New Iowan Centers Program Director
Barbara Bobb
Iowa Workforce Development
Phone: 515-281-5387
E-mail: bobbera@quest.net.com
www.iowaworkforce.org

Muscatine New Iowan Center
128 E. Second Street
Muscatine, IA 52761
Phone: 563-264-6014

New Iowans Center-Sioux City
Iowa Workforce Development Center
2508 4th Street
Sioux City, IA 51101
Phone: 712-277-8540

Ottumwa New Iowan Center
310 West Main
P.O. Box 717
Ottumwa, IA 52501
Phone: 641-684-0279

Center for New Community
Max Cardenas
Iowa Project Director
P.O. Box 41173
Des Moines, IA 50311
Cell phone: 515-988-5624
Phone: 515-271-4633
E-mail: cardenas@newcomm.org

CASA Center for Assistance, Service, and Advocacy
Nancy Visser and Ardith Lein
Sioux Center Chamber of Commerce
303 N. Main Ave
Sioux Center, IA 51250
Phone: 712-722-3324; 712-722-0195
E-mail: Ardith Lein scchambr@mtcnet.net

Des Moines Public Schools
Park Avenue School Welcome Center
3141 S.W. 9th
Des Moines, IA 50315
Phone: 515-246-8170

Hispanic Information Center
1413 Broadway
Denison, IA
Phone: 712-263-8022
Fax: 712-263-8022
E-mail: alma@pionet.net

La Casa Latina
715 Douglas Street
Sioux City, IA 51101-1021
Phone: 712-252-4259

Southwest Iowa Latino Resources Center
604 4th Street
Red Oak, IA 51566
Phone: 712-623-3591

Immigration Case Worker, Senator Tom Harkin
Emily Frommelt
210 Walnut Street
Des Moines, IA 50309
Phone: 515-284-4574
FAX: (515) 284-4937
E-mail: EMILY_FROMMELT@HARKIN.SENATE.GOV

Caseworker, Congressman Leonard Boswell
Karen T. Kinkel
709 Furnas, Suite 1
Osceola, IA 50213
E-mail: Karen.kinkel@mail.house.gov

Immigration Business Assistance Specialist
Mary Klemmesrud
Iowa Department of Economic Development
200 East Grand Avenue
Des Moines, IA 50309
Phone: 515-242-4808
Fax: 515-242-4776
E-mail: Mary.klemmesrud@ided.state.ia.us
www.smart.state.ia.us

Iowa Department of Human Rights
Lucas State Office Building
Des Moines, IA 50319
Phone: 515-242-6171
Fax: 515-242-6119
www.state.ia.us/government/dhr/

Iowa Division of Latino Affairs
Liz Salinas-Newby
Lucas State Office Building
Des Moines, IA 50319
Phone: 515-242-4070
Fax: 515-242-6119
www.state.ia.us/government/dhr/la/

Iowa Bureau of Refugee Services
1200 University Avenue
Des Moines, IA 50314-2330
Phone: 1-800-326-2780
www.dhs.state.ia.us/Homepages/dhs/refugee/

Iowa Civil Rights Commission
211 East Maple Street
Des Moines, IA 50309
Phone: 1-800-457-4416
Fax: 515-242-5840
www.state.ia.us/government/crc/index.html

Immigrant Rights Project
American Friends Service Committee
4211 Grand Avenue
Des Moines, IA 50312
Phone: 515-274-4851
Fax: 515-274-2003
E-mail: afscdesm@afsc.org

Iowa-Nebraska Immigrant Rights Network
Ed Leahy, Organizer
3605 Q St.
Omaha, NE 68107
Phone: 402-689-4249

Iowa Immigration Legal Project
2912 Beaver Avenue
Des Moines, IA 50310
Phone: 515-271-5730
Fax: 515-271-5757

United Action for Youth
Gladis Chaisson-Cardenas
410 Iowa Ave.
Iowa City, IA 52240
Phone: 319-338-7518

National Conference for Community and Justice (NCCJ)
Jesse Villalobos, Program Director
1227 25th St.
Des Moines, IA 50311
Phone: 515-274-5571
E-mail: Nccjiowa@aol.COM

Refugee Cooperative Ministry (Lutheran/Catholic Social Service)
3116 University Ave.
Des Moines, IA 50311
Phone: 515-277-4476
Fax: 515-271-7454
www.lssia.org/

Iowa Coalition against Domestic Violence
Sonia Parras
2603 Bell Ave, Suite 100
Des Moines, IA 50310
Phone: 515-244-8028
Fax: 515-244-7417

Refugee Cooperative Ministry (Lutheran/Catholic Social Service)
3116 University Ave.
Des Moines, IA 50311
Phone: 515-277-4476
Fax: 515-271-7454
www.lssia.org/

St. Ambrose Sudanese Catholic Community
St. Ambrose Cathedral
Sr. Pat Scherer
607 High Street
Des Moines, IA 50309
Phone: 515-288-7411 ext. 204

Recommended Readings on Minority, Immigrant and Refugee Health

Welcoming New Iowans: A Guide for Christians and Churches. Anne C. Woodrick and Mark A. Grey (2002). University of Northern Iowa New Iowans Program and Ecumenical Ministries of Iowa.
www.bcs.uni.edu/idm/newiowans/

Welcoming New Iowans: A Guide for Managers and Supervisors. Mark A. Grey (2002). University of Northern Iowa New Iowans Program.
www.bcs.uni.edu/idm/newiowans/

Welcoming New Iowans: A Guide for Citizens and Communities. Mark A. Grey (2000). University of Northern Iowa New Iowans Program.
www.bcs.uni.edu/idm/newiowans/

At Risk in America. Lu Ann Aday (2001). Discusses the health and health care needs of vulnerable populations in the United States.

U.S. Children of Kosovo: Stories of Horror. Albana Melyshi Lifschin (1999). A book of short stories related by children of Kosovo.

Lakota Woman. Mary Crow Dog (1994). Recounts the life of Mary Brave Bird Crow Dog growing up on the Rosebud Reservation in South Dakota.

Video: *Postville: Where Cultures Collide.* Iowa Public Television (2000). Discusses rapid ethnic diversification in Iowa.

The Scalpel and the Silver Bear. Lori Arviso Alvord, MD, (1999). Discusses the differences between Native American and Western health values.

The Spirit Catches You and You Fall Down. Anne Fadiman, (1997). Details the collision of cultures between a small county hospital in California and a refugee family from Laos over the care of a Hmong child diagnosed with severe epilepsy.

Life Narratives of African Americans in Iowa. Charline Barnes (2001). Transcribed oral histories of African American Iowans.

Survey and Analysis of the Health Needs and Disparities of the Immigrant Population in Iowa. Michele Yehieli, et. al. (2001, 2002, 2003). Primary Care Office, Bureau of Rural Health and Primary Care; Iowa Nebraska Primary Care Association; University of Northern Iowa Global Health Corps; State Public Policy Group; and Proteus.

THE UNI GLOBAL HEALTH CORPS AND NEW IOWANS PROGRAM

The University of Northern Iowa Global Health Corps is an award-winning, non-profit organization that is dedicated to addressing the public health needs of diverse and underserved populations around the world through improving the cultural competency of health providers and pre-professionals; implementing preventive health programming with underserved populations; and conducting applied research on the unique health needs and challenges of at-risk individuals. Founded in 1996 and housed in the Division of Health Promotion within the College of Education, the Global Health Corps has trained several thousand students and providers in how to work more effectively with diverse populations, and has directly served over 40,000 low-income clients in Iowa, South Dakota, Appalachia, Ghana, Haiti, St. Lucia, Mexico, Venezuela, Ecuador, Israel, Estonia, China and other regions. The Global Health Corps regularly works with refugees, immigrants, minorities, indigenous populations, rural farm families, the homeless, the uninsured, mothers and children, the elderly and many other underserved populations. The Global Health Corps is supported primarily through external grants, contracts and donations. Visit our Web site at www.globalhealthcorps.org.

The University of Northern Iowa's New Iowans Program (NIP) guides and prepares Iowa communities and businesses as they accommodate immigrant and refugee newcomers living and working in the state. NIP provides tailored consultation for community leadership, conducts research relating to issues facing newcomers and communities, develops innovative training programs for business and industry, and educates Iowans concerning the needs, challenges and opportunities of their new immigrant neighbors, co-workers and employees. All NIP programming incorporates a strong appreciation for the critical role newcomers play in ensuring the long-term social and economic vitality of Iowa's businesses and communities. Visit our Web site at www.bcs.uni.edu/idm/newiowans/.

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Latino Populations

African Americans

Native American Populations

East and Southeast Asian Populations

Russians and Other Immigrants from the Former Soviet Union

Bosnians and Other Refugees from the Former Yugoslavia

Somalis, Sudanese and Other Refugees from East Africa

The Amish

Jewish and Hassidic Jewish Populations

Muslim Populations

Orthodox Jewish Patients in Hospital Settings:

A Health Provider's Pocket Guide

Norman Feinstein, R.N., M.S.M.;
Michele Yehieli, Dr.P.H.; and
Mark A. Grey, Ph.D.

HEALTH FOR ALL IOWANS
PROJECT EXPORT
CENTER OF EXCELLENCE
UNIVERSITY OF NORTHERN IOWA
NATIONAL INSTITUTES OF HEALTH

New Iowans
A program of the
University of Northern Iowa

Notes

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About this Guide

This pocket guide is a practical resource for health care providers who work with Orthodox/Hassidic Jewish populations in the United States. Religious Jews, as well as other special ethnic populations, typically experience unique cultural, social, economic, and related barriers to care that can significantly affect their health status. With rapid ethnic diversification currently occurring in the United States, the provision of culturally competent health care has become a critical goal of hospitals, clinics, and public health departments around the country. The presence of minority populations in a community can pose a number of rewards, opportunities, and challenges for human service organizations. This book was developed, therefore, in response to growing demand among physicians, nurses, educators and community health workers for information and practical advice on how to work with Jewish and other minority populations in healthcare settings.

This book is intentionally formatted as a small, lightweight pocket guide. It can easily be carried in a lab coat or uniform pocket, and can offer quick reference information on patients when needed. The first section of this guidebook offers advice on providing culturally competent care to all clients. The second section provides more detailed recommendations for working in a culturally appropriate manner with Hassidic Jewish patients in hospital settings. A list of resources and information related to Jewish patients is also provided.

This pocket guide is a companion to A Health Provider's Pocket Guide to Working with Immigrant, Refugee, and Minority Populations in Iowa by Michele Yehieli and Mark Grey. These publications are available to the public free or at low-cost, and can be ordered through the New Iowans Program and Center of Excellence on Health Disparities at the University of Northern Iowa.

Part I:

Cultural Competency and Health Care

"It is much more important to know what kind of person has a disease, than what kind of disease a person has." Sir William Osler

Challenges for Health Care Providers and Minority Clients

Serving the health care needs of minorities can present a number of special challenges for health care providers. Health status varies dramatically by ethnic group in the United States. In general, minorities are disproportionately affected in comparison to the mainstream majority population by chronic illnesses, infectious diseases, mental health challenges, accidents, intentional injuries and other conditions. Interestingly, only a small portion of this disparity is considered to be a result of genetic differences that cannot be changed. More typically, broad differences in income, education, living conditions, lifestyle practices, insurance coverage, family support systems and other socioeconomic factors have far greater impact on the health status of minorities than do inherent biological differences.

In order to effectively respond to the challenges associated with health care provision for minorities, it is important to be familiar with some of the basic concepts of minority group relations. These concepts are culture, ethnicity and "race," religion, and language.

Culture

Culture is a word that is used by many people to mean a variety of things. In any human community, culture can be thought of as the "software" in people's brains that determines their behavior, attitudes, concepts of right and wrong, faith, dress, food and other habits of daily life. Culture is a set of similar ideas shared by a group of people about appropriate behavior and values. People who share these basic ideas tend to act generally the same, eat and dress the same way, and in many respects, think the same way about life. People usually don't think about their own culture unless they are confronted with another culture. But one way to think about one's own culture is by asking this simple question: "What are the things I do in my normal life that seem so natural that I forget them?" These things make up culture. Culture is passed from generation to generation, remaining stable over time

and shared by everyone in a community. Just the same, culture is also flexible. Cultures share ideas and values with one another, just as people do. A community can thus change its values and behaviors to better meet a changing environment, or because it is exposed to new and better ways of doing things.

Ethnicity and "Race"

Ethnicity is closely related to culture, but it is a more precise term that has to do with how people develop a sense of identity as individuals and members of groups. Like culture, ethnicity is flexible, often changing for different situations and through life. It is also closely related to language, where people live, their families and the people they call friends. Language and ethnicity are not always exact matches. For example, not all Spanish-speaking Americans call themselves "Hispanic" or "Latino." Indeed, many Mexican immigrants prefer the term "Mexicano" to either "Latino" or "Hispanic."

Ethnicity is a much more accurate term than "race," a word that is often used to describe physical differences among people in terms of skin color, hair or facial features. Race and ethnicity are very different things. Most social scientists do not believe that significant physical differences exist among humans. Rather, race is a cultural concept, not a scientific one. Physical differences themselves are meaningless unless people attach meanings to them.

Ethnicity does not rely on the physical characteristics of people. A person with black skin might identify him- or herself as Somali or Sudanese and would dislike being called an "African-American." Likewise, not all people with light colored skin like to be called "white," perhaps preferring to think of themselves as Italian or Jewish or Irish. The danger in relying on race to categorize people is that it contributes to stereotypes. There is always a great deal of ethnic diversity among people who otherwise share physical characteristics. Thinking in terms of ethnicity is more appropriate because it reflects how people understand their own identity, rather than using their appearance to impose an artificial identity on them.

Cultural Competency and Health Care

Religion

In the Jewish tradition, religion recognizes the existence of a Divine, Supreme, and Primordial Creator. It provides education about the Creator, the Creator's will, and how to perform that will. Included are learning about worship of the Creator, and directions for human conduct in this physical world.

Language

Language issues can also complicate diagnosis when a patient speaks no English and interpreters are not available. Sometimes newcomer children have learned some English and are used to translate in health care settings, but lack the English vocabulary necessary to help healthcare providers make appropriate diagnoses. The lack of appropriate interpretation can also mean that patients' questions and responses are not adequately communicated or misunderstood, and that doctors' instructions might be misunderstood. Many health education programs are developed primarily for white, middle-class populations and are not culturally sensitive to the specific health practices, needs and beliefs of minorities.

Culturally Competent Health Care

Providing culturally competent health care means that a provider or organization is sensitive to the cultural differences between patients, understands the influence of these differences on their health status, and can modify programs from a practical standpoint to meet the specific needs of diverse clients. Culturally competent health care is necessary, because many public health studies around the world consistently indicate that culture is a significant, common barrier to care for minority and immigrant patients. Cultural barriers may be quite obvious or more subtle. For instance, a Latino immigrant patient may be less likely to visit a local clinic if he knows that the providers there do not speak Spanish, his only language. On the other hand, a pregnant Somali refugee mother may be reluctant to be seen by a male Iowan physician for prenatal care, because she is more used to being supported by female lay midwives during labor, and does not consider pregnancy to be a medical condition requiring treatment. Health providers and their agencies, therefore, must be sensitive to the cultural nuances that affect the health status of their minority patient populations.

Becoming More Culturally Competent: Tips for Providers

Providers who are truly committed to their patients should always strive to be as culturally competent as possible with their minority clients. However, providers should also remember that culture is only one of the many factors that influence the health status of a patient. Age, gender, income, literacy, educational background, lifestyle, individual personality and many other issues are equally important to assess when trying to gain a complete understanding of a patient. However, in general, health providers can follow certain fundamental practices when trying to become more culturally sensitive, regardless of what ethnic group they may be serving.

They include the following:

- Be aware of, and sensitive to, your own cultural values and beliefs as a provider, and recognize how they influence attitudes and behaviors.
- Be aware of, and sensitive to, the cultural values and beliefs of patients, and how they may influence client attitudes and behaviors.
- Be aware of the historical events that have affected particular ethnic groups, and understand how oppression, discrimination and stereotyping currently affect people differently, both professionally and personally.
- Be aware of specific knowledge and information about the particular cultural groups you are serving, especially when it comes to their traditional health practices, attitudes and perceptions about various conditions.
- Determine what general style of communication is most common within a particular culture, and try to emulate it so that your patients relate better to you. For instance, some cultures value a more direct, open style of communication, while others tend to be more verbally passive and indirect. Cultures that are more passive may not openly share as much health information with you, so you may need to probe gently with open-ended questions to ascertain a patient's condition.

- Do not be offended that the first generation of immigrant workers has not learned the language of this country. Their intense work schedules and often-limited exposure to English in work places where their own cultural group surrounds them, makes it difficult for even the highly educated and motivated immigrants to learn it.
- Try to be aware of specific cultural "taboos" that apply to a particular ethnic group with which you may be working. For instance, most Jews and Muslims should not be encouraged to follow diets that include pork.
- If you work with patients who do not speak English as their native language, make an effort to learn at least a few introductory phrases used by them in their culture. This simple act can go a long way to establishing a friendly and trusting rapport between a provider and patient. Some of the best words to learn to say in a foreign language are "hello," "goodbye," "how are you," "thank you," and "please."
- Take the time to ask a lot of questions of your clients and listen actively. Try to treat the entire patient in a holistic manner, rather than just focusing on a particular disease. Learn about the culturally specific risk factors, signs, symptoms, barriers to prevention and methods of treatment that relate to medical conditions affecting minority patients.
- Recognize that diversity within cultures and individuals is often greater than the diversity between cultures. Therefore, customs may vary greatly within what you consider to be a homogeneous cultural group.
- Learn more about various cultural communities through a) interacting informally with individuals of a different culture; b) actively listening to their stories when talking with them, even if they are not health related; c) discussing with individuals of a similar cultural background about how your culture impacts your experiences in society; d) participating in cultural diversity workshops and cross-cultural community events; e) reading articles and books on cultural dynamics; and f) consulting with cultural advisors in your community as situations arise.

- Be humble, genuine and willing to learn. Know that you will often make mistakes. Don't be afraid to apologize and ask why you may have offended someone. Most individuals around the world, no matter what their ethnic background may be, will respond positively to sincere, kind and respectful behavior from others, regardless of whether a particular "cultural taboo" was broken.

Making Health Organizations More Supportive for Minority Patients

Just as there are multiple strategies that individual health providers can undertake, health organizations can also adopt a variety of deliberate strategies to become more culturally effective with minority and immigrant patients.

They include the following:

- Health agencies should work together with other organizations in their local community to help provide a welcoming environment for refugees and immigrants. Hospitals and clinics can join schools, law enforcement, social service agencies, houses of worship, city councils and the like in sponsoring town hall meetings, diversity information sessions and other such services to help prepare local residents for any impending arrival of significant numbers of refugees and immigrants to a community. This welcoming environment should also include outreach services for existing minority populations as well in the community.
- In order to reduce linguistic barriers to care, health programs should be conducted in the native language of the minority clients who are being targeted for service. Ideally, health providers, or if necessary, interpreters who are native speakers of the foreign language are preferable over those who just speak it as a second language.

- As often as possible, deliver health care services on-site where minority and immigrant populations live, work, study, play, worship, shop and celebrate. Most minority groups in Iowa and the United States significantly underutilize healthcare services. Programs that can be delivered on-site tend to be much more effective. Consider conducting screenings, vaccinations and preventive education programs, for example, in schools, immigrant trailer parks, church lobbies, laundromats, ethnic markets and festival sites for increased access.
- Provide healthcare services at non-traditional hours. Many minority and immigrant patients are lower-income, and work at multiple jobs. Medical offices that are only open Monday through Friday, 9 a.m. – 5 p.m., are likely to miss serving large numbers of minority clients. Consider having flexible scheduling on weekends and nights.
- Allow extra time for patient visits when working with many minority and immigrant clients. Many of these people come from non-western backgrounds that place greater emphasis on face-to-face interaction and do not appreciate being rushed through a medical visit. Many of these clients will present with multiple conditions as well, and will require more than a standard 10-minute visit for care.
- Code of Professional Conduct should be enough. Nevertheless, long-term medical economics and recent civil rights legislation make cultural sensitivity a financially and legally sound practice.
- What Americans consider to be "alternative" health practices might be the front line of treatment in an immigrant's home country.
- Many non-western cultures place less emphasis on a strict sense of time, in comparison to mainstream American culture. Appointments and scheduling may need to be flexible when dealing with refugee and immigrant patients in particular, who may not necessarily be willing or able to show up at an exact time on a precise day for care.

- Recruit minority and immigrant members to serve actively on hospital boards, non-profit advisory councils and other external decision-making entities. Have cultural interpreters in the local community periodically review programs, written material and policies.
- Provide extra assistance to refugee, immigrant and some minority patients who may have limited understanding of the complexities of receiving healthcare in the United States. Many newcomers, in particular, come from countries with excellent national healthcare systems, and they are not used to having to pay for services, utilize insurance or fill out claim and aid forms.
- If your clients are very diverse, make sure that signs in your hospital or healthcare facility are posted in multiple languages. Also have available written health education material and payment forms that are in the native languages of your clients. When distributing written material with illustrations, it is important to have any photographs or drawings culturally specific as well.
- Have all staff in your facility participate in periodic diversity trainings and refresher courses. Remember that most patients from non-western cultures place a great deal of emphasis on the word-of-mouth reputation of your healthcare organization. They will care less about fancy marketing brochures than they will about what other minorities say about a particular doctor, hospital or agency. Make sure that all staff, even your front office workers, is trained in how to work effectively with immigrant and minority clients, in order to make their experience more positive.
- Health agencies should draw upon the immense amount of data, studies, brochures, materials and other sources of information on minority, immigrant and refugee services that already exist from public health organizations in large urban and border states, as well as federal and international sources. Too often, provider agencies feel overwhelmed by minority health issues and often think they must create culturally appropriate programs on their own. Many other countries have been actively addressing minority, immigrant and refugee health issues for decades and have a wealth of experience and resources to share.

Orthodox Jewish Patients

Introduction

The guidelines provided in the previous section are designed to be general recommendations for providers and their organizations when working with minority populations. If followed carefully, they will greatly improve a clinician's ability to work more effectively with minority patients. However, in order to truly improve cultural competency, providers must gain a further understanding of the specific characteristics that are common in particular ethnic groups.

The information provided in this section will introduce some of the fundamentals of working with the specific population of Orthodox Jews, who are religious and ethnic minorities in the United States. This information is to be used only as a general guide and as a starting point for providers trying to learn basic cultural competency points. All people are ultimately individuals and this information is not meant to stereotype any group. Remember, as stated previously, culture is only one factor that influences a patient's behavior and health status. In an effort to be culturally competent, providers should not ignore other fundamental factors like gender, age, lifestyle, education level and individual personality traits in their patients that are equally important.

The information provided in this section is meant to be only an introduction to working with this particular cultural group. Ultimately, providers must be willing to immerse themselves in working with people of diverse backgrounds over a regular period of time if they truly wish to improve their cultural competency. Also, keep in mind that the observance of the culturally specific rules, customs, and codes described in the following pages about Hassidic Jews usually should not jeopardize a person's health. If these customs seem to stand in the way of proper, immediate, or essential care, make that case to the patient or to those who influence the decision for a patient. When questions on Jewish Law arise, they should be presented to a local Orthodox Jewish Rabbi, because different communities have different standards.

Orthodox Jewish Patients

Overview of Judaism

Judaism is one of the world's oldest religions and was the first major one to recognize one god (monotheism), rather than pantheism (multiple gods). Judaism has been practiced for several thousands of years. Judaism believes that the world was created 5764 years before this present time, Spring of 2004. At that time, "Adam" received the first commandments from G-d*. Twenty generations later, Abraham brought the recognition of G-d back to the forefront after many years of paganism. His descendants through the line of Isaac, Jacob (also known as Israel), and Jacob's twelve sons became the Jews. The twelve sons were the progenitors of the "12 tribes of Israel." The Torah (Bible) presents G-d's giving the Land of Israel to Abraham with the inheritance passing down through the chain of Isaac, Jacob, and the 12 Tribes. The Jews accepted the Torah from G-d as a nation at Mt. Sinai seven weeks after the Exodus from Egypt, approximately 3,300 years ago. The observance of the Torah involves the realms of Torah study, prayer, and good deeds. This extends into thought, speech, and action.

- Jews were one of the original ethnic groups inhabiting the Middle East more than 5,000 years ago. Although some remained behind, Jews were largely dispersed 2,000 years ago from the Eastern Mediterranean region known today as Israel due to Roman occupation and persecution. During this "Diaspora" period, the Jews fled as refugees to areas as far away as Europe, Asia and Africa. The modern state of Israel was declared a nation in 1948 by the United Nations, and is now inhabited by many Jews from Europe, the Middle East, and other regions.
- A prior Diaspora took place with the destruction of Jerusalem and the Great Temple by the Babylonians. The Jews returned to the land of Isreal after 70 years.
- Many Jews continue to reside in countries outside of Israel. For instance, the United States experienced a large influx of Jews fleeing persecution in Europe in the first half of the 20th century, particularly from countries such as Germany, Poland, and Russia. Today, there are approximately 5 million Jews throughout the entire United States, with large concentrations living in urban areas such as New York, Los Angeles, and Miami.

Orthodox Jewish Patients

- Jews are one of the smallest but most active minority populations in the United States. Jews are also extremely diverse among themselves. Those of Eastern and Northern European origin are called Ashkenazi Jews, while those of Spanish, Mediterranean, and Middle Eastern origin are called Sephardic Jews.
- Jewish religious leaders and teachers are called Rabbis and Rebbes. Orthodox Jews worship in synagogues or "shuls."
- Jews may be either reform (not very traditional), conservative, or orthodox (very traditional). Reform, conservative, and orthodox Jews may be found throughout the entire United States. Hassidic Jews Hassidic (Hah-SEE-dik) or Hassidic (pronounced with a guttural CH sound) are ultra-orthodox Jews.
- Hassidic Jews follow Orthodox doctrines and believe that the Torah and its teachings are the "laws of life" according to G-d. Any copying of Torah related documents must be meticulously done, and closely reviewed for accuracy. Therefore, customs, acts, and beliefs that would today seem to be antiquated in most cultures are held to be valid due to an unbroken chain of tradition.
- Over 300 years ago an Orthodox Jew presented a Torah observance framework that was later called the Hassidic movement. Included in its thrust was revealing previously secretive mystical teachings which helped to describe mans' relationship with his Creator, efforts to get a greater spectrum of teaching to the unlearned, making joy in serving G-d an essential motivator, and reinforcing brotherhood. At the movement's foundation remained the original Torah code of laws and the necessity for their careful observance.
- The Hassidic movement itself had offshoots. They usually centered on rabbis who were outstanding students of the founder's philosophical dynasty. These "Rebbes" settled in the areas of Eastern Europe, Western Russia, and the Ukraine. For that reason, Hassidics often have variations in names, dress, and customs.

**Out of respect for the sacredness and holiness of the Divine Name, Orthodox Jews will not spell out the name of the Creator in writings. This lessens the chance of it being erased, destroyed, or discarded, even in languages other than Hebrew.*

Language

- The native language spoken by a Hassidic Jew will usually depend on the country of origin. For instance, the native language of Jews in Israel today is Hebrew, but many Hassidics will not use Hebrew except in the milieu of Holy-Torah matters. Yiddish or Jewish, which has facets of the German language, is often used as the "working" language for European immigrant Jews, and is considered to be the international language among Ashkenazi Orthodox and Hassidic Jews.
- Modern Hebrew is derived from ancient Hebrew, which was the original language spoken until the separation of the nations at the Tower of "Babel." Afterward, Aramaic became a main language at intervals when Jews were not in the Land of Israel. Aramaic was heavily used in Talmudic Literature and was used as a popular translation for Torah.
- Because Jews can be found in many nations throughout the world, they are often multilingual.
- Many Hassidic men who have recently migrated to the United States may not be as proficient in the English language as the women. They are often highly educated but may work in a "kosher product facility," Jewish store, or spend long hours in houses of study and worship with their peers. Thus, there is often a lack of exposure to English. Nevertheless, health providers can certainly attempt to speak English first with their Hassidic patients.

Barriers to Care and Common Health Conditions

- Hospital care that is provided in a culturally and linguistically appropriate manner can increase the willingness of a population to utilize services and recommend referrals. Nevertheless a proper physician is considered to be an agent of G-d in the healing process. Ability and a record of good results are highly regarded no matter what the doctor's or institution's background might be.
- Jews in their culture are encouraged to get a second opinion when possible. This is not as a result of the perception of any doctor's ability.

- Some Hassidics, particularly if they are recent immigrants or on work visas from Israel or other countries, may not have adequate health insurance and could experience significant financial barriers to care. Because a family size could be large, even those with insurance might have financial difficulties in accessing medical care.
- They may have some type of insurance from the home country, so a social work financial consult could be appropriate in order to optimize their benefits, and prepare them for billing practices found here, particularly if coming from a country such as Israel with a strong national health care system.
- Among the Hassidic Jews, some of the more common health conditions can include maternal and child concerns, occupational injuries, and the prevention of chronic diseases.

Traditional Health Beliefs and Practices

- Hassidic Jews typically have large families. This is due to the fact that not only are many children desired, but also that there are restrictions regarding the use of any type of birth control. The Old Testament commandment of "be fruitful and multiply" is among those that guide this behavior. When a married couple has not been able to have a child, it can become a very sensitive issue. Some such women could find it difficult to sit amongst friends who are talking about child raising. Fertility consults and therapies can be taxing physically, emotionally, and financially. Others may take it in stride, but it might be a source of unexpected sensitivity if you are not aware.
- There are also Biblical commandments that concern acts and procedures that prevent conception. "Traditional" Jewish married women are very aware of their menstrual cycles, and they will be quite concerned if any OB/GYN procedure will be likely to cause bleeding. Health providers should discuss and explain anything that may be related to this matter or fertility, or upsetting the menstrual cycle, well before any initiation of a procedure.

- Most Jews will usually take an active role in maintaining their own health. They often pool and organize information about the quality of providers. There are formal "visiting the sick societies" (Bikkur Cholim) which have such information. Bikkur Cholims will arrange many facets of community support including: bringing in kosher food, providing companions or visits to the bedside, and communicating with physicians and administrators. In larger cities they are not infrequently considered as a referral source.
- Health providers may experience Hassidic Jews intently probing about the seriousness, necessity, or urgency of a recommended procedure. The reason is that they might feel that the situation warrants consultation with their "High Rabbinical" leaders. Try hard to support this effort since it is incredibly important to them, and will foster an endearment towards the staff of the facility. To ridicule this conduct will place tremendous stress on the decision-making process. Most Hassidic Jews will be very persistent about getting advice from their leaders. Outside of this group few people have no idea how historically effective the process is. Resultant changes in the course or declining the recommended course of therapy have many times led to very positive results. Books have been published describing many of these scenarios, from the actual participants.
- Even if no change in plan occurs, consultation with high Rabbinical leaders on a medical issue will result in the Hassidic Jewish patient receiving a valued blessing for a good result. The actual outcome of a medical procedure, no matter how it is rated, will be more accepted by the Jewish patient with less speculative hindsight. Of course, if any delay or change in plan is felt to be an immediate threat to "life or limb," providers should make the point clearly to the patient or family. Provision of a long-distance telephone could help facilitate the matter. Diagnostic results may be requested.
- Some patients may bring along a Holy book to a special procedure. Such a book is considered as a channel for Divine assistance. Hospitals should try to let the book be made suitable for keeping by the patient in restricted areas. This could include other types of amulets or pictures.

Orthodox Jewish Patients

- Before and after the Sabbath and religious holidays, religious Jews may request to light candles. A prior arrangement to provide a space in a "flame safe" area would be appreciated. If this is impossible, providers should remember to inform the patient or family to arrange for an electric type candle apparatus. These could also be made available as a pastoral care resource.
- Many Hassidim are themselves or have family members involved in highly regarded social organizations that deal with rescue, and care of the sick. They may be quite knowledgeable in modern Western, as well as "alternative medicine" practices. They may ask a lot of questions to health providers, but it is usually just to improve their understanding of a procedure, and not to challenge a provider's knowledge and ability.
- Orthodox traditional Jews believe strongly in the power of speech. According to Genesis, "The voice is the voice of Jacob." With that in mind they do not speak of things that could be considered negative to destiny. Often they will not speak the actual name of a disease entity, or give credence to a morbid diagnosis.

Kosher Dietary Practices

- "Kosher" in Hebrew is something that is proper or fit according to Jewish Law. Jewish law is found in and extrapolated from Old Testament writings, which Jews call the Torah. These Kosher laws are direct from G-d.
- Explanations or clarifications of the written Torah Laws were initially transmitted by word of mouth teachings from Moses, the greatest Jewish prophet, to the Jewish nation. This oral modality was used until the times of the compilation of the "Talmudic" writings, when the oral teachings were documented in order not to be lost during evolving hardships and wars. This era culminated in the previously mentioned massive, extended Diaspora from the Land of Israel 2,000 years ago. The Talmudic writings were later codified and categorized for easier access and understanding. Torah writings discuss categories of laws including but not limited to civil, personal daily conduct, subjects of marriage, education and those regarding general agriculture practices, food sources, and food preparation.

Orthodox Jewish Patients

- Kosher dietary laws are very complex and may vary in observance of certain additional restrictions, even among members of the same family. Many views of what is absolutely kosher can vary between different Jewish regulating and inspecting agencies. Hassidic Jews pay exceptional attention to the issue of Kosher dietary laws.
- A listing of the some of the more common foods generally considered "not" to be Kosher are listed in the appendix to this pocket guide.
- The use of animal flesh as food for Jewish people has many stipulations. Production of kosher meat deals with what animals are permitted, their physical health, ritual slaughtering, removal of blood, and what parts of the animal are permissible. All of these and more are involved, in addition to the regulations of the country in which it is produced. This complex process results in the need for a significant cadre of dedicated, highly trained, full-time rabbinical staff at the sites of slaughtering, processing, and packing. Hence there can be the development of a Hassidic community in the Midwest, such as is found in Postville, Iowa.
- Due to the complexity and variance in kosher regulations, some Orthodox and Hassidic patients will not use food from "kosher kitchens" of many Jewish Hospitals. Do not be offended!
- There are many basic laws regarding what is kosher to eat. Those laws by themselves will not tell you enough about what, and how to serve to a person. If at all possible, consult the patient, a family member, or a local Orthodox Rabbi regarding what to buy or how to prepare it. Please check before doing any of the following:
  - Obtaining prepared goods that are believed to be kosher
  - Buying from a foodservice enterprise that is believed to be kosher.
  - Opening any packaging or bags.
  - Placing food on utensils or surfaces.
  - Warming food
  - Washing their own utensils
  - Storing leftovers

Orthodox Jewish Patients

- Kosher dairy and meat products are not served together, need different utensils and serving containers, and have waiting intervals between eating. There are many ramifications of these laws.
- Because of complexities and customs, not every Jew will eat in the kosher house of another Jew. Therefore take no offense if an effort to provide kosher food might not be utilized. One person's way of observance does not necessarily mean that someone else has to do it the same way
- This pocket guide deals only with the basic elements of Kosher dietary laws. More information can be obtained from the Internet, Jewish bookstores, local Rabbinical leaders, and the patients or families themselves.
- Many things are Kosher in their pristine state. By the time they get to a person processing, preparation, and some precautionary regulations could take them out of consideration for consumption.
- Families are usually ready to arrange for food. Hospital staff can assist this process by providing accessible refrigeration and disposable single use utensils, plates, bowls, and cups.
- When clients bring their own food, check with each patient regarding their requests for following preparation procedures:
  - Cutting food
  - Warming food
  - Storing and refrigerating food
  - Opening kosher packaging or containers
  - Making hot drinks
  - Using non-disposable utensils and appliances which are designated for kosher use
- Protocols for washing and storing of non-disposable utensils and appliances should be developed with local rabbinic leaders immediately after a purchase order is obtained for the items. Some of these, or their parts, may require a trip to a ritual bath before their first use.

- Most families of Hassidic patients will gladly work with doctors, nurses, and dieticians to explain Kosher dietary laws. Health providers should work closely with these people to ensure client satisfaction and proper nutrition in a culturally appropriate manner.
- The exchange of food is a highly regarded sign of friendship and warmth in many cultures. However, because of strict Jewish dietary laws, it is usually best that hospital staff make no effort to provide unsolicited non-Kosher food. This applies even to non-medical gatherings. This could wind up being a very embarrassing situation for both parties, as religious Jews would typically decline eating these food gifts.
- Medicine in capsules could present a problem due to the gelatin composition of the capsule. This is normally a product from animals, not usually kosher in species, or in mode of processing. There are differing views in Jewish Law regarding gelatin use in medical situations. Some people already know if they will use the capsule or request a tablet form of the same drug. There might be a request for an alternative medication, which comes as a tablet. Asking ahead of time could save extra calls to the physician and pharmacist.
- In communities where there are many Hassidic Jews, hospitals should work closely with local Kosher markets and restaurants. These facilities are under rabbinical supervision, and usually can be contracted after approval of the patient or family, to provide Kosher-prepared meals to patients.
- Medical-dietary consultation might be necessary. If concerns exist, mention them to the patient, family, or use standard protocols. In the event there is no one who can make arrangements and there is no Kosher kitchen in the hospital, contact the hospital chaplain or local rabbinical leader.

Observance of the Sabbath and Holidays from the Bible. Health providers may find different levels and scopes of observance among their patients that could affect the stay in the hospital. Some laws of Jewish observance are absolute. Some permit gray areas and others allow dispensation under certain conditions. In general, there are leniencies in certain religious laws at the time of an emergency, which includes "labor" and childbirth. A table listing the religious holidays typically observed by Orthodox Jews is included in the appendix of the pocket guide.

- Most observant Jews celebrate many religious holidays. The standard "worldwide" solar calendar dates for these holidays vary from year to year, because they follow a traditional lunar calendar.
- The Jewish Sabbath begins just before sundown on Friday night, and ends in complete darkness on Saturday evening. All Jewish Holidays follow a similar time pattern of beginning and ending at nightfall, as do all Jewish calendar days.
- Sunday is a working day in Israel and most Jewish communities around the world.
- Outside of the Land of Israel most Jewish Biblical holidays are two days in a row, except for Yom Kippur, which lasts one day. "Intermediate Days" are attached to Succoth and Passover. They are of the spirit of the Holidays but somewhat less restrictive.
- During the Sabbath and Holidays, observant Jews are not involved in their occupations. "Rest" is a part of the Sabbath observance, but refraining from certain endeavors might be a more descriptive term for changes in conduct on these days. For example, religious Jews:
  - Do not turn appliances or any other electric switch on or off
  - Do not drive
  - Do not cook on the Sabbath, different for most Holidays
  - Do not start or put out fires on the Sabbath

  - Do not do creative activities
  - Do not write
  - Do not paint
  - Do not build things
  - Do not farm
  - Do not do plumbing
  - Do not handle money or financial affairs
  - Do not participate in business activities
  - Do not carry things on the Sabbath except in certain designated areas. (With the details of this law there may be inquiries regarding establishing areas outside of patient rooms where they can carry items).

- Patients who are discharged on the Sabbath or holiday might not be able to leave the health facility until that day is over.
- Unless it is absolutely necessary for the safety and well being of the patient, hospitals should try to not schedule elective surgery on Jewish patients during these religious holidays or on the Sabbath. One interpretation is not even three days prior to the Sabbath.
- On the Sabbath and holidays please provide box tissue with single, separate sheets, in the place of "roll" bathroom tissue
- If a signature is needed from a Jewish patient in the hospital on a holiday, most administrations will accept a witnessed verbal statement. A written signature may be obtained on a following day. Some holidays may last three days.
- During an emergency, a Jewish patient may drive him or herself to the hospital, or may be driven by another Jew or non-Jew. However, observant Jews will leave the engine running in the car at the completion of the trip, since that "work" is no longer required for the emergency. Hospital workers should feel free to ask if they can move and turn off the power in the vehicle for the Jewish patients.
- Jewish emergency workers or "Hatzolah" are permitted to return to their communities with their vehicle since their presence is considered essential to the welfare of the members.

The Roles of Men and Women

- Among Orthodox Jews, male and female roles are well defined. The men tend to be the heads of household and primary wage earners while the women are in charge of the family and home. Many of the Hassidic women also work as educators or in other social service positions. They also can be active in providing volunteer services for their community.
- Orthodox Jews follow a number of religious rules about interaction between men and women. In Jewish tradition, these rules were established to promote modesty and appropriate behavior, and to prevent the slightest chance of improper social conduct or accusation of such. These rules should not be misinterpreted as an inference towards superiority or inferiority between sexes or ethnic groups.
- Orthodox Jewish men and women do not mingle unless they are married to each other, or are immediate family members. This includes social gatherings, schools, worship, and other religious ceremonies. Large barriers such as curtains may be seen at many functions such as parties or weddings, in order to prevent male and female attendees from seeing each other. Both enjoy the privacy when amongst peers in gender.
- Casual conversation between men and women even in public is also frowned upon. A health worker who is of the opposite sex from an Orthodox Jewish patient may exchange information to assist the sick or understand a religious practice as necessary. However, small talk beyond those kinds of necessary medical inter actions should be limited.
- Physical contact between the sexes is usually not practiced, and handshaking between males and females is generally avoided. Shaking hands between men is allowed, but not enthusiastically practiced. A verbal greeting and a nod could be more than adequate, but a handshake will be accepted or even initiated to comply with its importance in this country.

- Male and female seclusion should be avoided unless needed for health care treatment. As is the general practice, a female will want to have another female present if a male medical staff member must perform a procedure in a private room. If this is not possible and it is absolutely necessary, the door should be unlocked or even left ajar, still keeping in mind privacy and modesty. If at all possible, give care to a male by a male staff member, and care to a female by a female staff member.
- Orthodox Jewish boys and girls are separated in schools, usually in different buildings.
- Remember that there is a difference between socially touching a person of the opposite sex, and medically serving that patient's needs. For instance, a handshake may be avoided, but the same patient in the same place may allow medical care to a normally less exposed part of the body. Once the health care is finished, it is important to return to the non-touching mode as soon as reasonably possible.
- When riding in a vehicle, men and women will likely choose to separate by using the front and back seats. The number and composition of people in a vehicle could influence whether a ride is accepted. Night travel might be declined, especially in non-city roads.
- Men are not to hear women sing or be around women who are provocatively dressed.
- Hassidic Jewish women have a dress code that includes:
  - Dresses or skirts which cover the knees in all positions Pants are not allowed
  - Socks, stockings, or tights that cover all exposed skin of the leg
  - Upper garments that cover the elbows and collarbones, and the waist
  - No garment that is revealing as a result of being tight, semi-transparent or loosely open around buttons
  - All hair of the head covered on married women with wigs, large kerchiefs, some types of hats, or operating room head coverings, if needed

- Women who come as labor coaches, or accompany children for procedures where street clothes are prohibited would appreciate access to hospital attire that meet the modesty guidelines described above. This could also include female patients who are being transported to procedures in or out of the hospital.
- Outside, females are permitted to wear appropriate clothes that are attractive in style and color. Jewelry and make-up are also used.
- Orthodox Jewish men, in general, limit body exposure but without some of the absolute restrictions designated for women. Men who are normally dressed for daily routines will almost automatically have appropriate coverage. Men will also be appreciative of adequate body coverage where street clothes are not used in health care settings.
- Religious Jewish men cover their heads at all times to be reminded that G-d is above them at all times and in all ways. They usually wear a small skullcap called a kipa or yarmulka. They will also wear a set of strings coming out of their shirts, which is part of a four-corned garment mentioned in the Torah. Each corner of the garment has these strings or fringes (tzitzis).
- Hassidic men do not shave, cut, or remove their beards or mustaches, nor the hair at the temples and in front of the ear. If a procedure absolutely requires cutting hair in these locations, every effort should be made to discuss the matter ahead of time with the patient or his designee.
- What may be commonplace for many people to see and hear in the media may be embarrassing to a Hassidic Jew. They are especially concerned if their children might be exposed to media and materials normally found in waiting rooms, or even with patient educational materials. Hospitals should be aware that some religious Jewish clients will feel very uncomfortable being exposed to these materials, and may ask to be isolated from them in public.
- Because of modesty and proprietary requirements regarding content of material, Hassidics usually do not have televisions in their homes. Their video and CD players will typically have tapes mainly produced by Orthodox Jewish media organizations.

Other Rituals

- Judaism has at least three prayers scheduled each day. Men have a more stringent obligation in this matter and will use designated apparel, varying with the prayer. They will appreciate knowing where East is, when external cues are not readily available.
- A place for prayer should be empty of all religious tokens. Bare walls, good lighting, a place to sit, and a table on which to place prayer books and religious items will be very appreciated.
- Prayers are ideally done with a minimum quorum of ten males of age 13 years or older. Such groups may consolidate when a man must remain in the hospital. They will usually abide by hospital rules if this should occur. Some of the accessory items may include a white cape called a Talis, black boxes and straps called Tefillin, and a black sash called a Gartel. Different holidays may include some other items.
- Ritual hand washing is done for different situations. At the bedside is needed a washbasin and a cup, with the source of a water outside of the bathroom, if possible and reasonable. This is additional to regular washing for cleanliness. In and out of the hospital washing for cleanliness after restroom use is done with the restroom sink. Many will do a small hand rinse at another water source as part of additional ritual cleaning.
- Some Hassidic Jews may be uncomfortable about answering casual questions about the status of life situations. Even in their own groups, they stay away from asking about the number of children in family, ages, measures of their business success, or the amount of people in their community. Providers should be sensitive to these issues and ensure the patient of confidentiality when asking for demographics or health histories.
- If a mistake is made in cultural interaction, consider it only as a mistake. Providers do not need to think it will be looked upon as a denigration of their character or ability, if sincerity and concern have already been observed and demonstrated.

Orthodox Jewish Patients

Care of the Dead

- In the case of the death of a Jewish person anywhere, the body should be covered and if at all possible not moved, except by family or members of their community.
- Do not remove "IV" lines or any other therapeutic tubes. Do not remove blood or any body tissue from in or around the body, to the extent that the clothes or sheets that are stained with blood should go with the body.
- In a place where death occurred outside of the hospital the rescue personal should also follow these rules: If the death is a result of an injury, save the surrounding cushions or soil that may contain blood or other tissue. Any body part that is removed as a result of an autopsy, accident or even surgery should be slated for burial. There could be some exceptions with tissues excisions but a Rabbi needs to be consulted.
- Jews will not embalm or cremate, and make every effort to avoid an autopsy.
- The body should not be left without direct supervision until burial. Family and friends will take over this ritual from health providers as soon as possible.
- Jews will usually recite the Kaddish, a special prayer in honor of the dead. This prayer will be said daily for the first 11 months of the mourning period. They will "sit shiva" for seven days, which means that they will curtail most daily activities and mourn the dead. During shiva, they will rip a garment, cover mirrors and sit on low stools. A special candle will usually be lit to honor the dead. The full mourning period lasts one year, at which time a special yahrtzeit memorial ceremony is offered. Jews usually honor the anniversary of the death of a loved one for many years into the future.
- Many Jews, particularly those of Sephardic background, may be highly expressive and visibly distraught when a loved one dies or is seriously ill. To remain stoic and silent, as is more common in dominant American culture, would imply lack of true feelings for the deceased, and not likely to provide for needed release of grief.

- It is a mitzvah (proper deed) to comfort mourners, so many people may come to visit after the burial.
- Jews typically bury the body as soon as possible. Viewing is limited to identification of the body by a relative or appropriate party.
- Religious Jews believe that part of the soul remains with the body, and utmost respect is due to the body, as if it were a living person.

Interactions Between the Religions

- Most Jews in America are acutely aware of the challenges associated with being a minority. They are generally willing to explain their religion and practices to those who are interested. Inquiries about their religion should be for the sake of understanding and assisting them in their care. Comparing religions at best or discussing the validity of a religion at worst will close many doors once the trend is detected. Broaching the subject of conversion to another religion is not likely to be in your job description.
- Jews are very protective of their beliefs and even have their own religious school systems. They do not try to convert others to their religion, but do have a respect for people who follow their own religion and are considerate of mankind. They feel that any "comparative" religious discussion will have no positive result for either party, no matter whose point of view may be finally recognized.
- Jewish Law considers people to be Jewish if they are born to a Jewish mother, or converted according to Orthodox Jewish Law.
- Jews do believe that people who are not Jewish can be considered righteous and can go to Heaven without converting to Judaism. Following the Seven Laws given by G-d for the general offspring of Noah does this. They are taken from the Old Testament, and more details about them can be found at the website www.7for70.com.

- Rabbi Moses ben Maimon (Mamonides-RaMBaM) a great Torah Scholar and physician in the time of the 12th Century C.E. formulated the "Thirteen Principles of the Jewish Faith." These were taken from his vast knowledge of Torah Teachings handed down from the time of Moses. A listing of these thirteen principles can be found in the appendix to this pocket guide. The 12th Principle is: "I believe with a complete faith in the coming of Mashiach (Messiah), and though he may tarry, I will wait every day for him to come."
- The topics of organ donation and using procedures to prolong life when death is not unexpected will be mentioned briefly. In-depth discussion is not for this pocket guide due to the complexity of these issues, the range of views of Rabbinic Authorities, and the need to consider each case individually. Families and decision makers should be reminded to consult their Rabbis for guidelines and rulings, if such situations seem significant. Routine consents and "living wills" at the time of patient admission might be disregarded.

Additional Information and Resources on Judaism

The Thirteen Principles of the Jewish Faith

(Based on the Commentary on the Mishnah Sanhedrin 10:1 by the Jewish Rambam)

ANI MAAMIN – I BELIEVE

1. I believe with complete faith that the Creator, blessed be His name, is the Creator and Guide of all the created beings, and that He alone has made, does make, and will make all things.
2. I believe with complete faith that the Creator, blessed be His name, is One and Alone, that there is no oneness in any way like Him; and that He alone is our G-d, was, is, and will be.
3. I believe with complete faith that the Creator, blessed be His name, is incorporeal; that He is free from all anthropomorphic properties; and that He has no likeness at all.
4. I believe with complete faith that the Creator, blessed be His name, is the first and the last.
5. I believe with complete faith that the Creator, blessed be His name, is the only one to whom it is proper to pray, and that it is inappropriate to pray to anyone else.
6. I believe with complete faith that all the words of the prophets are true.
7. I believe with complete faith that the prophecy of Moses our teacher, peace unto him, was true; and that he was the father of the prophets, both of those who preceded and of those who followed him.
8. I believe with complete faith that the whole Torah which we now possess was given to Moses, our teacher, peace unto him.
9. I believe with complete faith that this Torah will not be changed, and that there will be no other Torah given by the Creator, blessed be His name.

10. I believe with complete faith that the Creator, blessed be His name, knows all the deeds and thoughts of human beings, as it is said, "It is He who fashions the hearts of them all, He who perceives all their actions" (Psalms 33:15).
11. I believe with complete faith that the Creator, blessed be His name, rewards those who observe His commandments, and punishes those who transgress His commandments.
12. I believe with complete faith in the coming of the Mashiach (Messiah), and although he may tarry, nevertheless, I wait every day for him to come.
13. I believe with complete faith that there will be resurrection of the dead at the time when it will be the will of the Creator, blessed be His name and exalted be His remembrance forever and ever.

Common Jewish Terms, Symbols, Practices, and Artifacts

Item	Description and Usage
Menorah	Candelabra used on Chanukah. Initially was one of the components of the Holy Area of the Mishkan (Tabernacle) described in the Torah. It eventually entered the Ancient Bais HaMigdosh (Great Temple) in Yerushalayim (Jerusalem), which was destroyed twice, and will be built for the third and final time by the Moshiach; (The Messiah).
Mezuzah	Parchment of holy writings which is attached to the door post of Jewish dwellings. Origin from five books of Moses
Kipa or Yarmulke	A Jewish headcovering worn for worship, religious study, meals, or at any other time.
Tefillin Shel Rosh	("Tefillin of the head"). Of the two tefillin, the one worn on the head.
Tefillin Shel Yad	("Tefillin of the hand&arm). Of the two tefillin, the one worn on the arm and hand.
Tallis(t)	A large, four-cornered shawl with fringes and special knots at the extremities, worn during Jewish morning prayers. The fringes, according to the Bible (Numbers 15.38-39), remind the worshiper of God's commandments. It is traditional for the male to be buried in his tallit, but without its fringes. Tallis(t) Katan ("small garment"). Refers to a small four-cornered garment, with tzitzis at each corner.
Torah	(Heb., "teaching, instruction"). In general, Torah refers to study of the whole gamut of Jewish tradition or to some aspect thereof. In its special sense, "the Torah" refers to the "five books of Moses" in the Hebrew scriptures (see Pentateuch). In the Quran, "Torah" is the main term by which Jewish scripture is identified. Other groups may call it Old Testament.

Item	Description and Usage
Talmud	The book compiling the Oral Torah. It has more than one section, each representing related works of different eras. It covers nearly the whole scope of Jewish tradition; containing laws, customs, philosophy, history, and roots of their inception.
Siddur	(from Hebrew., "to order"). Jewish prayer books used for weekdays and the Sabbath. Special editions are made for Holidays. There are varied combinations of Siddurs.
Payos	Side locks of hair on boys and men. Extending from temples to the vicinity in front of the mid-ear. Some customs encourage extending the payos well beyond the ear.
Brit (or Berit) Milah	(Hebrew: "covenant of circumcision"). Ceremony for boys. Ideally at eight days of age.
Bar (Bat) Mitzvah	(Hebrew: "son (daughter)-of-the-commandment(s)"). The phrase originally referred to a person responsible for performing the divine commandments of Judaism; it now refers to the occasion when a boy or girl reaches the age of religious majority and responsibility (thirteen years for a boy; twelve years for a girl).
Eruv	Usually pertains to boundary markers which establish areas where Jew can carry and walk on the Sabbath. They can be natural or man-made. An eruv might be required in the hospital setting on the Sabbath with no structural changes normally needed, just a little transaction.

Common Words and Phrases in the Hebrew Language

Hebrew	English
Shalom	Hello, Goodbye, and Peace
B' Vakasha	Please.
Todah	Thank you.
Mah Schlom chah?	How are you? (male)
Mah Schlom ech?	How are you? (female)
Mah Schlom chem?	How are you? (mixed group)
Tohv	Good.
Lo Tohv	Not Good.
Beseder	Okay.
Na-eem Meh-ohd	Nice to meet you.
Mazel Tov	Expression of congratulation, literally luck/good.
Schmee...	My name is ...
Baruch H-Shem	"Thank G-d." A good answer for most questions of the status of one's life. To paraphrase; G-d only presents what is essentially good.
Simcha	Joyous occasion, usually based on reaching a religious milestone.
Kehn	Yes.
Lo	No.
Mentsch	A person who consistently conducts him/herself according to Torah Ways.

Animal Foods that are Typically Considered Kosher and Non-Kosher by Religious Jews

Kosher animals are described in the Torah, Book of Leviticus, Chapter 11, starting at the first verse.

Meat

Only land animals that both chew the cud and have split hooves are permitted and must be slaughtered in a special way. Fowl is considered a meat food and also has to be slaughtered in a special manner. Ritual slaughtering is only one process needed to make meat from permissible animals Kosher to eat.

Permitted:
goat, beef, sheep, chicken, turkey, duck

Not Permitted:
Having one of the "signs"
pigs, camels, llamas

Having No "signs"
horses, cat family, bear, dog, reptiles in the water

Fish[1]

Only those fish having fins and scales in the water are permitted.

Not Permitted:
catfish, shark., lobster, clams, crayfish, prawns, mussels, shrimp
oysters, crab, conch, mollusks, squid, octopus, abalone, snails

Meat products may not be eaten with milk products, or immediately thereafter.

[1] *For a comprehensive list of Kosher and Non-Kosher fish, visit the website http://www.kashrut.com/articles/fish/*

Calendar of Holidays Celebrated by Orthodox Jews

Holiday	Season	Length	Description
Rosh Ha Shana	Fall	2 days, even in Israel	Jewish New Year, very solemn. Sabbath type observance. Will use Shofar (Rams horn).
Fast of Gedalia	Day after Rosh Hashana	1 Day	Fast from dawn till night fall.
Yom Kippur	Fall	1-Day	Day of Atonement for sins. Fast over 24 hours, very solemn. Sabbath type observance. Shofar at end.
Sukkoth	Fall	2 Days	Festival with dwelling outside in "huts." Celebrates ingathering of crops. Very joyous. Sabbath-like observance. The 5 intermediate days of Sukkoth have fewer restrictions.
Shimini Atzeras & Simchat Torah	Fall	2 Days	Celebration of the Torah and completion of the yearly reading cycle. Sabbath-like observance. Also very joyous.
Chanukah	Winter	8 Days	Festival of Lights. Lighting candelabra "Menorah." No restrictions, except time to light and watch the Menorah.
Tenth of Teves	Winter	1 Day	Dawn till nightfall fasting.

Holiday	Season	Length	Description
Tu-bishvat	Late Winter	1 Day	New Year for tree harvest, with buying of special fruits. Not restrictive
Fast of Esther	Day before Purim	1 Day	Dawn till nightfall fasting
Purim	Early Spring	1 Day	Secular commitments avoided, although not restrictive. Very joyous. Costumes may be seen on children.
Passover	Spring	8 Days	Freedom of the Jewish Slaves from Egypt. No bread or other products of grain fermentation. Use of Matzos (flat bread). Sabbath-like restrictions on days 1,2,7,8; Intermediate days 3-6 less restrictive.
2nd Passover (Pesach Sheini)	Late Spring	1 Day	Not restrictive, but need Matzos.
Lag B' Omer	Late Spring	1 Day	There might be a parade and bonfire. Joyful day. Not restrictive
Shevouth	Summer	2 Days	Giving of the Torah to the Jewish nation at Mt. Sinai. Sabbath-like observance. Harvest implications
17th of Tammuz	Summer	1 Day	Fasting from dawn till nightfall.

Holiday	Season	Length	Description
Three-week period from the 17th of Tammuz to Tisha b' Av.			Observance of many laws of mourning. Meat is not eaten during the last 9 days.
Tisha B' Av	Summer	1 Day	Mourning for the destruction of the Temple in Jerusalem. Fasting over 24 hours. Elective procedures will be avoided.

NOTE: Fast days will likely need adjustment in the glucose regulation of diabetics. Some Holidays may tend towards high caloric food, or other variations in menu. Physician/Rabbinical intervention might be necessary; of special concern may be a patient's tolerance to fasting.

General Resources on Jewish Health

National Institute of Judaism and Medicine
Michael "Moshe" Akerman, MD, Director
c/o Office of Continuing Medical Education
450 Clarkson Avenue, Box 1244
Brooklyn, New York 11203
Phone 718-270-2422
Email: OCME@downstate.edu
Internet: www.nijm.org

Organized Kashrus Laboratories.
"Ⓚ" Reference for kosher products. Inspects and certifies products as kosher.
Brooklyn, New York
Contact: Rabbi Chaim Fogelman
Phone: 718-756-7500
Email: cfogelman@ok.org

The Jerusalem Center for Research: Halacha and Medicine
P. O. Box 57058
Jerusalem, Israel
Phone and Fax: 972-2-538-3558,
E-mail: HYPERLINK "mailto:info@j-c-r.org" info@j-c-r.org
Internet: http://www.j-c-r.org/

Hatzalah. Rescue and Emergency Ambulance Service
New York, New York
Contact: Rabbi Mechel Handler, Executive Director
Phone: 718-998-9000 (non-emergency number)
Email: central@hatzalah.org

Chesed Shel Emes
Handles all aspects of care of the dead including transportation in and out of New York City and the U.S.A.
Contact: Mendy Rosenberg. Executive Director
Phone: 917-559-8250 or 718-436-2121

Jewish Board of Family and Children Services
General Family Services and Assistance with Developing Bikkur Cholim Organizations (societies for visiting, caring, and monitoring the care of the sick)
Phone: 212.632.4663

Parents Caring and Sharing
Extensive support to families having children with cancer
Phone: 718-596-1542

OHEL- Jewish Children's' Services
Deals with a Full Range of Disabilities, Behaviors and Children Protection Issues
1563 49th Street, Brooklyn, NY 11219
Phone: 718-436-4967

Jewish Family Service
Central Resource Agency for Family Situations.
Jewish Board of Children & Family Service
60 Lafayette Street, New York, NY 10013
Phone: 212-233-0280

Lubavitch Youth Organization
Listings for locating Rabbis in your area, National and International.
www.chabad.org/centers
718-953-1000

Seven Laws for Children of Noah
www.7for70.com Select Noah and 9/11

Web-Based Resources on Jewish Diabetes

http://www.jewishdiabetes.org/
Good overview with many useful details.

www.umassmed.edu/diabeteshandbook
Recommended Handbook: The Healing Handbook for Persons with Diabetes available in English and Hebrew.

www.novo.co.il/
Novo Nordisk Israel Website (in Hebrew)

www.friendswithdiabetes.org
Jewish Diabetes Website in English

http://www.matalk.co.il/
Ma_Talk -Diabetes Site (in Hebrew)

http://www.sukeret.co.il/
Israeli Diabetes Society (in Hebrew)

Books on Jewish Health

Eichlers Books and Gifts in Brooklyn, New York. 1-888-EICHLERS. www.eichlers.com. Classic and current books on Judaism and Jewish health.

Shemirath Sabbath by Rav Yehoshua Neuwirth. Feldheim Publishers. Information on Sabbath observances and laws.

Sanity and Sanctity: Mental Health Work Among the Ultra-Orthodox in Jerusalem
by David, M.D. Greenberg, Eliezer, M.D. Witztum (2001). Yale University Press,

Illness and Health in the Jewish Tradition
by David L. Freeman, Judith Z. Abrams (1999) Jewish Publication Society of America

Caring for the Jewish Patients
by Joseph Spitzer (2003). Radcliffe Medical Press.

Jewish Values in Health and Medicine
by Levi Meier (1991). Rowan & Littlefield Publishers.

Ye Shall Surely Heal: Medical Ethics from a Halachic Perspective
By Rabbi Yaakov Weiner, Shlita Rosh Kollel
The Jerusalem Center for Research: Halacha and Medicine

Judaism, Medicine, and Healing
by Ronald H. Isaacs (1998). Jason Aronson Publisher.

Health and Medicine in the Jewish Tradition: L'Hayyim--To Life (Health/Medicine and the Faith Traditions).
By David M. Feldman (1986). National Book Network.

Medical Halachah for Everyone
By Abraham S. Abraham (1980). Feldhiem Publishers.

Halachah & Medicine Today
Edited by Mordechai Koenigsberg (1997). Feldheim Publishers.

The Mission of **Veterans Memorial Hospital** in Waukon, Iowa is to enhance and restore health while accepting the limits of our humanness by providing services that benefit the community with a commitment to quality, integrity, and caring to all we serve. It is located in scenic Northeast Iowa and is the hospital of Allamakee County that has experienced significant, multicultural immigration over the last 15 years, due to the labor demands of growing agricultural processing. In cooperation with the University of Northern Iowa and regional human services agencies, it has initiated and completed a comprehensive health and individual "assets" survey of the Russian speaking, Latino, and Jewish cultures in the Postville, Iowa area. Its staff reflects the dedicated work ethic found in this region providing patient care which excels in personalized delivery, quality, and cultural sensitivity.

The **Project EXPORT Center of Excellence on Health Disparities at the University of Northern Iowa** is an award-winning organization that is committed to addressing health disparity issues among refugees, immigrants, minorities, and farm families in Iowa. The Center on Health Disparities is part of the national Project EXPORT (Excellence in Partnerships in Outreach, Research, and Training) series of organizations throughout the United States that are funded by the National Center on Minority Health and Health Disparities. The Center assists health agencies and providers in meeting the special needs of diverse and underserved populations by conducting specialized cultural competency trainings, applied research projects, educational outreach programs, and other important services. Visit the organization's website at www.iowahealthdisparities.org.

Information and Resources on Judaism

The **University of Northern Iowa's New Iowans Program** (**NIP**) guides and prepares Iowa communities and businesses as they accommodate immigrant and refugee newcomers living and working in the state. NIP provides tailored consultation for community leadership, conducts research relating to issues facing newcomers and communities, develops innovative training programs for business and industry, and educates Iowans concerning the needs, challenges and opportunities of their new immigrant neighbors, co-workers and employees. All NIP programming incorporates a strong appreciation for the critical role newcomers play in ensuring the long-term social and economic vitality of Iowa's businesses and communities. Visit our Website at www.bcs.uni.edu/idm/newiowans/.

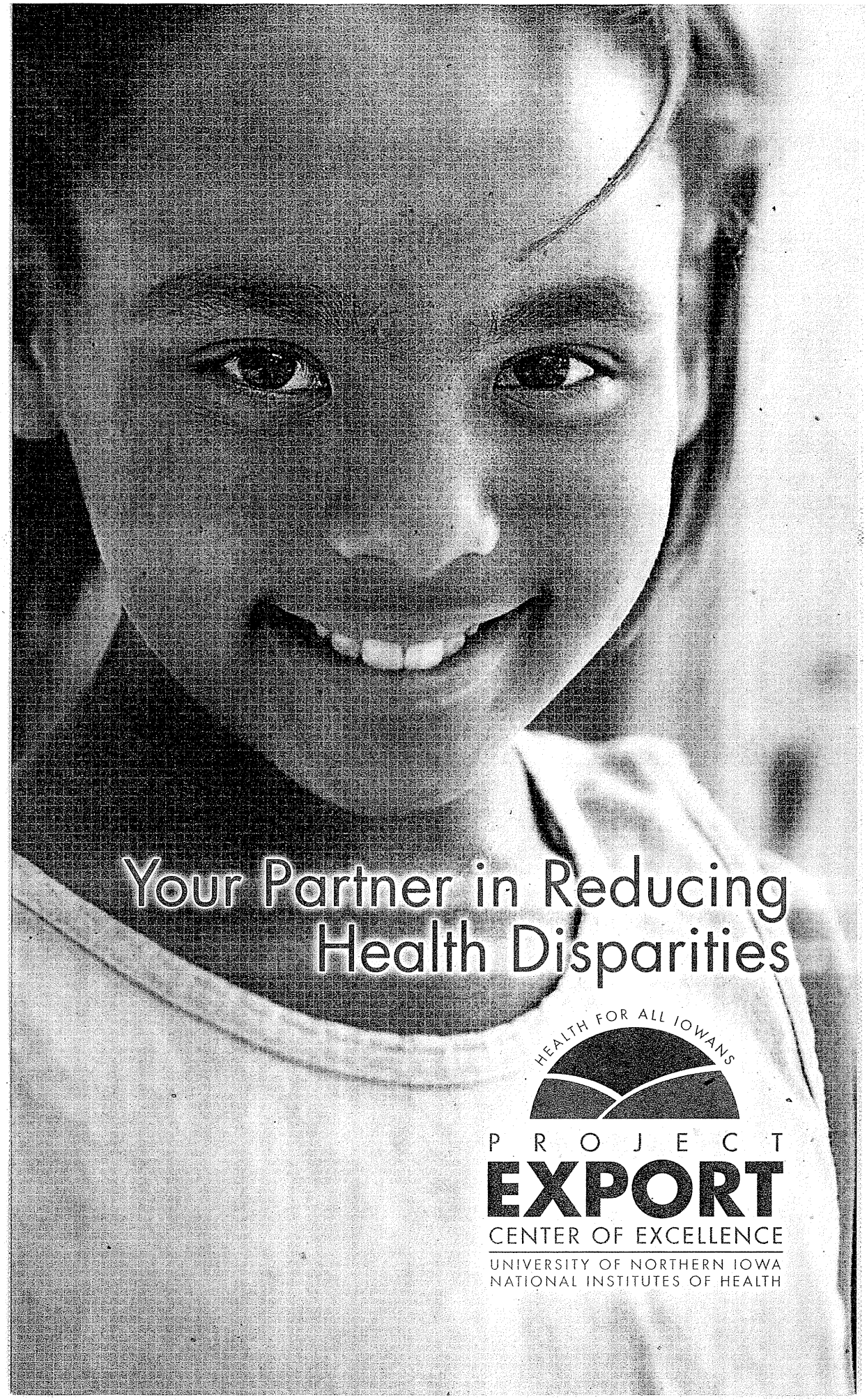
Funding for this publication was made possible by support from the:

National Center on Minority Health and Health Disparities
National Institutes of Health and
Veteran's Memorial Hospital, Waukon, Iowa

Notes

Project EXPORT Center of Excellence on Health Disparities
New Iowans Program
220 Wellness and Recreation Center
University of Northern Iowa
Cedar Falls, IA 50614-0241
P: 319.273.7965 . F: 319.273.6413

www.IowaProjectEXPORT.org


Your Partner in Reducing
Health Disparities
HEALTH FOR ALL IOWANS
PROJECT
EXPORT
CENTER OF EXCELLENCE
UNIVERSITY OF NORTHERN IOWA
NATIONAL INSTITUTES OF HEALTH

They're all Iowans

They have the same health needs.
But they may not have the same health status.

Iowa's diversity is one of its greatest assets. But along with this richness of diversity comes the challenge of promoting good health among all of the state's residents.

Many minorities, refugees, immigrants and farm families are underserved in our state.

Working together with us, committed agencies like yours can make a difference.

PROJECT EXPORT CENTER OF EXCELLENCE ON HEALTH DISPARITIES . F

Our Services Include

Specialized Training

(available onsite and online)

- Cultural competency for health providers
- Health disparities
- Medical interpreter training

Applied Research & Technical Consulting

- Needs assessments
- Public health program evaluations
- Minority health assessments
- Strategic planning studies
- Rapid health assessments
- Knowledge and attitude assessments
- Health behavior surveys

Missions and Study Tours

- Specialized immersion and education tours of ethnic communities in Iowa and abroad

Publications

- Health disparity newsletters for agencies and providers
- Peer-reviewed academic journal on health disparities

Information Clearinghouse

- Extensive website on health disparities in Iowa
- Referrals to leading multicultural health and disparity organizations
- Multicultural health education information in different languages
- Fact sheets and minority health comparison tables for Iowa

Education and Outreach

- Multicultural health education programs and curriculum for underserved populations

Partnerships and Advocacy

- Professional partnerships with public health departments, non-profit agencies, state offices and hospitals
- Advocacy with legislators and policymakers on health disparity issues

Continuing Education for Working Professionals and Students

- Certificate in Minority Health and Health Disparities for working professionals, available online
- Award-winning cultural competency training program for students
- Opportunities to serve as health disparity scholars and researchers

HEALTH FOR ALL IOWANS

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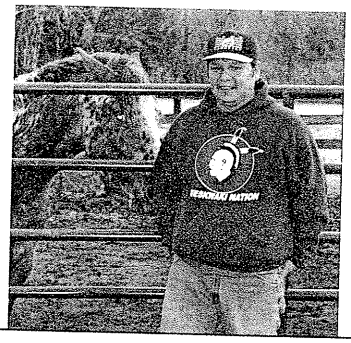
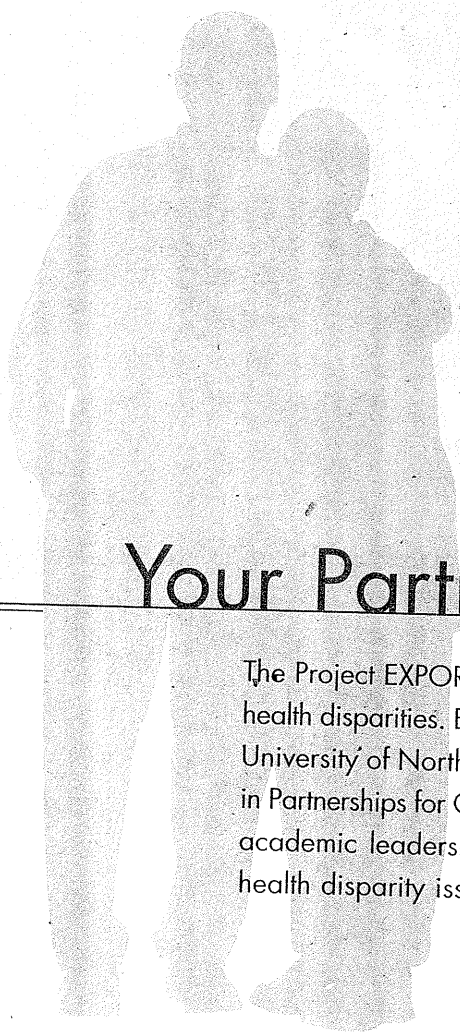




Your Partner in Prevention

The Project EXPORT Center of Excellence is your partner in reducing health disparities. Established by the National Institutes of Health on the University of Northern Iowa campus, the EXPORT Center (Excellence in Partnerships for Outreach, Research and Training) provides statewide academic leadership to organizations challenged with addressing health disparity issues.

or more information about our services please give us a call at 319.273.7965 or vis

Organizations

The EXPORT Center links elements of three organizations at the University of Northern Iowa that have extensive experience working in the disparity and diversity fields. These agencies include:

The Global Health Corps:

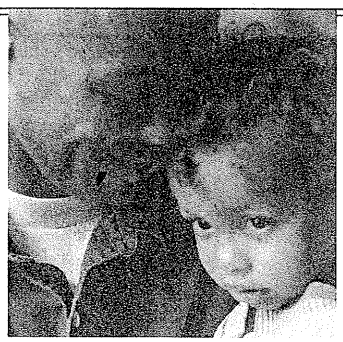
An award-winning organization that specializes in improving the cultural competency of health students and professionals when working with diverse clients;

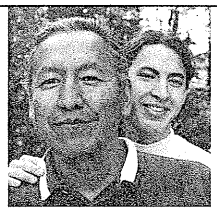
The Center for Social and Behavioral Research:

An outstanding unit that conducts a variety of field-based research projects for agencies around the country on important socio-economic issues;

The New Iowans Program:

A model organization that specializes in improving the ability of Iowa communities and employers to receive new immigrants in the state.

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CENTER FOR HEALTH DISPARITIES

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www.IowaProjectEXPORT.org . www.IowaHealthDisparities.org

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NATIONAL INSTITUTES OF HEALTH

LEGISLATIVE ADVOCACY STATEMENT ON PUBLIC HEALTH POLICIES FOR NEWCOMERS IN IOWA

The Iowa EXPORT Center of Excellence on Health Disparities is funded by the National Institutes of Health. It is a model organization whose mission is to serve as a statewide academic leader in addressing health disparities among immigrants, refugees, minorities, and rural families through applied research, education, training, and outreach. The Iowa EXPORT (Excellence in Partnerships for Outreach, Research, and Training) Center promotes strategies at the state level that reflect national priorities for the reduction of health disparities among newcomer populations. To that end, the Iowa EXPORT Center urges the state legislature to support the policies and programs below:

- Recruit, train, and retain health care professionals in Iowa, particularly those that are minorities, to address workforce shortages in key communities;
- Adopt the Development, Relief, and Education for Alien Minors (DREAM) Act in Iowa to allow children of undocumented residents to qualify for in-state tuition so that they may attend health professional schools more affordably;
- Increase the financial obligations of large, new employers, particularly those in small rural towns, to help pay for medical interpreters, nurses, and other needs of health organizations that must serve their newcomer workers;
- Improve the ability of health providers to work effectively with newcomer and minority patients through mandatory cultural competency training;
- Expand programs and eligibility for low-cost preventive and medical services for high-risk newcomer populations, such as pregnant women and young children;
- Recognize and support the practical necessity of providing health information in the native languages of newcomers, until their skills in English become better;
- Recruit, train, and retain qualified medical interpreters in the state;
- Provide health services on-site where newcomers work, live, and study;
- Monitor, track, and disseminate health disparity data among newcomers; and
- Strengthen the Office of Multicultural Health at the Iowa Dept of Public Health.

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P: 319-273.7965 . F: 319.273.6413 . www.IowaProjectEXPORT.org . www.IowaHealthDisparities.org

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ASIANS IN IOWA

A Snapshot of Health Disparity Issues

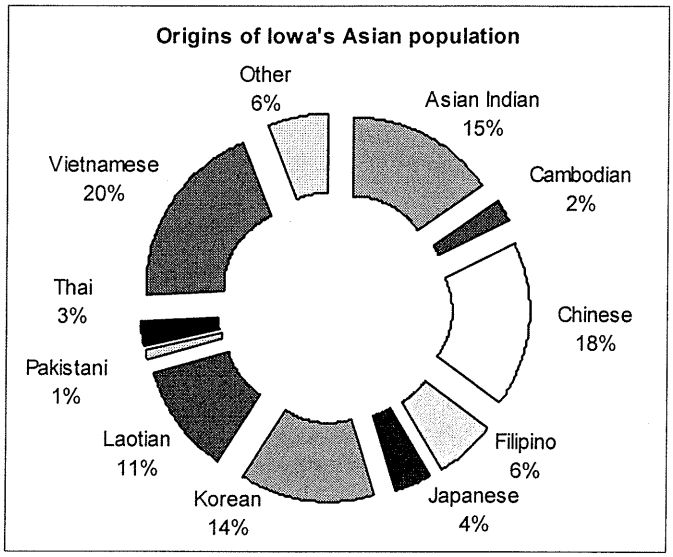


Figure 1: Total Population 35,023 [1] A high level of diversity exists amongst Iowa's Southeast Asian population. They come from distinct countries and cultures with radically different histories and languages.[2]

Southeast Asians in Iowa

Iowa has a proud history of welcoming Southeast Asian refugees. In 1975, Iowa was the first state to welcome thousands of refugees from Southeast Asia. Most Americans remember the so-called "boat people" of Vietnam; 600,000 of them risked their lives on the open sea to escape the communist regime in Vietnam. Many used unseaworthy craft, including oil drums strung together with rope. An estimated 45 percent of the boat people died at sea. In 1975, Iowa was the only state to open its arms to thousands of Tai Dam (or Black Tai) and other Lao, Khmer (Cambodian) and Hmong refugees who fled the aftermath of the Vietnam War to settle in the United States.

Hundreds of Iowa families, churches and communities sponsored families. They located across the state in communities large and small, and Iowa became the first and only state to have a government agency to work on refugee issues. This agency went through several organizational and name changes, but it eventually became the Bureau of Refugee Services (BRS). For more than 25 years, the Bureau of Refugee Services has settled thousands of refugees in Iowa from around the world.[3]

What Is the Difference Between Immigrants and Refugees?

The distinctions between immigrants and refugees are economic, social and legal. Refugees are forced to leave their home countries because of war, environmental disasters, political persecution and/or religious or ethnic intolerance. They come to the United States with a special immigration status that gives them automatic admission into the country and eases their reunification with family members. This status also provides them with a "green card" or work authorization permit. In addition, short-term financial assistance is funded by the U.S. Department of Health and Human Services through private and state agencies like the Iowa Bureau of Refugee Services. Refugees are "invited" to live in the United States to start a new life.

Immigrants generally come to the U.S. for one of two reasons; they are joining family members who already live in this country, or they are "economic immigrants" seeking work and a better life for themselves and their families.

Both refugees and Immigrants experience similar challenges coming to the U.S. and Iowa, including new cultures and languages. They are often ethnic minorities who might face open racism or other forms of hostility, regardless of their immigration status.[4]

Why Do Immigrants and Refugees Leave Their Home Countries?

Aside from civil or tribal wars and natural disasters, the economic forces from globalization have greatly influenced the displacement of people throughout Africa and Asia, bringing groups to the U.S. and to Iowa.

- Increased poverty and food scarcity
- Reduced national revenues due to tax breaks and foreign investment incentives
- Increased problems of balance of payments and national debt to multi-lateral agencies like the World Bank
- Increased inequality between the rich and poor
- Increased environmental degradation
- Cultural displacement
- Capital flight

Refugees and immigrants have the same goals and desires as all humans do. Living in Iowa provides them with the opportunity to start a new life for themselves and their children.

- *Availability of jobs*
- *Low cost of living*
- *Affordable housing*
- *Safe communities*
- *An excellent education system for children* [5]

What is "Secondary Migration"?

Modern day refugees and immigrants do not always intend to settle in a particular new territory. Many had to leave their own countries unwillingly, moving wherever they could to start a new life. Thus, many of our newcomers were already relocated once outside of Iowa, and then chose to move here to join family, accept jobs, or live in a different climate. Many of the ethnic Lao refugees in Storm Lake, for example, are "secondary migrants" who initially settled in Oklahoma and Minnesota before migrating to Iowa. The U.S. Census Bureau estimates that between 1995 and 2000 nearly 13,000 foreign-born people moved from other states to Iowa.[6]

Religion

Southeast Asians practice a variety of indigenous, Eastern, and Western religions. In Vietnam, for example, traditional religion involves a mixture of animism, Buddhism, Taoism and Confucianism. Catholicism and Protestantism are also practiced there. Islam is also followed by many Southeast Asians.

Just as European, Latino and African Christians have done, Asian Christians have interpreted religious principles in the context of their own customs in Christian ceremonies.[7]

Buddhism is quite common in Southeast Asian cultures. Buddhists worship both in temples as well as privately. This religion has been brought to the United States and Iowa, and there is a Buddhist Temple in communities such as Des Moines and Storm Lake. [8]

Honoring Ancestors

For many Asians, honoring ancestors is an important part of religious life. In its simplest form, people who practice ancestor honoring acknowledge the benefits and opportunities they received from their parents and grandparents, and they thank them in private ceremonies. Involving the ancestors in funerals, weddings and other significant rites of passage is also common. In this sense, ancestor honoring acknowledges the belief that ancestors retain an interest in the family's affairs. It is common for Southeast Asian refugees to maintain small family shrines in their homes. These usually include photos of ancestors and a place to burn incense. Prayers are often offered at these shrines.[9]

Population Comparisons in Iowa

- 31% of Southeast Asian/Pacific Islanders are 19 and under while 5% are 60 and over

- 27% of Whites in Iowa are 19 years or younger, while 20% are above the age of 60

- Average family size for Southeast Asians is 3.5 compared to2.97 for Whites

- Median age for Southeast Asians is 27.6 compared to 37.6 for Whites

- Average household size is 2.91 for Southeast Asians and 2.43 for Whites

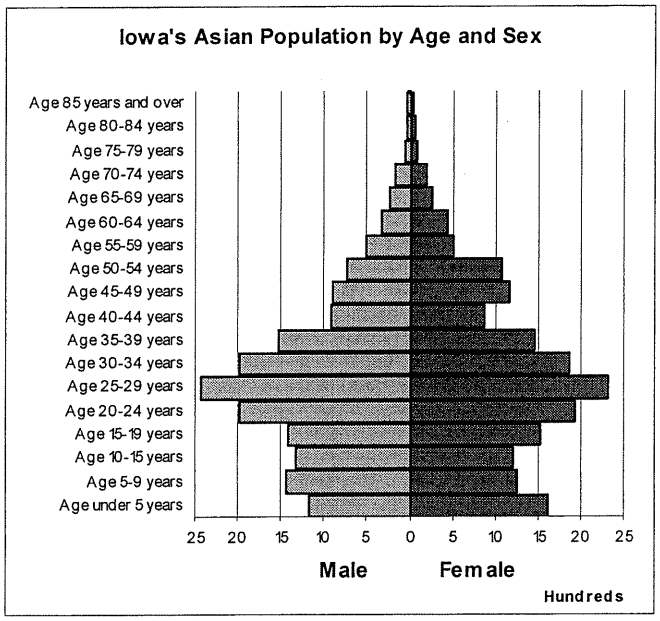


Figure 2: Population 31,327[10]

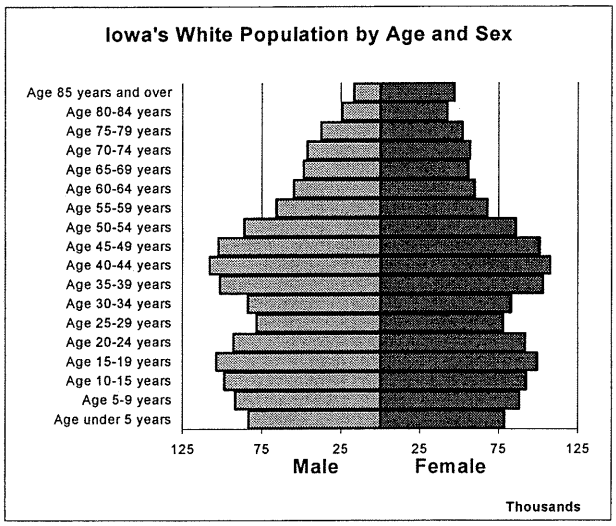


Figure 3: Population 2,749,737[11]

Family Structure

- In 2000 there were 7,326 Asian households in Iowa. 81% were married couple families, and 19% were single parent households.[12]

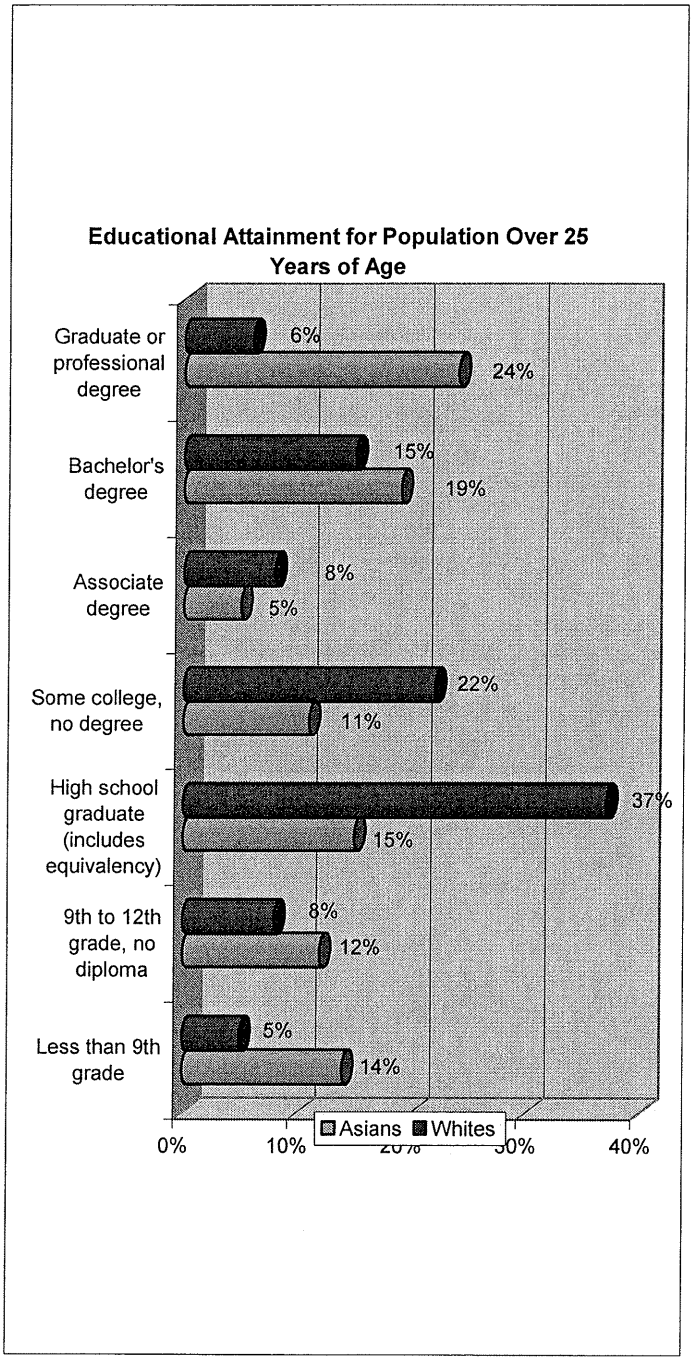
- Many Asian minorities, particularly in larger communities, live in distinct ethnic neighborhoods. They tend to be distrustful of outsiders, preferring to rely on their own for assistance.

- Asian Americans tend to have an extremely strong cultural value placed on the extended family. Each person, such as a parent or child, has a distinct and well-defined role in the family.

- While gender preferences in children may favor boys in many Asian cultures, women are still afforded high levels of respect from a familial standpoint. Many Southeast Asian and Pacific cultures place great emphasis on the power of women, with females often running small businesses.

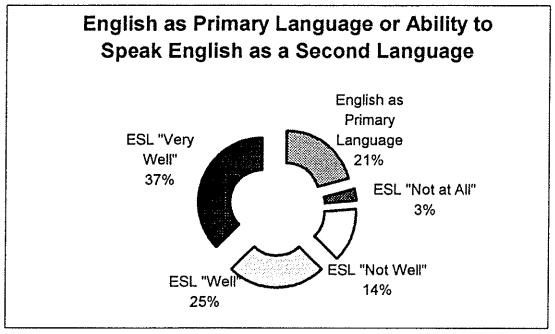
- Elders are absolutely revered and valued for their age and wisdom, while young children are genuinely adored. Aging and child health programs are supported well by this group.[13]

Education



- 43% of Asians have a bachelors or graduate degree compared to 21% of Whites
- Asians in Iowa are 4 times as likely to have a graduate or professional degree as Whites[14]

Language

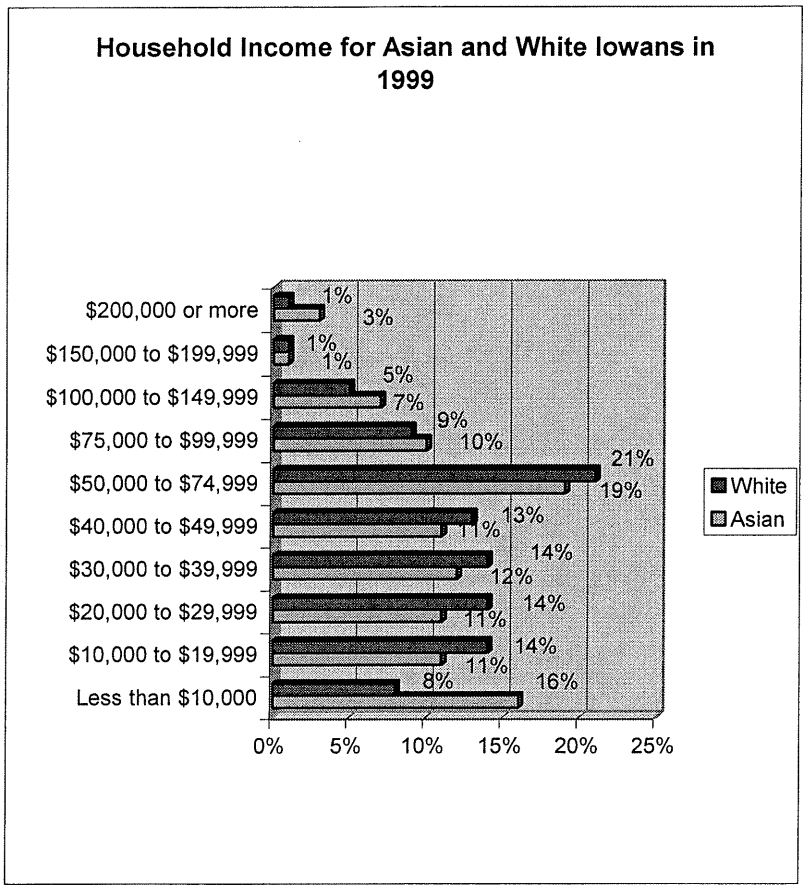


Communication Style:

- Tend to be fairly reserved and thoughtful when speaking
- Often place a high value on the importance of respect and "saving face"
- Generally try not to embarrass or put others in awkward positions
- Emphasize honor and politeness at all times in interactions
- Usually avoid direct eye contact, close body spacing, and casual touching while a highly defined sense of formality exists in all relations
- Tend to be less willing to openly express their opinions or feelings, particularly if they are negative[15]

Income and Poverty

In 1999 the Median Household Income in Iowa for Asians was $40,348, an Asian Family's Median Income was $50,126 and per capita Income for Asians was 18,279. These numbers were $39,986, 48,790 and $20,249 respectively for White Iowans.



Cultural Differences: What is Health?

Differences in what is considered "health" and "wellness" can prevent the U.S. health care system from working well for minorities. For example, the person who has a chronic disease but is still able to function by working and attending to family matters might consider himself "well" and fail to seek out medical attention that established residents would consider mandatory. There might also be critical differences in assumptions about how to treat or prevent the condition, and cultural differences can increase the likelihood of a missed or inappropriate diagnosis. The results can be costly if health problems are not handled appropriately and become critical, requiring a visit to the emergency room.

Barriers to Healthcare

- Many Asian immigrants are not comfortable using western medical care, and prefer to be seen by healers from their own culture.
- In ethnic neighborhoods, language can present significant barriers to care for Asian Americans.
- Health services are not always located where minority and immigrant populations often live, and they may not have easy car or bus transportation to reach them.
- Many immigrant workers in meat packing plants work double shifts with only one day off per week. Standard office hours of 9:00-5:00, Monday –Friday are not accessible for them.
- Cultural access is also a common barrier to care when the minority patient cannot be seen by providers familiar with their unique ethnic background or sensitive to their needs.
- Lack of interpreters for Asians with limited English is a significant limitation.[16]

Along with these barriers to care, providers of medical services to newcomer Southeast Asians may be challenged with:

- Limited or no medical records from the patient's country of origin.
- No patient health-history for reference (ex: immunizations, allergies, medical conditions).
- Diseases from the home country, that are less common in the United States and unfamiliar to health care providers in Iowa.
- Higher rates for diseases found in mobile populations, like tuberculosis, certain parasites or viruses, and sexually transmitted diseases.
- Different cultural ideas about the role of health care professionals[17]

Health Disparities

Today, Asian Americans have made extreme strides in their standard of living, and generally have an excellent reputation for hard work and educational achievement. Their health status as a group is usually among the very best in the country, often higher than the European American majority, because of genetic factors and positive lifestyle practices. Life expectancies are usually longer, and mortality rates are lower than those for most other cultural groups in America. However, with each generation born in America, fewer differences in health status exist. [18]

Traditional Health Practices

Leading Causes of Mortality in Iowa[19]	Asians	Whites
Cancer	33%	23%
Disease of Heart	22%	30%
Unintentional Injuries	5%	4%
Pneumonia	4%	3%
All Infective and Parasitic Disease	4%	1%
Diabetes Mellitus	3%	3%
Cerebrovascular Disease	8%	8%

Asian traditional healing systems are among the oldest and most complex in the world. Many of these systems have been well documented for thousands of years in standardized texts. In general, they tend to emphasize health from a holistic standpoint. Rather than treating a disease symptom, like in the West, they usually emphasize maintaining balance, harmony, and interconnectedness of the body, mind, and spirit. Many exercise programs in the United States today, like yoga and Tai Chi, are actually ancient Asian healing systems. Most Asian cultures have well-defined usages for many herbal remedies as well. Multiple forms of energy healing, like acupuncture and qi-gong, are used in many Asian cultures, and work on rebalancing the electromagnetic field surrounding living beings. In their health belief system, this rebalancing is necessary to remove blockages of energy that can ultimately cause illnesses and disease[20]

Birth Events-Iowa 2001[21]	Asians	Whites
Births out of Wedlock	19%	27%
Mothers Under Age 20	7%	9%
Low Birth Weight <2500 Grams	8%	6%
Fetal Deaths	12%	1%
Infant Deaths	3%	1%

Working with Southeast Asians

- Interventions are best conducted through train-the-trainer models and other programs using native providers.
- Remember to modify programs to emphasize the relevance of family roles, rather than the individuals role.
- Understand that families often request that the patient not be told about their terminal illness or impending death.
- Create a welcoming environment. Make sure that all staff is trained in how to work effectively with immigrant and minority clients, in order to make their experience more positive.
- Have Asians on your staff, and throughout your organization.
- Deliver health care services on-site; in churches, stores community centers, and schools.
- Provide healthcare services at non-traditional hours including weekends and nights.
- Make Asians part of the health care community through membership on hospital boards, non-profit advisory councils, and other external decision-making entities.
- Always treat elderly Southeast Asians patients with great respect.
- Remember that face-to-face interactions and family connections are valued in this culture. Many referrals are made by word-of-mouth, particularly in immigrant communities.[22]

ENDNOTES

[1] U.S. Census Bureau, Census 2000
[2] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[3] *The New Iowans: A Companion Book to the PBS Miniseries The New Americans* .Mark A. Grey, Ph.D., Anne C. Woodrick, Ph. D., Michele Yehieli, D. P.H., and James Hoelscher, University of Northern Iowa, New Iowans Program In Collaboration with Iowa Public Television
[4] *ibid*
[5] *ibid*
[6] *ibid*
[7] *ibid*
[8] *ibid*
[9] *ibid*
[10] US Census Bureau, Census 2000
[11] *ibid*
[12] *ibid*
[13] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[14] US Census Bureau, Census 2000
[15] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[16] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[17] *ibid*
[18] *ibid*
[19] Vital Statistics of Iowa, 2001
[20] *ibid*
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[22] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program

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AFRICAN AMERICANS IN IOWA

A Snapshot of Health Disparity Issues

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AFRICAN AMERICANS IN IOWA

African Americans have been in Iowa since before the first census in 1850, but were less than 1% of the population until 1970. Currently they make up 2.2% of the population. While slavery was never permitted in Iowa, institutional racism was law. In 1844 the constitutional convention unsuccessfully tried to keep Blacks from being state residents. The constitution of 1857 gave Blacks property rights and legal standing in courts, but deprived them of the rights to vote, sit on juries, and be members of the General Assembly. However, in 1868, not only did Iowa start admitting African Americans to public schools but also became one of only five states to give Blacks the vote (seventeen states refused). Between 1960 and 1990 discrimination in schools and employment was reduced through anti-discrimination laws and Black activism. However, housing discrimination still exists. [1]

GEOGRAPHIC DISTRIBUTION

Since most of their employment opportunities were limited to railroads, mining, packing-houses and factories African Americans settled in urban areas.[2] Today 89% of Blacks in Iowa still live in urban areas. The cities with the greatest percentages of the African American population are Des Moines (29% of African Americans) and Waterloo (16% of African Americans). Significant African American populations are also in Davenport/Bettendorf (16%), Cedar Rapids (8%), Iowa City (5%), Sioux City (3%), Burlington (2%), Ames (2%), Fort Dodge (2%), Fort Madison (2%), and Clinton (2%).[3]

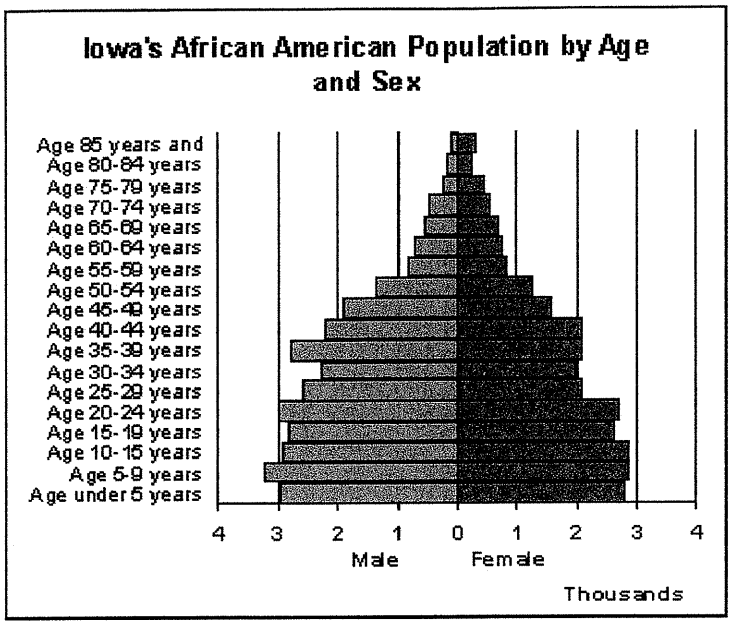

Figure 1: Iowa's African American Population[4]

In 2001 there were 72,512 African Americans in Iowa making them the second largest minority group after Latinos (82,473)[5] This is a significant change from the 1990 Census in which Blacks were the largest minority group in Iowa. Of Blacks 9% are above 60 years of age and 39% are under the age of 20. Their median age is 25.3 and their average family size is 3.33.[6] In 2001 their live birth rate per 1000 population was 17.7[7] with a life expectancy of 72.2 years. [8]

POPULATION CHARACTERISTICS

In comparison, the White population is the majority population in Iowa making up 95% of residents[9]. While 27% of White Iowans are under 20 years, 20% are over 60, and the White life expectancy is 77.7 years of age.[10] [11] The average family size is 2.97 and the live birth rate is 12.7 per 1000 population

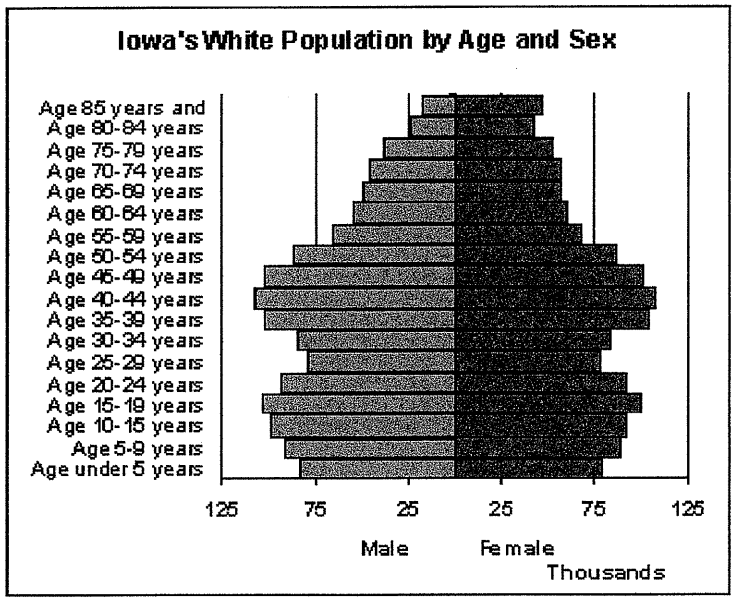

Figure 2: Iowa's White Population[12]

Household Income in 1999	Black	White
Less than $10,000	22%	8%
$10,000 to $19,999	18%	13%
$20,000 to $29,999	17%	15%
$30,000 to $39,999	11%	14%
$40,000 to $49,999	10%	12%
$50,000 to $59,999	6%	10%
$60,000 to $74,999	7%	11%
$75,000 to $99,999	5%	9%
$100,000 to $149,999	3%	5%
$150,000 to $199,999	1%	1%
$200,000 or more	1%	1%[13]

African Americans earn nearly 40% less per capita than Whites.[14]

In 1999 per capita income for Blacks was $12,400, while for Whites it was $20,249.

In 1999 African Americans were four times as likely to live below the poverty level as Whites.

27% of Black families lived in poverty in 1999.

Only 8.1% of White families lived in poverty in 1999.

70% of African American families in poverty have single women as the head of the household.[15]

Iowa Poverty Status by Age 1999	White Alone Not Hispanic or Latino	Black or African American
Income in 1999 below poverty level:		
Under 5 years	1%	5%
5 years	0%	1%
6 to 11 years	1%	5%
12 to 17 years	1%	4%
18 to 64 years	5%	16%
65 to 74 years	0%	1%
75 years and over	1%	0%
Total Population	8%	32%[16]

Educational Attainment for Population 25 Years and Older	Black or African American Alone	White Alone Non-Hispanic
Less than 9th grade	7%	5%
9th to 12th grade, no diploma	16%	8%
High school graduate (includes equivalency)	31%	37%
Some college, no degree	25%	22%
Associate degree	6%	8%
Bachelor's degree	10%	15%
Graduate or professional degree	5%	6%[17]

African American Iowans tend to have lower education levels than Whites. Lack of education impacts every area of a person's life from earning ability to birthrates and life expectancy. Literacy is one of the strongest, most direct predictors of health status and poverty.[18]

HEALTH DISPARITIES

As a group, the health status of African Americans is among the worst in the nation, with significantly higher morbidity and mortality rates for almost all diseases and injuries. Some of these figures are due to genetic factors, but most are a result of higher poverty and unemployment levels, lower education and literacy levels, institutional racism, more single-parent families, limited financial and cultural access to health care, and lifestyle factors. Blatant as well as more subtle forms of discrimination likely contribute to higher levels of stress among African Americans, which can negatively affect their health status as it relates to hypertension, low birth weight, headaches, and other conditions. [19]

As evidenced in the 2001 Vital Statistics of Iowa, there are a number of significant health disparities between the African American and White populations.

Blacks have an occurrence nearly twice that of Whites for low birth weight babies, fetal deaths, infant deaths and deaths from heart disease.

Neonatal deaths (death of live born infant occurring within the first 27 days of life) among Blacks occur at more than 3 times the rate of Whites.

The Black population has a higher rate of diabetes.

75% of children born to African American women in Iowa are born out of wedlock.[20]

African American women are nearly 2.5 times more likely to give birth under the age of 20 than White women.

Iowa Birth Events 2002	Rate per 1000 live African American Births	Percentage of all African American Births	Rate per1000 live White Births	Percentage of all White Births
Births out of wed-lock	739.7	74%	279	28%
Mother under age 20	213.6	21%	87.9	9%
Low Birth Weight <2500 grams	103.7	10%	60.8	6%
Congenital Malformations	7.0	1%	10.2	1%
	per 1000 live African American Births	African American Deaths	per 1000 live White Births	White Deaths
Fetal Deaths	9.4	3%	5.2	1%
Neonatal Deaths	7.0	2%	3.0	0%
Perinatal Deaths	16.4	6%	8.2	1%
Infant Deaths	14.0	5%	4.5	1% [21]

HEALTH DISPARITIES

Leading Causes of Death in Iowa	Rate Per 100,000 African American Midyear Population	Percenatge Total African American Deaths	Rate Per 100,000 White Midyear Population	Percentage Total White Deaths
Pnuemonia	9.2	2%	33.1	3%
Certain Conditions Originating in the Perinatal Period	12.2	2%	3.0	0%
Alzheimer's Disease	13.8	2%	31.9	3%
Chronic Lower Respiratory Diseases	19.9	3%	55.3	6%
Homicide and Legal Intervention	19.9	3%	1.7	0%
Other Infective and Parasitic Diseases	23.0	4%	12.7	1%
Diabetes Mellitus	24.5	4%	25.6	3%
Unintentional Injuries	36.7	6%	37.8	4%
All Other Diseases	41.3	7%	105.8	11%
Cancers	143.9	25%	224.8	23% [22]
Major Cardiovascular Diseases	205.2	35%	391.2	40%

BARRIERS TO HEALTH CARE

African Americans are much less likely to access health care in a timely manner in Iowa and the United States. They often enter the system when their medical conditions are more complicated and pronounced. Early intervention programs are best provided on an outreach basis in schools, neighborhoods, churches, and other locations where African Americans already are, rather than waiting for them to seek care.

Because of cost, lack of insurance or being underinsured, lack of transportation, limited hourly access and lack of information about the ins and outs of the health care system, Black patients will often seek treatment for health problems later than the majority white population and are more likely to present with multiple, more advanced conditions.

Many continue to value alternative and more natural types of healthcare. Just as there are multiple strategies that individual health providers can undertake, health organizations can also adopt a variety of deliberate strategies to become more culturally effective with minority and immigrant patients.

Most Blacks are much more likely than Whites to take care of ill relatives and friends at home, rather than send them to formal providers or nursing homes.[23]

AFRICAN AMERICANS

WORKING WITH

Create a welcoming environment. Make sure that all staff is trained in how to work effectively with immigrant and minority clients, in order to make their experience more positive.

Deliver health care services on-site: in churches, stores, community centers, schools, and work places.

Provide healthcare services at non-traditional hours including weekends and nights.

Make African Americans part of the health care community as members of your staff, hospital boards, non-profit advisory councils, and other decision-making entities.[24]

Loss of Trust

Due to a historical legacy of slavery, institutional racism, legal segregation, unethical scientific experiments, racial profiling, and other human rights abuses over the past two centuries, lack of trust in the predominantly white American medical system is a factor in African Americans not seeking medical attention.[25]

ENDNOTES

[1] *The African American Encyclopedia*, Second Edition. Michael W. Williams, editor.
[2] *Iowa's Black Legacy.* Charline J. Barnes and Floyd Bumpers. Arcadia Publishing, Great Britain, 1990.
[3] SETA: Office of Social and Economic Trend Analysis. Iowa State University.
[4] US Census Bureau, Census 2000.
[5] Iowa Department of Public Health, Vital Statistics, 2001.
[6] US Census Bureau, Census 2000.
[7] Iowa Department of Public Health, Vital Statistics, 2001.
[8] National Vital Statistics Reports, Vol.51, No. 3, December 19, 2002.
[9] Iowa Department of Public Health, Vital Statistics, 2001.
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[11] National Vital Statistics Reports, Vol.51, No. 3, December 19, 2002.
[12] US Census Bureau, Census 2000.
[13] United States Census Bureau, Census 2000, Summary File 3, Tables P151B & P151I
[14] *ibid*
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[16] United States Census Bureau, Census 2000 Summary File 3 Tables P159I and P159B
[17] United States Census Bureau, Census 2000, Summary File 3 tables P148B and P148I
[18] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program.
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[21] Iowa Department of Public Health, Vital Statistics, 2002. Tables 4A and 4B
[22] *ibid*
[23] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program.
[24] *ibid*
[25] *ibid*

Appendix: The Cultural Communities: African Americans. From: *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program.

Appendix
Working With Communities: African American Patients

The information provided in this section will introduce some of the fundamentals of working with specific populations. This information is to be used only as a general guide and as a starting point for providers trying to learn basic cultural competency points. All people are ultimately individuals, and this information is not meant to stereotype any group. Remember, as stated previously, culture is only one factor that influences a patient's behavior and health status. In an effort to be culturally competent, providers should not ignore other fundamental factors like gender, age, lifestyle, education level, and individual personality traits in their patients that are equally important.

Finally, the information provided in this section is meant to be only an introduction to a particular cultural group. Ultimately, providers must be willing to immerse themselves in working with people of diverse backgrounds over a regular period of time in they truly wish to improve their cultural competency.

AFRICAN AMERICANS
Overview:

• African Americans have experienced a unique history as a minority population in the United States, and this experience has profoundly affected their socioeconomic and health status. African Americans were the only major ethnic group that came to the Western Hemisphere against their will. They comprise one of the largest forced migrations of humans in history. In most cases, they were taken from their homes or were prisoners of African wars; separated from their families; spent time in slave dungeons in West Africa; transported in cramped quarters on ships across the Atlantic where many of them died; and then sold to plantation and business owners in the New World.

• African Americans were generally forced to convert from their traditional religions, kept uneducated, and were treated as property for decades in the United States. It was only about 140 years ago in parts of America that slavery was still legal. It was only about 30 years ago that Blacks in many areas of this country, particularly the south, were completely segregated from whites by law in housing, education, and jobs.

• The historically negative relationship between the dominant population in the United States and the minority African American group has had significant impact on the health status of blacks in the country and their use of services. From a public health standpoint, it is no coincidence that African Americans and Native Americans, the two minority groups that have had the worst historical relationships with the majority population, continue to have the lowest health status in the country.

Language and Religion:

• Because their families have been in the United States for centuries, most African Americans speak English as their native language. A number of subtle black dialects exist, though, in the country that are unique to urban inner cities or rural Southern communities.

• Most African Americans practice some form of Christianity in the United States. Many, particularly those who migrated to Iowa from the South, are Baptist. The percentage of Black Muslims has also been increasing, though, in the United States and Iowa, particularly among younger males.

Family and Social Structures:

• The family is the foundation of African American society. The family usually revolves around the mother, her elders and siblings, and her children. Fathers may not necessarily live with the family, particularly if they are lower income and the children were born out of wedlock. Families, in general, tend to be large and caring. Black women are especially recognized for their strength and nurturing tendencies.

• Although African Americans as a group have lower income levels than most other minority populations in the United States, the African American middle class is expanding rapidly in the country. Black women, in particular, have made great strides and many have become financially successful, although young black males continue to lag behind as a group.

• Many predominantly black communities throughout Iowa are organized into neighborhood associations, which are often associated with a particular local church. These neighborhood associations are often active socially and politically in the community. Health providers and organizations should take the time to meet the leaders of these neighborhood associations, talk to their residents, and incorporate them into outreach programming. Many health services for blacks will be utilized heavily if they are provided on site in church basements, schools, neighborhood centers, and the like.

• Most African Americans are much more likely than whites to want to take care of ill relatives and friends at home, rather than send them to formal providers or nursing homes.

Communication Style:

• In general, many African Americans are more openly expressive than European Americans. They will often display more direct eye contact, closer body spacing, and a higher level of physical touch than many whites. Verbally, they may be more likely than whites to share their opinions openly or ask questions directly. They may also display a higher level of verbal emotion and expression than European Americans. When conducting health education programs, adjust to these cultural nuances and use interactive activities that allow ample opportunity for discussion, problem solving, and hands-on learning.

Barriers to Care and Common Health Conditions:

• Cost is generally the greatest barrier to care for African Americans in Iowa and the United States.

• Some public health studies have also shown that blacks, as a whole, are less trusting of the American medical system and its providers, who are primarily white. This mistrust is a very important cultural barrier to care, and should not be underestimated. Many African Americans, even those that are highly successful and educated, feel that the historical legacy of slavery, institutional racism, legal segregation, unethical scientific experiments, racial profiling, and other human rights abuses over the past several centuries has significantly damaged black-white relationships in the United States, and will require additional time and effort to reconcile. As such, many African American patients question the methods and motives used by white providers and health organizations that provide them with care, and blacks will often be particularly sensitive and insulted by poor treatment from white providers.

• Providers should recognize the implications that the legacy of slavery and discrimination has had on the health status of African Americans. Because it has only been in the last few decades that legal discrimination has been less common, a number of factors combine to put African Americans at very high risk for poor health. As a group, their health status is among the worst in the nation, with significantly higher morbidity and mortality rates for almost all diseases and injuries. Some of these figures are due to genetic factors, but most are a result of higher poverty and unemployment levels, lower education and literacy levels, institutional racism, more single-parent families, limited financial and cultural access to health care, and lifestyle factors. Blatant as well as more subtle forms of discrimination likely contribute to higher levels of stress among African Americans, which can negatively affect their health status as it relates to hypertension, low birth weight, headaches, and other conditions.

• Blacks are disproportionately represented among those on federal or state medical assistance programs, as well as among the unemployed and underemployed.

• African Americans are much less likely to access health care in a timely manner in Iowa and the United States. They often enter the system when their medical conditions are more complicated and pronounced. Early intervention programs are best provided on an outreach basis in schools, neighborhoods, churches, and other locations where African Americans already are, rather than waiting for them to come to clinics for care.

• Common health concerns include hypertension, diabetes, breast cancer, unintentional and intentional injuries, and others based upon demographics. They experience much higher morbidity and mortality rates for many diseases when compared to the population as a whole in the United States.

Bereavement:

• Bereavement practices will vary somewhat among African Americans, depending on the form of Christianity the patients practice. In general, many African Americans are deeply spiritual, and place great emphasis on their Christian values. The patient's minister or other religious leader should usually be notified in the case of serious illness or death.

• African Americans typically have a strong belief in the afterlife.

• Large numbers of extended family and friends, particularly women, will likely visit patients that are ill or have died. Visitors may be visibly upset about the condition of the patient. Open displays of emotion are common and acceptable bereavement practices for this culture.

• In some cases where the communication between health providers and family members has been poor, visitors may be suspicious about what caused the death or illness of the patient.

• Cremation is less common among African Americans than it is among whites.

Traditional Health Practices:

• Public health studies clearly show that African Americans as a whole often have different health beliefs and attitudes about various medical conditions than do whites or other ethnic populations. Providers should take the time to really listen to their minority patients and try to understand why they may feel a certain way about a condition.

• In general, African Americans have been shown to have a higher external locus of control than European Americans. In other words, while whites may feel that they personally can control many things in their own lives, blacks are more likely to feel that factors other than their own behaviors are the cause of various life events. Providers will need to help their African American clients develop a sense of empowerment and personal involvement with their own health.

• African American cultures, as well as that of many other non-Europeans, generally believe in a higher sense of fate and destiny as they relate to health and other issues.

• Faith and spirituality play an extremely important role in the lives of most African Americans, and are significant sources of strength in times of illness and poor health.

• Because many African Americans have been shown to have a general distrust of white physicians and of the medical community in general in the United States, providers should actively focus on developing trusting, warm, and respectful relationships with their African American patients.

• Africans, when they were first brought to the United States several centuries ago, carried with them a wealth of knowledge regarding traditional healing through herbs, rituals, and spirituality. Much of this direct knowledge from West Africa was eventually lost throughout the years, although many continue to value alternative, more natural treatments to care.

HISPANICS IN IOWA
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HISPANICS IN IOWA - POPULATION CHARACTERISTICS

Hispanics numbered 82,473 or 2.8% of Iowa's population in the 2000 Census. This is an increase of more than 150% since the 1990 Census, and represents 2/3s of Iowa's population growth for that period. Thus, Hispanics are the largest minority group in Iowa, and exceed African Americans by 20,000. In 2000, 66% of Hispanic households had lived in Iowa since 1995, and of those 30.4% lived in the same house for five years. (By comparison, 58.2% of White residents lived in the same house between 1995 and 2000). While many Hispanics came here initially for work in meatpacking facilities, they have now moved into entry-level jobs in construction, hospitality, manufacturing, wholesale, and others.[1] [2]

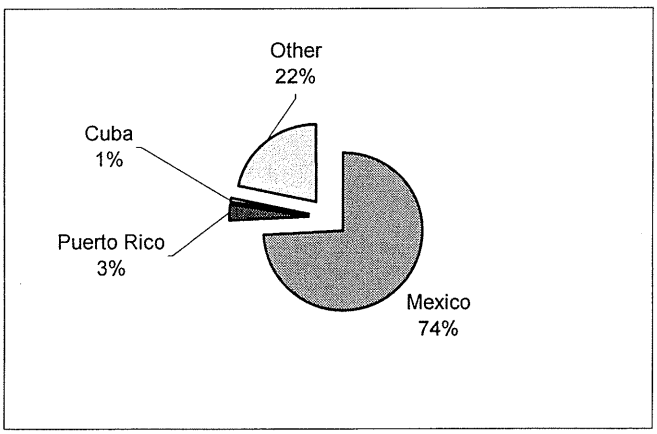


Figure 1: Countries of Origin for Iowa's Hispanic Population[3]

Hispanic-Latino: What's the difference? "Hispanics" are grouped together for purposes of data collection. They can be of any race and from several different countries of origin, including Mexico, Puerto Rico, Cuba, the Dominican Republic, the countries of Central and South America, and Spain. Nearly 75% of Iowa's Hispanic population comes from Mexico, while the rest are from 15 other Latin American countries. "Latino" usually refers to someone from Latin America, in the Western hemisphere. "Hispanic" usually refers to people who speak Spanish. The United States government considers Hispanics to usually be racially White, although of Spanish-speaking origin. Both terms, Hispanic and Latino, are often used by people of this ethnic group.[4]

The percentage of minorities in Iowa is expected to continue to grow significantly in future years. This will occur for a number of reasons, including higher birth rates for most minority groups; low birth rates for Whites; an aging White population, and an exodus of young working people from Iowa.[5]

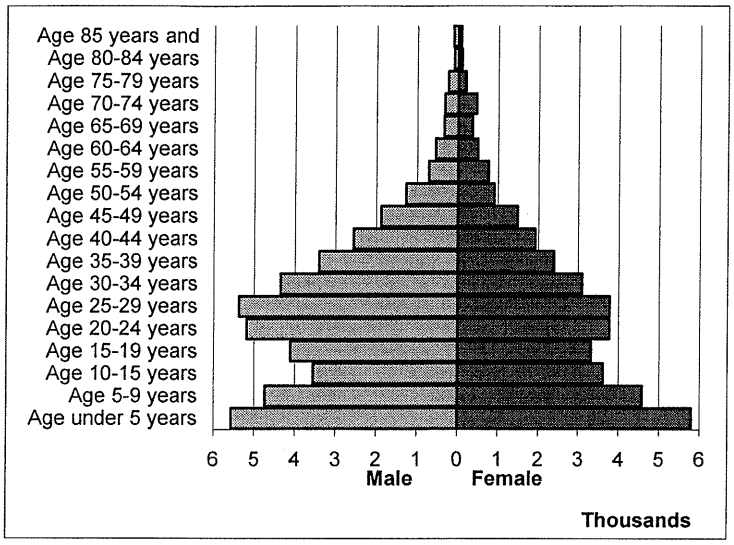


Figure 2: Iowa's Hispanic Population by Age and Sex[6]

FAMILY STRUCTURE

Hispanics are well known for their strong tradition of family and extended family. Cousins, for example, are often as valued as siblings, while aunts and uncles can serve as second parents. They tend to have close family support, and fairly strong identity of their roles within the family by age and gender. [7]

- In 2000 there were 20,900 Hispanic households in Iowa. 53.3% were married-couple families, 23% were single parent households and 15% of Hispanic households were single people (56.5%, 10.6%, and 27.4% for Whites respectively).

- 41% of children born to Hispanics in 2000 were born out of wedlock (Whites 27%).

- 17% of Hispanic women giving birth were under 20 years of age (9% Whites). The average household size was greater for Hispanics (3.51) than Whites (2.43).[8]

AGE

There are important differences in age ranges between Hispanic and White populations. While only 4% of the White population is 9 years of age and below, 25% of Hispanics are in this age group. As pictured in figures 1 and 2, the age range above 60 years is just as dramatic: 20% of Whites are over 60, while only 4% of Hispanics are in this group. The median age for Hispanics (22.6 years) is much less than that of Whites (37.9 years). In Hispanic culture, age is highly respected, and elders are valued for their knowledge and value to the family.[9]

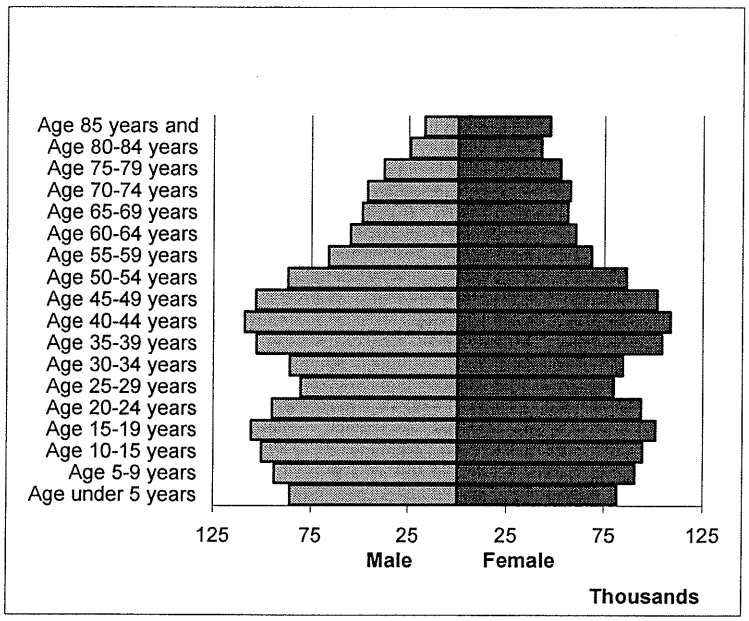
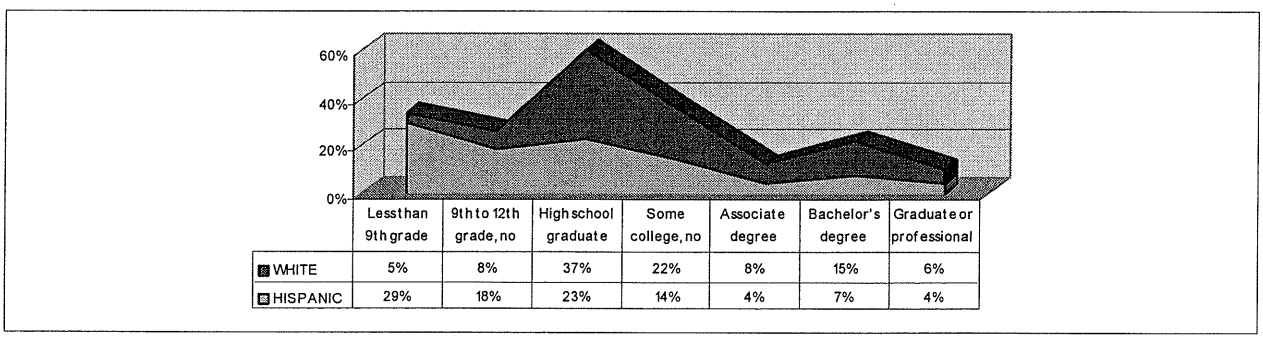


Figure 3: Iowa's White Population by Age and Sex[10]

EDUCATION

Hispanics in Iowa lag behind Whites in educational attainment at every level. While 52.3% of Hispanics over the age of 25 earned a high school diploma in the 2000 Census, 87.2% of non-Hispanic Whites had graduated. This disparity continues at the college level where 10.9% of Hispanics earn a degree compared to 21.3% of Whites.[11]



	Less than 9th grade	9th to 12th grade, no	High school graduate	Some college, no	Associate degree	Bachelor's degree	Graduate or professional
WHITE	5%	8%	37%	22%	8%	15%	6%
HISPANIC	29%	18%	23%	14%	4%	7%	4%

Figure 4: Educational Attainment for Hispanics and Whites in Iowa over 25 Years of Age[12]

HISPANIC INCOME AND POVERTY IN IOWA

- Median household income in 1999 for Hispanics/Hispanics was $32,971 compared to $39,923 for Whites.
- Median per capita income of $10,848 for Hispanics/Hispanics versus $20,249 for Whites.
- 20.2% of Hispanics lived below poverty level compared to 8.1% of Whites.
- A Hispanic person working full time in 1999 made $22,380 while a White person made $29,379 or 24% more.
- 23% of families with children 17 and younger lived below poverty level.
- 47% of Hispanics families living in poverty are headed by single females.[13]

LANGUAGE

34% of Hispanics in Iowa speak English as their primary and only language. Of those Hispanics who speak it as a second language only 15% speak it "not well" and only 8% do not speak English at all.

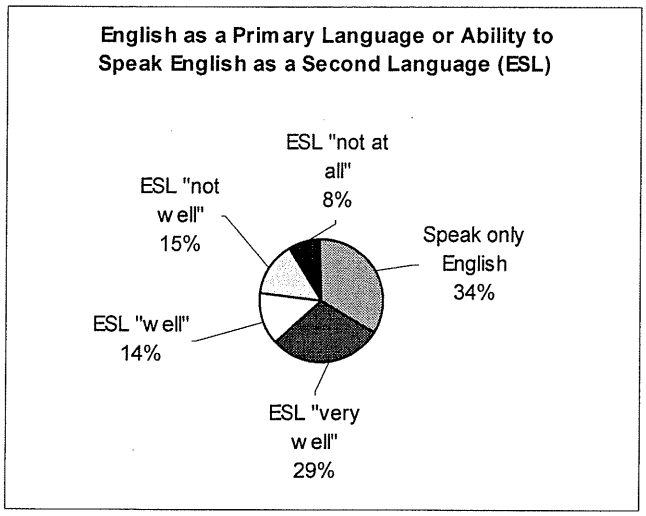


Figure 5: Ability of Hispanics in Iowa to Speak English[14]

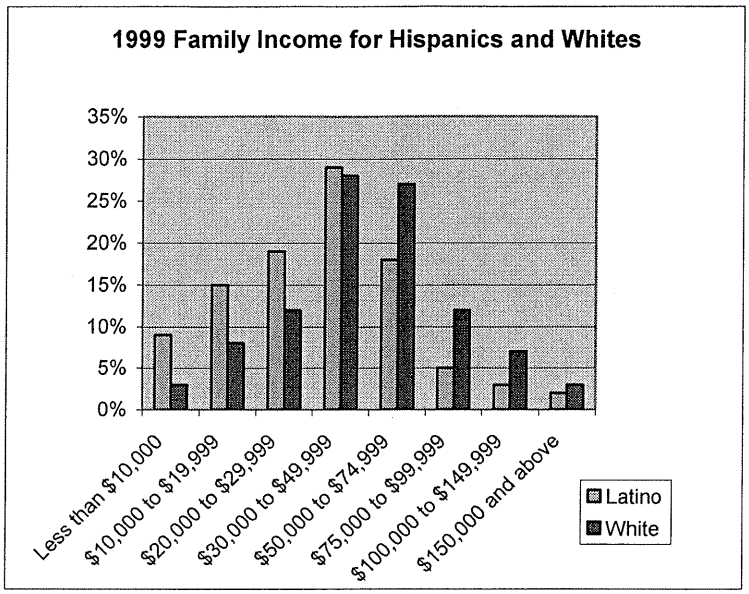


Figure 6: 1999 Family Income for Hispanics and Whites[15]

BARRIERS TO HEALTHCARE

Cost and transportation are particularly difficult challenges to address for minorities in Iowa and the rest of the United States.

- Hispanics who are in the United States without the proper legal documentation are particularly likely to be uninsured. Indeed, in Iowa, new reports indicate that 50% or more of the Hispanic population may not have medical insurance. Many lack adequate personal finances to pay out-of-pocket.

- Health services are not always located where minority and immigrant populations often live, and they may not have easy car or bus transportation to reach them.

- Many Hispanic workers in meat packing plants work double shifts with only one day off per week. Standard medical office hours of 9:00-5:00, Monday–Friday, make it difficult for many Hispanic workers to access care.

- Cultural access is also a common barrier to care when the minority patient cannot be seen by providers familiar with their unique ethnic background or sensitive to their needs.

- Lack of interpreters for Hispanics with limited English skills make language one of the most significant barriers to their care.[16]

Along with these barriers to care, providers of medical services to newcomer Hispanics may be challenged with:

- Limited or no medical records from the patients country of origin.

- No patient health-history for reference (ex: immunizations, allergies, medical conditions).

- Diseases from the home country which are less common in the United States and unfamiliar to health care providers in Iowa.

Access to care is the greatest barrier to good health for minorities and newcomers in the United States.

- Higher rates for conditions associated with poverty such as scabies or high infant mortality.

- Higher rates for diseases found in mobile populations, like tuberculosis, certain parasites or viruses, and sexually transmitted diseases.

- Different cultural ideas about the role of health care professionals[17]

Cultural Differences: What is Health?

Differences in what is considered "health" and "wellness" can prevent the U.S. health care system from working well for minorities. For example, the person who has a chronic disease but is still able to function by working and attending to family matters might consider himself "well" and fail to seek out medical attention that established residents would consider mandatory. There might also be critical differences in assumptions about how to treat or prevent the condition, and cultural differences can increase the likelihood of a missed or inappropriate diagnosis. The results can be costly if health problems are not handled appropriately and become critical, requiring a visit to the emergency room.[18]

HEALTH DISPARITIES IN IOWA

Broad differences in income, education, living conditions, lifestyle practices, insurance coverage, family support systems, and other socioeconomic factors have a far greater impact on the health status of minorities than do inherent biological differences.[19]

Births Events in Iowa[20]	Hispanic	White
Births Out of Wed-lock	41%	27%
Mothers Under Age 20	17%	9%
Low Birth Weight Below<2500 Grams	5%	6%
Fetal Deaths	1%	1%
Neonatal Deaths	1%	0%
Infant Deaths	1%	1%

In general, minority patients will often seek treatment for health problems later than the majority White population, and are more likely to present with multiple, more advanced conditions.

Birth Event Definitions:

Neonatal Deaths: Death of live born infant occurring within the first 27 days of life.

Fetal Death (stillbirth): A birth that fails to show any sign of life after delivery.

Perinatal Death: Death of a Fetus of greater than 20 weeks gestation or death of a live born infant under 28 days of life.

Infant Death: Death of a live-born infant under one year of age. Includes both neonatal and post-neonatal deaths.[21]

- 41% of Hispanic births are out of wed-lock compared to 27% of White births.
- 17% of Hispanic mothers are under the age of 20 compared to 9% of Whites.

Iowa 2001, Leading Causes of Death per 100,000 Population[22]	Hispanic	White
Major Cardiovascular Diseases	31%	41%
Unintentional Injuries	14%	4%
Cancers	13%	23%
Homicide and Legal Intervention	6%	0%
Certain Conditions Originating in the Perinatal Period	4%	0%
Diabetes Mellitus	4%	3%

Working with Hispanics

- Create a welcoming environment. Make sure that all staff is trained in how to work effectively with Hispanic clients, in order to make their experience more positive.
- Incorporate Hispanics on your staff, and throughout your organization.
- Deliver health care services on-site; in churches, stores, community centers, schools, and workplaces.
- Although it varies greatly by region, most Hispanic culture places great emphasis on pride, self-respect, and family honor. This is particularly true among males.
- Always treat elderly Hispanic patients with great respect.
- Make Hispanics part of the health care community through membership on hospital boards, non-profit advisory councils, and other external decision-making entities.
- Provide healthcare services at non-traditional hours including weekends and nights.
- Recognize that, in general, Hispanics are an expressive, warm, and hospitable population. They tend to have closer body spacing and eye contact with others.
- Understand that face-to-face interactions and family connections are valued in this culture. Many referrals are made by word-of-mouth, particularly in immigrant communities.[23]

Endnotes

[1] US Census Bureau, Census 2000
[2] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[3] US Census Bureau, Census 2000
[4] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[5] *ibid.*
[6] US Census Bureau, Census 2000
[7] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[8] US Census Bureau, Census 2000
[9] *ibid.*
[10] *ibid.*
[11] *ibid.*
[12] *ibid.*
[13] *ibid.*
[14] *ibid.*
[15] *ibid.*
[16] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program
[17] *ibid.*
[18] *ibid.*
[19] *ibid.*
[20] Iowa Department of Public Health, Vital Statistics 2001
[21] *ibid.*
[22] *ibid.*
[23] *A Health Providers Pocket Guide to Working with Immigrants, Refugees and Minority Populations in Iowa.* Michele Yehieli and Mark A. Grey, University of Northern Iowa Project EXPORT and New Iowans Program

AFRICAN AMERICANS FROM THE GULF COAST:

CULTURAL AND HEALTH INFORMATION FOR HURRICANE RELIEF AND PUBLIC HEALTH WORKERS

www.iowahealthdisparities.org
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Overview

- Hurricane Katrina severely affected multiple states along the Gulf of Mexico, including Louisiana, Mississippi, Alabama, and parts of Florida. African Americans are the largest minority population in this "Deep South" region of the United States. In fact, within these affected states, African Americans are actually the majority population in many counties.

- Many populations have had an important socio-economic influence on the history of the Lower Mississippi Delta and Gulf Coast regions. The cultures of indigenous populations, African slaves, and colonists from France, Spain, and England contributed to the unique character and culture of this region that developed over the past few centuries. For instance, Cajuns are descendants of the French Acadians from Canada that settled in Louisiana, while Creoles are mixed-race descendents of French, Spanish, or Caribbean slaves and natives.

- Many African American communities in the states affected by Hurricane Katrina, particularly those living in the Lower Mississippi Delta region, experience some of the worst health, education, and economic disparities of any minority population in the United States. For example, the percentage of black families with incomes below the poverty level can be as high as 68% in some Mississippi counties, compared to that of the white population which can range from 7% to 14%. Similarly, up to 24% of blacks in some Mississippi counties are unemployed, compared to 5% of whites in those areas.

- The legacy of slavery, racism, segregation, and political disenfranchisement continues to have profound influences on the health and wellbeing of African Americans from this region, and can contribute to their general mistrust of health providers, relief workers, and others from outside this group.

- Victims of Hurricane Katrina are technically classified as evacuees or internally displaced persons. The term "refugee" should not be used, as it is a legal designation by the United Nations that refers to people who have crossed their own international border to flee persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

Language and Religion

- African Americans from the Gulf Coast overwhelmingly speak English as their native language. However, a number of regional black dialects exist that are unique to urban inner cities or rural southern communities. Residents of New Orleans, for instance, do not speak with a stereotypical "southern drawl", but rather with a lilt and pattern all their own. An example of this would be the pronunciation of "New Orleans" by locals as "Nawlins." Also, unique slang words can be part of the language of blacks from the region that reflect historic French, Cajun, African, or Creole influences. Health and relief workers should listen carefully to clients and ask for clarification if they do not understand a regional dialect.

- Most African Americans from the Gulf Coast devoutly practice some form of Christianity, and religion plays an extremely important role in the lives of most residents. Mississippi, for example, has more churches per capita than any other state in the country.

Family and Social Structure

- Large, extended families are the foundation of African American society in the Gulf. The family often revolves around the mother, her elders and siblings, and her children. Fathers may not necessarily live with the family, particularly if they are lower income and the children were born to unmarried parents. Black families provide great strength in times of crisis. Black women are especially recognized for their strength, leadership, and nurturing.

- In a number of cases, Hurricane Katrina relief workers are finding that large numbers of African American extended family members are choosing to stay at length with their relatives in other states, rather than seeking private temporary residences through emergency housing.

- Many predominantly black communities are organized into neighborhood associations or connected to a particular local church. These neighborhood associations or churches are often active socially and politically in the community. Where possible, it is helpful for relief workers to link with leaders of these religious and neighborhood associations and incorporate them into providing care. For instance, many black evacuees might feel more comfortable in a smaller relief shelter operated by an African American church of the same denomination, than they would in a more impersonal, larger setting operated by a government agency.

Cultural and Communication Style

- In general, many African Americans are more openly expressive than European Americans. They often display more direct eye contact, closer body spacing, and a higher level of physical touch than many whites. Many black children, though, avoid direct eye contact with adults out of respect. Face-to-face interaction is typically preferred over written communication, particularly if literacy levels are lower.

- Verbally, African Americans may be more likely than whites to share their opinions openly or ask questions directly. They may also display a higher level of verbal emotion and expression. When providing relief services, workers should allow ample opportunity for discussion, problem solving, hands-on learning, and visual explanations.

Older Adults

- The United States Office of Minority Health notes that 33% of older African Americans live below poverty. They have the highest overall rates for cancer of any minority group, and experience very high levels of obesity, diabetes, hypertension, and other chronic conditions.

- Older adults in the African American community are highly respected members of the family, and they often heavily influence decisions made within the extended family. Most African Americans are much more likely than whites to take care of ill older relatives and friends at home, rather than send them to formal providers or nursing homes for care.

- Older adults may serve as the primary caretakers for their grandchildren. Relief workers should recognize this extra "caretaker" responsibility, and be aware that there may be questions and medical issues to be addressed as a result. For instance, elderly women may be responsible for purchasing and preparing food for their young grandchildren, but may now have serious medical or financial problems that limit their ability to do so.

Health Issues

- As a group, the health status of blacks from the Lower Mississippi Delta and parts of the Gulf Coast is among the worst in the nation, with significantly higher morbidity and mortality rates for almost all diseases in comparison to whites and other minority groups. Some of these figures are due to genetic factors, but most are a result of higher poverty and unemployment rates, lower education and literacy levels, racism, institutional bias based on ethnicity, limited financial and cultural access to health care, and lifestyle factors.

- Relief workers should ensure that a thorough medical assessment has been conducted on evacuees to determine their short- and long-term health needs. Numerous African American adults will need assistance obtaining their prescription medicines again after the disaster, while others may need durable medical equipment such as wheel chairs, walkers, and canes.

- Numerous public health studies have shown that blacks have a low level of trust in the United States medical system and its providers, who are primarily white. This mistrust is a very important cultural barrier to care and should not be underestimated. Relief providers should focus on developing trusting, warm, face-to-face, and respectful relationships with clients.

- Many evacuees are currently experiencing extremely high levels of stress, anxiety, grief, and depression, which will likely continue for weeks or months after Hurricane Katrina. Some may have difficulty sleeping, concentrating, or thinking until they have been reunited with loved ones or feel more confident about their future in light of the disaster. These are common human reactions to uncommon circumstances, and should be expected. Mental health programs should be implemented simultaneously with other relief efforts to address these challenges in the short- and long-term. Mental health workers should recognize, also, that many African American evacuees feel that racism and poverty were factors that contributed to blacks being affected most severely by the hurricane.

- Prior to Hurricane Katrina, many low-income African Americans from the Gulf Coast utilized emergency rooms as their primary form of medical care, and often delayed seeking treatment until diseases were in an advanced state due to financial, cultural, and other barriers to care. Relief workers should educate clients on the importance of early disease intervention and detection, and make preventive, routine health services available to these hurricane victims on-site in shelters and temporary housing facilities.

Serious Illness and Bereavement

- Bereavement practices vary somewhat among African Americans depending on religious denomination. In general, many African Americans, particularly women, are deeply spiritual, and place great emphasis on their religious values. A religious leader from the client's faith should usually be notified in the case of serious illness or death.

- Many extended family members and friends, particularly women, will likely visit patients who are ill or have died. Visitors may be visibly upset about the condition of the patient. In some cases where the communication between health providers and family members has been poor, visitors may be suspicious about what caused the death or illness of the patient.

- Cremation is less common among African Americans than it is among whites. Most African Americans are reluctant to allow organ donations by family members, but will generally allow autopsies when necessary.

Traditional Health Beliefs and Practices

- Public health studies clearly show that African Americans as a whole have different health beliefs and attitudes about various medical conditions than do whites or other minority populations. Health workers should take the time to listen to these patients and try to understand why they may feel a certain way about a condition or illness.

- In general, African Americans have been shown to attribute their health status to factors outside their own control, such as fate, God's will, or destiny. In other words, while whites may feel that they can control many things in their own lives, blacks are more likely to feel that factors other than their own behaviors are the cause of various events. God is also seen as a source of significant strength in times of illness and poor health. Indeed, many blacks place greater emphasis on the role of God in healing disease than in medical providers.

- Africans, when they were first brought to the United States several centuries ago, carried with them a wealth of knowledge about traditional healing through herbs, rituals, and spirituality. Much of this direct knowledge from West Africa was eventually lost over the years, although many African Americans today continue to value alternative, natural treatments to care, such as herbal remedies, holistic healing, and prayer.

- Hurricane relief workers may find it beneficial to partner with African American community clergy, families, networks, resources and organizations to assist with networking and the delivery of services. Where possible, it is also helpful to have at least some public health and relief workers of the same ethnicity as the evacuee clients to help provide culturally appropriate support, comfort, reassurance and resources during this time of tragedy.