



Meeting the Diverse Healthcare Needs of
Our Patients and Our Members

Cultural Guide



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1

Why does inclusiveness matter at Intermountain?

The communities we serve are increasingly more diverse, as are our employees. Intermountain Healthcare’s Mission, Vision, and core Values of integrity, trust, excellence, accountability, mutual respect, set the foundation for us to increase our awareness about the backgrounds and expectations of those we serve in order to provide safe, high-quality healthcare to diverse patient and member populations.



patient rights and responsibilities

The Patient Rights and Responsibilities have been adopted to promote quality care with satisfaction for patients, families, physicians, and staff. Intermountain prohibits discrimination of these rights and responsibilities based on age, race, color, ethnicity or national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, veteran status, and/or the ability to pay. – Intermountain Healthcare

2

What is the purpose of this guide?

The purpose of this guide is to help you meet the needs of our diverse patients and members. To obtain maximum value from this resource, read all the at-a-glance information sheets and quick facts. Although you are encouraged to consider the tradition of the group you serve, be cautious not to stereotype or to overgeneralize, nor to characterize all members of a cultural or ethnic group as alike. Individuals from the same cultural group may not hold the same values, and a person’s cultural values may not be factors in the way the illness is experienced. Aspects to consider in assessing the situation include individual characteristics, socioeconomic status, ethnicity, education, age, gender, and the stages, conditions, and adjustment to the migration experience, as well as whether the family lived in a rural or urban area in their native country.



cultural competence

The ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and language needs brought by the patient to the healthcare encounter. Cultural competence requires organizations and their personnel to do the following:

- value diversity;
- assess themselves;
- manage the dynamics of difference;
- acquire and institutionalize cultural knowledge; and
- adapt to diversity and the cultural contexts of individuals and communities served.

– The Joint Commission

Included on this page is a ten minute self-assessment tool to stimulate your thinking about inclusiveness. Remember, your view on diversity and inclusion is an ongoing process, not a one-time occurrence. The assessment will offer you the opportunity to assess yourself and your progress over time.

Cultural Diversity Self-Assessment

Read each statement and circle the number that best describes your behavior or belief. Remember be as candid as possible with your responses, there are no right or wrong answers.

	Almost Never 1	Sometimes 3	Always 5
1. I am aware of my own biases and how they affect my thinking.			1 2 3 4 5
2. I can honestly assess my strengths and weaknesses in the area of diversity and try to improve myself.			1 2 3 4 5
3. I assume good intent and ask for clarification when I don't understand what was said or implied.			1 2 3 4 5
4. I challenge others when they make racial/ethnic/sexually offensive comments or jokes.			1 2 3 4 5
5. I speak up if I witness another person being humiliated or discriminated against.			1 2 3 4 5
6. I do not participate in jokes that are demeaning to any individual group.			1 2 3 4 5
7. I don't believe that my having a friend of color means that I'm culturally competent.			1 2 3 4 5
8. I understand why a lack of diversity in my social circle may be perceived as excluding others.			1 2 3 4 5
9. I realize that people of other cultures have a need to support one another and connect as a group.			1 2 3 4 5
10. I do not make assumptions about a person or individual group until I have verified the facts on my own.			1 2 3 4 5
11. I have multiple friends from a variety of ethnicities and abilities.			1 2 3 4 5
12. I connect easily with people who do not look like me and am able to communicate easily.			1 2 3 4 5
13. I'm interested in the ideas and beliefs of people who don't think and believe as I do, and I respect their opinions even when I disagree.			1 2 3 4 5
14. I work to make sure people who are different from me are heard and accepted.			1 2 3 4 5
15. I recognize and avoid language that reinforces stereotypes. (Ex: "Jew them down on the price.")			1 2 3 4 5
16. I know the stereotype of my ethnicity.			1 2 3 4 5
17. I encourage culturally diverse people to speak out on their issues and concerns and validate their issues.			1 2 3 4 5
18. I avoid assuming that others will have the same reaction as me when discussing or viewing an issue.			1 2 3 4 5
19. I understand that I'm a product of my upbringing and believe there are valid beliefs other than my own.			1 2 3 4 5
20. I do not take physical characteristics into account when interacting with others and when making decisions about competence or ability.			1 2 3 4 5
21. I recognize that others stereotype me, and I try to overcome their perceptions.			1 2 3 4 5
22. I include culturally diverse people in team decision making processes that impact them.			1 2 3 4 5
23. I actively seek opportunities to connect with people different than me and seek to build rapport.			1 2 3 4 5
24. I believe "color blindness" is counterproductive and devalues a person's culture or history.			1 2 3 4 5
25. I avoid generalizing behaviors or attitudes of one individual group to another group. (Ex: "All men are..." or "All Asians act..." or "Handicapped people usually...")			1 2 3 4 5
26. I actively convey that nontraditional employees or students are as skilled and competent as others.			1 2 3 4 5
27. I do not try to justify acts of discrimination to make the victim feel better. I validate his/her assessment of what occurred.			1 2 3 4 5
28. I try to learn about and appreciate the richness of other cultures and honor their holidays and events.			1 2 3 4 5
29. I believe there are policies and practices in place that negatively impact people outside the majority culture.			1 2 3 4 5
30. I understand the definition of internalized racism and how it impacts people of color.			1 2 3 4 5
31. I believe that race is a social construct or concept, not a scientific fact.			1 2 3 4 5
32. I know and accept that a person's experiences and background impacts how they interact and trust me.			1 2 3 4 5

TOTAL SCORE:

1

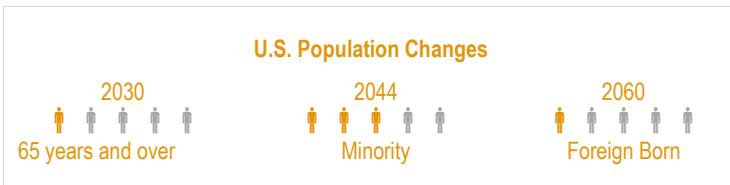
Why are diversity statistics important?

Interesting statistics provide more reasons why learning as much as we can about one another and doing our best to be an inclusive organization is crucial.

2

How is the U.S. population changing?

It is changing *dramatically*. The forecast by the U.S. Census Bureau lists several changes America will undergo in the next 45 years. Some highlights include: by 2030, one in five Americans is projected to be 65 and over; by 2044, more than half of all Americans projected to belong to a minority group (any group other than non-Hispanic White alone); and by 2060, nearly one in five of the nation's total population is projected to be foreign born.

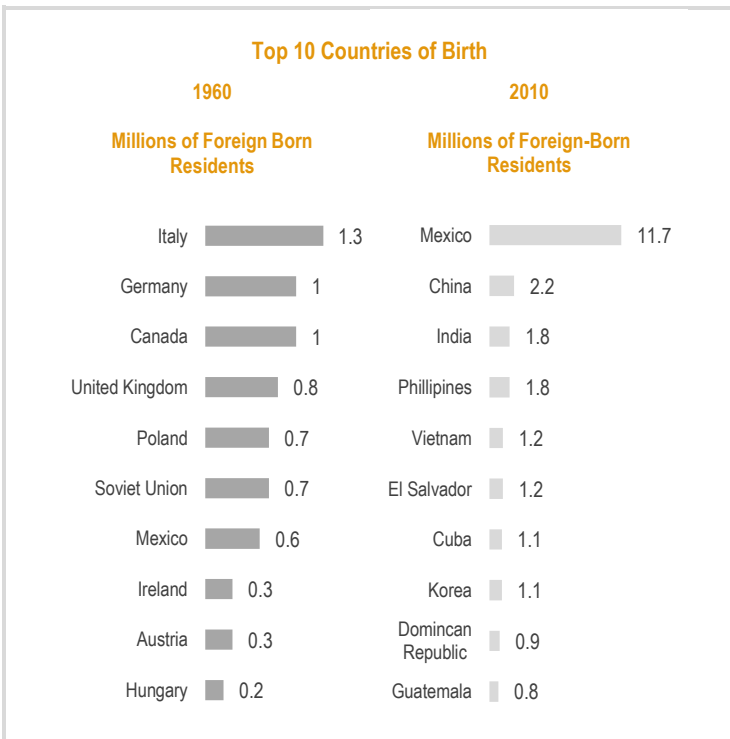


Source: [Projections of the Size and Composition of the U.S. Population: 2014 to 2060](#). 2015); U.S. Census Bureau, (P.1)

3

Where do foreign born people come from?

During the last 50 years, the foreign born population of the U.S. has undergone dramatic changes in size, origins, and geographic distribution. This population represented about 1 in 20 residents in 1960, mostly from countries in Europe who settled in the Northwest and Midwest. Today's foreign born population makes up about one in eight U.S. residents, mostly immigrants from **Latin America** and **Asia** who have settled in the West and South.



Source: [America's Foreign Born in the Last 50 Years](#): U.S. Census Bureau.

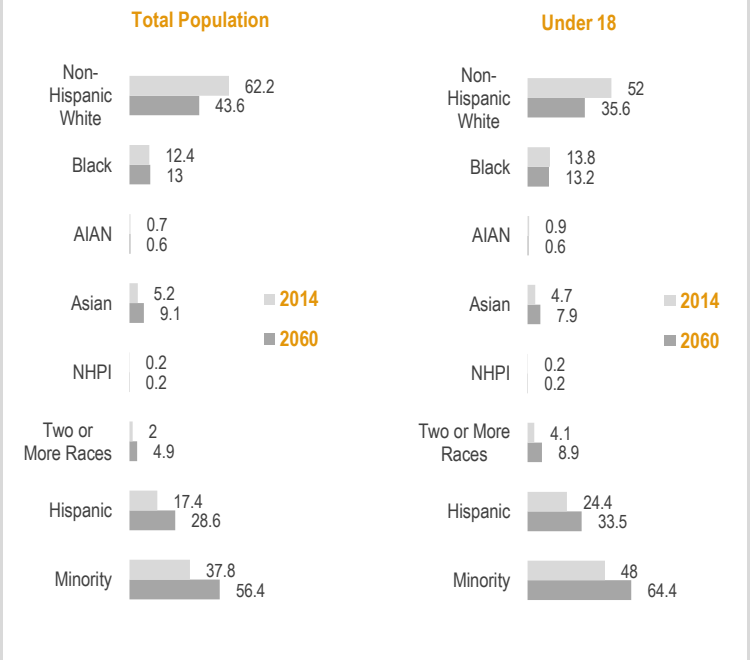
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How is the youth population changing?

The racial and ethnic composition of the U.S. is markedly different when looking at just children (under 18 years of age). The graphic below compares the distribution of the total and the child populations by race and Hispanic origin in 2014 and the projection for 2060. This illustrates how diverse the child population is compared with the total. This figure presents results for the non-Hispanic population by race and aggregates Hispanics, of any race, into one category so that the sum of the percentages for the groups for a given year equals 100. The percentage minority is also shown at the bottom, as a way to summarize the trends in diversity over time.

A much smaller percentage of the child population is non-Hispanic White alone, as compared with the total population. In 2014, 52 percent of children are projected to be non-Hispanic White alone, compared with 62 percent of the total population. Thus, among those under age 18, the U.S. is already nearly a majority-minority nation. The percentage of the population in this group is projected to decrease to only 36 percent by 2060.

Distribution of the Population by Race and Hispanic Origin for the Total Population and Population under 18: 2014 and 2060



Note: The percentages for the total population or the population under 18 may not add to 100.0 due to rounding. Unless otherwise specified, race categories represent race alone. NHPI=Native Hawaiian and Other Pacific Islander, AIAN=American Indian and Alaska Native. Minority refers to everyone other than the non-Hispanic White alone population. Source: U.S. Census Bureau, 2014 National Projections.

Source: [Projections of the Size and Composition of the U.S. Population: 2014 to 2060](#). 2015); U.S. Census Bureau, (P.10)

To make this information stick: Share what you learned here, including your insights, at work today or later this week.

1

Is there equity in healthcare?

Unfortunately, Americans too often do not receive care they need, or they receive care that causes harm. Care can be delivered too late or without full consideration of a patient's or a member's preferences and values. Many times, our system of healthcare distributes services inefficiently and unevenly across populations. These disparities may be due to differences in access to care, provider biases, poor provider-patient communication, or poor health literacy.

2

What is the status of healthcare disparities?

It is important to note that the following key findings from the Agency for Healthcare Research and Quality (AHRQ) provides a snapshot of healthcare prior to implementation of most of the health insurance expansions and consumer protections included in the Affordable Care Act, and serve as a baseline against which to track progress in upcoming years.

	Status	Change over time	Areas improving	Areas lagging
Quality	Fair <ul style="list-style-type: none"> 70% of recommended care actually received Large variation across States 	Getting better	Improving more quickly <ul style="list-style-type: none"> Hospital care CMS publicly reported measures Adolescent vaccines Performing well <ul style="list-style-type: none"> New England and West North Central States 	Improving more slowly <ul style="list-style-type: none"> Ambulatory care Diabetes care Maternal and child health Performing more poorly <ul style="list-style-type: none"> West South Central and East South Central States
Access	Fair <ul style="list-style-type: none"> 26% with difficulties getting care* 	Getting worse*	Improving <ul style="list-style-type: none"> Availability of providers by telephone 	Not improving <ul style="list-style-type: none"> Private health insurance coverage*
Disparities	Minorities and people in poverty with worse quality and access for large proportion of measures	No change	Disparities getting smaller: <ul style="list-style-type: none"> HIV disease Patient perception of care Few gaps in disparities data on Blacks, Hispanics, and Asians	Disparities getting bigger: <ul style="list-style-type: none"> Cancer screening Maternal and child health Many gaps in disparities on Native Hawaiians and Other Pacific Islanders

* Findings reflect access prior to implementation of most of the health insurance expansions included in the Affordable Care Act. After a decade of deterioration, access was better in 2011 than in 2010. **Key:** CMS = Centers for Medicare & Medicaid Services. **Note:** For the vast majority of measures in the reports, trend data are available from 2000-2002 to 2010-2011. Source: [U.S. DHHS Agency for Healthcare Research and Quality \(AHRQ\): National Healthcare Disparities Report, 2013 \(P.1\)](#)

3

Where are healthcare disparities decreasing and where are they increasing?

The following table summarizes disparities in healthcare quality for each major group tracked in the 2013 National Healthcare Quality and Disparities Report. For each group, it shows the measures of healthcare quality where disparities favor the reference group and are improving at the fastest rate (disparity present at start of tracking, becoming smaller in magnitude over time or has

been eliminated entirely) and the measures where disparities favor the reference group and are worsening at the fastest rate (disparity present at start of tracking and becoming larger in magnitude over time or new disparity that has developed).

Healthcare quality that are changing most quickly over time

	Disparities Improving	Disparities Worsening
Black compared with White	<ul style="list-style-type: none"> HIV infection deaths per 100,000 population New AIDS cases per 100,000 population age 13 and over Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over 	<ul style="list-style-type: none"> Maternal deaths per 100,000 live births Postoperative pulmonary embolism or deep vein thrombosis per 1,000 surgical admissions, age 18 and over People with current asthma who report taking preventive medicine daily or almost daily (either oral or inhaler)
Asian compared with White	<ul style="list-style-type: none"> Patients under age 70 with treated chronic kidney failure who received a transplant within 3 years of date of renal failure Hospital patients age 65 and over with pneumonia who received a pneumococcal screening or vaccination Adult hospital patients who sometimes or never had good communication with nurses in the hospital 	<ul style="list-style-type: none"> Adults ages 18-64 at high risk who ever received pneumococcal vaccination Children 0-40 lb. for whom a health provider gave advice within the past 2 years about using a child safety seat while riding in a car Live-born infants with low birth weight (less than 2,500 grams)
AIAN compared with White	<ul style="list-style-type: none"> Adjusted incident rates of end stage renal disease due to diabetes per million population Patients under age 70 with treated chronic kidney failure who received a transplant within 3 years of date of renal failure Surgical resection of colon cancer that includes at least 12 lymph nodes 	<ul style="list-style-type: none"> Adults age 50+ who ever received a colonoscopy, sigmoidoscopy, or proctoscopy
Hispanic compared with Non-Hispanic White	<ul style="list-style-type: none"> New AIDS cases per 100,000 population age 13 and over HIV infection deaths per 100,000 population Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over 	<ul style="list-style-type: none"> Home healthcare patients who have less shortness of breath Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy People with a usual source of care who usually asks about prescription medications and treatments from other doctors

○ = HIV disease measures; ◆ = diabetes measures; □ = patient perceptions of care; ✦ = cancer screening measures; + = respiratory disease measures; ○ = maternal and child health measures. For the vast majority of measures, trend data are available from 2000-2002 to 2010-2011. Source: [U.S. DHHS Agency for Healthcare Research and Quality \(AHRQ\): National Healthcare Disparities Report, 2013 \(P.19\)](#)

Note: Quality of care varies across types of care and across regions of the country. Knowing where to focus efforts improves the efficiency of interventions. Delivering data that can be used for local benchmarking and improvement is a key step in raising awareness and driving quality improvement.

Since 2005, AHRQ has used the State Snapshots tool (<http://www.ahrq.gov/research/data/state-snapshots/index.html>) to examine variation across states. This website helps health leaders, researchers, consumers, and others understand the status of healthcare quality in individual states.

To make this information stick: Share what you learned, including your insights, at work today or later this week.

1

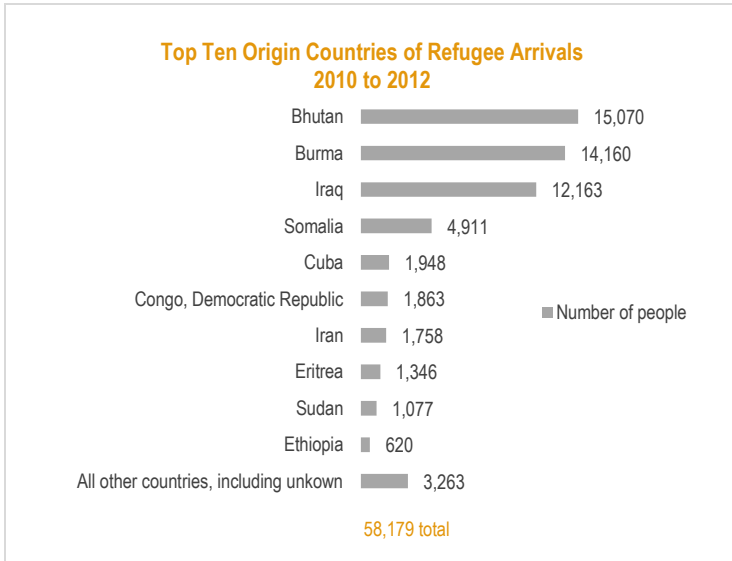
What is a refugee?

Refugees are individuals who are unable or unwilling to return to their country of origin or nationality because of persecution or a well-founded fear of persecution.

2

From where do recent refugees arrive?

The actual number arriving in the U.S. during 2012 through the resettlement program was **58,179**. Nationals of Burma, Bhutan, and Iraq accounted for more than 70 percent of refugee arrivals to the U.S. in 2012.



Source: [Refugees and Asylees in the U.S. 2014; Migration Policy Institute](#)

3

How do refugees get to the U.S.?

The graphic below is a quick snapshot of the resettlement process from the perspective of an individual refugee.

Refugee Resettlement

START: The refugee flees his/her country of origin. The refugee registers with the [UNHCR](#) (The United Nations High Commissioner Refugee Agency). This agency makes sure that the individual qualifies as a refugee under international law.

The UNHCR refers the individual to a U.S. Embassy with a Refugee Processing Post. The refugee receives a medical examination and usually some type of cultural orientation to the U.S.

The refugee is met at the airport by staff from a local refugee resettlement agency and taken to an apartment that has been prepared for him or her

END: Resettlement agencies provide the refugee with services such as case management, assistance learning English, and finding employment.

Source: [Refugee 101; Bridging Refugee Youth & Children's Services \(BRYCS\)](#)

4

How many refugees live in the U.S.?

Since 1980, when formal U.S. refugee resettlement began, 1.8 million refugees have been invited to live in the U.S. About 35 to 40 percent of refugees resettled in the U.S. are children. The vast majority of refugee children – about 95 percent – resettle in the U.S. with their parents. About five percent of refugee children are resettled with relatives or other adults who have agreed to care for the children, while about 100 to 200 children per year are placed in specialized foster care programs.

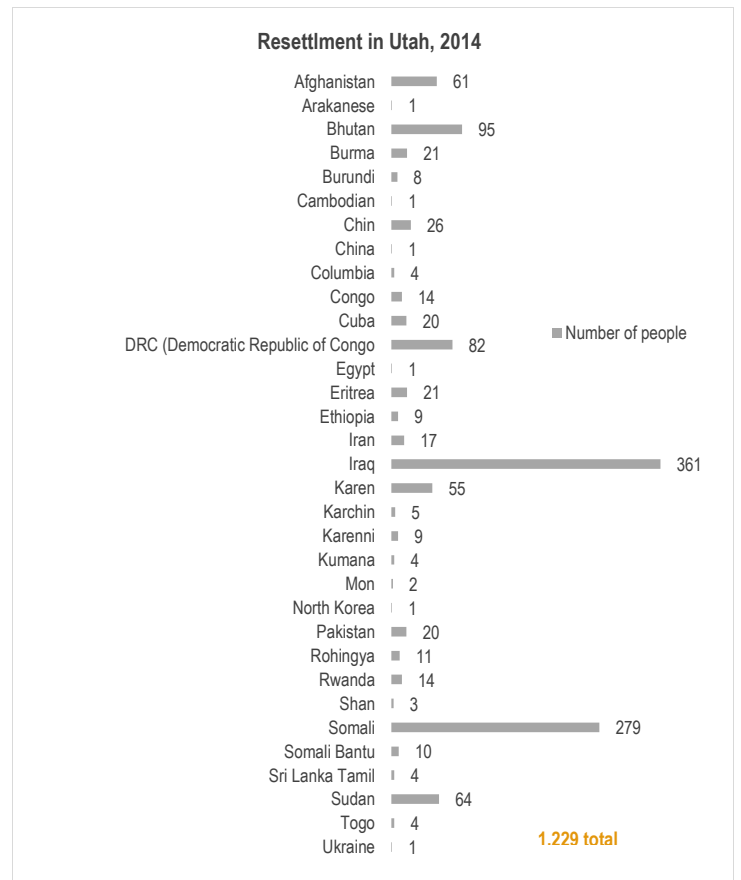


Source: [Refugee 101; Bridging Refugee Youth & Children's Services \(BRYCS\)](#)

5

Who are Utah's most recent refugees?

In Utah, there are estimated to be over 25,000 refugees, speaking more than 40 languages; roughly 1,100 refugees arrive in Utah each year.



Source: [Utah Refugee Health Program Manual; Utah Department of Health \(P.9\)](#)

Learn from other sources:

[BRYCS \(Bridging Refugee Youth & Children's Services\)](#) offers information for empowering immigrant children and their families

[Intermountain.net](#) see [Patient Rights and Responsibilities](#), [Language Services](#), [Communications Assistance Policy](#)

[COR Refugee Backgrounders; Cultural Orientation Resource Center](#) provides key information about various refugee populations

[UDOH Utah Refugee Health Program Manual](#) provides information from the Bureau of Epidemiology Treatment and Care Services Program

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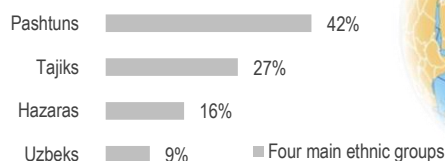
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What are some quick facts?

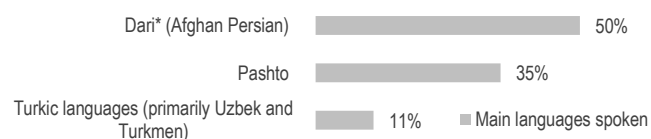
Introduction

- As a result of the 1979 invasion of Afghanistan by the Union of Soviet Socialist Republics (USSR) and subsequent civil war in the 1980s, many Afghan people (including educated professionals) sought refugee status in the U.S.
- In the late 1990s, a number of Afghan people came to U.S. fleeing the Taliban regime.
- After the U.S. and Britain initiated a North Atlantic Treaty Organization (NATO) supported war on the Taliban in October 2001, more Afghan people fled as refugees.
- Places of transition: Pakistan and Iran.

Ethnicity

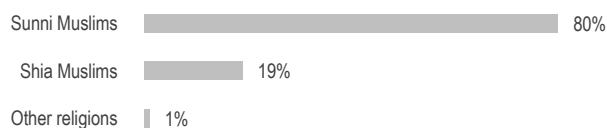


Language



- * Hazaragi is a dialect of Dari spoken by the Hazara ethnic group of Afghanistan. Hazaras comprise between 16 to 20 percent of the population of Afghanistan and they account for more than 50 percent of the Afghan refugees who have arrived between 2006 and 2010.
- Thirty other minor languages are spoken. Many people are bilingual.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Muslim men and women may be reluctant to shake hands with people of the opposite gender. It is advisable that, in such situations, it is left to the Muslim person to decide what is appropriate.
- Afghan Americans may greet others by placing their hands over their heart and bowing slightly.
- Eye contact is generally avoided between men and women. Eye contact between men is acceptable but is usually only occasional, not prolonged.
- An Afghan American elder's nod may merely be a social custom showing politeness and respect for authority rather than a sign they understand or agree with what the healthcare provider is saying.
- As a sign of respect, Afghan Americans do not call older people by their given name.
- Afghan Americans are likely to show their appreciation of a service provided to them by expressing words of blessing.

Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Traditional Afghan causes of illness include: an imbalance of *hot* and *cold* forces in the body, not adhering to the principles of Islam and the will of God, possession by evil spirits called *jinn*, being given the *evil eye*, or sometimes witchcraft. *Jinn*, the *evil eye* and witchcraft are mainly seen to cause mental illness.



Anesthesia: Muslims may prefer to decrease sedation at the time of death so that the person is able to hear the final part of the same blessing he or she heard at birth. The final part of the blessing, which is called the *Kalima* or confession of the faith, should be the last thing one hears at death.



Inpatient: Beliefs about preserving health include living in accordance with the precepts of Islam which strongly emphasizes personal daily hygiene including washing before prayer.



Labor and Delivery: Religious rituals and customs at birth and death are important. A Muslim birth custom involves having an adult male be the first person to speak to a newborn infant. This male, who becomes a special person in the infant's life, whispers a secret blessing in the ear of the child. This is usually the *Adhan*, or what is usually recited as a call for prayer.



Language Services: There may be fear in the Afghan community that interpreters will not abide by confidentiality requirements.



Mental Health: As a result of their experiences of war and displacement, and their experiences as refugees, which in many cases has included mandatory detention, Afghan refugees are at high risk of mental illness and emotional issues. A strong cultural stigma is attached to mental illness. Many mental health conditions such as depression may not be considered an illness. Afghan Americans may be reluctant to access mental health services.



Registration: Older Afghan Americans have a strong preference for receiving care from same gender healthcare providers, particularly in nursing tasks such as assistance with personal care.



Spirituality: Beliefs about preserving health include living in accordance with the precepts of Islam which strongly emphasizes personal daily hygiene including washing before prayer. Regular exercise, eating fresh food and a balanced diet, staying warm, and getting enough rest are also seen as important for health.



Women's Health: Many Afghan American women wear a *burka* (loose body covering) and *hijab* (head covering) in public. It is normal for people of the same gender (men/men, women/women) to shake hands, kiss on the cheek, and hug (particularly among men) when greeting. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include: 1 What brings you here today? 2 What do you call your illness, problem? 3 What do you think has caused the illness, problem? 4 What have doctors, nurses, other caregivers done so far? What have you or other family members done so far? 5 How has the illness affected your life? 6 How has it affected you and your family? 7 What worries you most about the illness and its treatment? 8 What would you like to have happen today? ➔ *Document the answers in the patient's records.*

Adapted from: *Cultural Competence in Healthcare*; A. Rundle, M. Carvalho, M. Robinson

Learn from other sources:

[EthnoMed](#) includes information about cultural beliefs, medical issues, and other pertinent healthcare issues

[Think Cultural Health](#) offers free E-learning courses

[Queensland Health](#) offers practice guides, handbooks and other resources for health professionals

[AAFP Quality Care for Diverse Populations](#) has seven 3 to 8-minute videos showing clinicians thoughtfully communicating

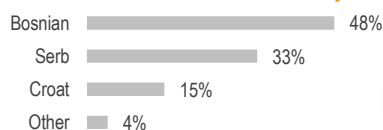
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What are some quick facts?

Introduction

- The Socialist Federal Republic of Yugoslavia (SFRY) was formed in 1945 and comprised the states of Bosnia-Herzegovina, Croatia, Macedonia, Montenegro, Serbia, and Slovenia.
- Within each state, there coexisted a multitude of ethnic groups as diverse as Bosnian Muslims, Romani (Gypsies), Albanians, Hungarians, Croats and Serbians. It was not until the late 1960s that the government of the SFRY formerly recognised the Bosnian Muslims as a distinct “nation” with a separate ethnic identity.
- In 1991, Slovenia and Croatia declared their independence from the federation of states, followed by Bosnia-Herzegovina and Macedonia. The subsequent civil war involved atrocities including rape, torture and murder, as ethnic communities fought each other for the right to self-determination.

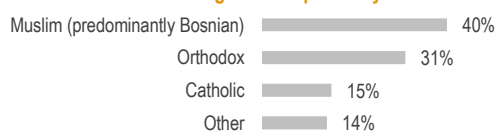
Ethnicity



Language

- The official languages for Bosnia-Herzegovina are Bosnian, Croatian, and Serbian.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- The level of English proficiency among Bosnian Muslim Americans varies according to age and education, with the younger people tending to be more proficient.
- It may be difficult to gain rapport with some Bosnian Muslim Americans because of their recent trauma.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Health Services: Bosnian Muslim Americans tend to openly discuss their suffering. The relatives give moral and physical support. ■ Healthcare providers may be expected to give high significance to discussions of symptoms and complaints. ■ Some Bosnian Muslim Americans may have a fear of serious disease approaching a phobia. ■ Many Bosnian Muslim Americans will want detailed explanations of tests and procedures. ■ It is expected that the Bosnian Muslim family will care for the elderly at home, and the suggestion of a nursing home may appear insulting. ■ Many recent Bosnian Muslim refugees have had little health and dental care in the past five years and may require extra services initially. ■ Bosnian Muslims coming from camps and other difficult circumstances may have a higher incidence of TB. ■ Awareness of public health issues tends to be high but this is often not reflected in lifestyle choices. Exercise is uncommon, and there is a tendency towards being overweight. Smoking amongst men is relatively common. ■ Bosnian Muslim American males tend to have a higher than average mortality from diseases of the digestive system.

Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.



Language Services: Although the Bosnian language shares many of the features of Serbian and Croatian, and the speakers can frequently understand one another, care needs to be taken to ensure that the patient's or the member's interpreter is from an acceptable ethnic group.



Mental Health: Bosnian Muslim may have witnessed horrific events, in some cases torture and rape. Bosnian Muslim Americans may also have survivor guilt and be worried about those left in Bosnia. ■ Unemployment, in men particularly, may be associated with depressive illness. Alcohol may be used to compensate for feelings of inadequacy. ■ Psychological distress may be expressed as somatic symptoms, particularly gastro-intestinal or respiratory symptoms. ■ Mental health-seeking behavior is often limited by language proficiency and lack of knowledge of services. ■ There is a stigma associated with admitting to mental illness. ■ There may be the view that medication is the only treatment. Psychotherapy, group therapy or occupational therapy may be rejected.



Nutrition: It may be necessary to ask Bosnian Muslim Americans if they follow Islamic rules. In Islam, only *halal* meat can be consumed. Pork products are forbidden as is alcohol.



Pediatrician: Bosnian Muslim American children may have unexplained behavioral problems related to previous traumatic experiences in Bosnia. Children may have to cope with severe emotional problems amongst older family members.



Pharmacy: Treatment is often not considered complete without medication.



Registration: Many Bosnian Muslim women will prefer to see only female healthcare providers and would refuse gynecological examinations by males. This may also extend to male interpreters being present during consultations.



Spirituality: Ramadan is one of the major religious events in the calendar for Bosnian Muslim Americans. Fasting is required between sunrise and sunset for a period of 30 days and for some members, this may include the taking of medication. Bosnian Muslim Americans who are young, old, or sick are excused from religious fasting if it can be detrimental to their health.



Social Services: Bosnian Muslim American parents of a disabled child may feel shame and isolate themselves from the rest of the community, thus not taking advantage of social services available. ■ Many of the aged Bosnian Muslim Americans are in need of health and welfare services, but are not accessing them because of poor English, lack of mobility and lack of knowledge of the services. ■ It is expected that the family will care for the elderly at home, and the suggestion of a nursing home may appear insulting.



Women's Health: Bosnian Muslim American women tend to have a higher than average incidence of musculoskeletal problems such as muscle and joint pains. Adapted from: [Queensland Health Community Profiles](#) and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include: 1 What brings you here today? 2 What do you call your illness, problem? 3 What do you think has caused the illness, problem? 4 What have doctors, nurses, other caregivers done so far? What have you or other family members done so far? 5 How has the illness affected your life? 6 How has it affected you and your family? 7 What worries you most about the illness and its treatment? 8 What would you like to have happen today? ➔ *Document the answers in the patient's records.*

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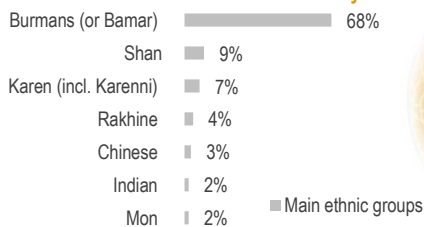
1

What are some quick facts?

Introduction

- The name Myanmar was adopted by the Burmese Military Government in 1989 and subsequently recognized by the United Nations, other international organizations and many Burmese expatriates who oppose the military government continue to use the old names, Burma and Burmese.
- Burma is one of the most ethnically diverse countries in the world. The largest ethnic group, Burmans (or Bamar).
- Place of transition: Since 1988, approximately one million Burmese people have fled to neighboring countries, predominantly to nine main refugee camps on the border between Thailand and Burma. Other countries of transition are Malaysia and India

Ethnicity



Language

- Burmese is the official language of Burma and is the main language spoken by Burmans.
- Karen people speak several dialects of the Karen language including Sgaw Karen, Pwo Karen, Karenni and Pa-o.
- Shan, Chin and Rohingya people all have distinct languages and dialects within these language groups. In all, more than 100 languages are spoken in Burma.

Religion and Spirituality

- Burmans, Shan and Mon: Approximately 90 percent are Theravada Buddhists.
- Karen: About 70 percent are Theravada Buddhist, Buddhist animist or animist and about 20-30 percent are Christian.
- Karenni (a subgroup of Karen): Most are animist.
- Chin: A large number are Christians. Others continue to practice animism
- Rohingyan: Predominantly Muslim.

2

What is their communication style?

Communication Patterns and Value Orientation

- Karen people who have travelled widely in the Karen State are usually able to speak a number of dialects of the Karen language. However, those people who have not travelled often have difficulty understanding other dialects.
- Burmese Buddhists: it is disrespectful for legs to be stretched out with feet pointed towards a person, the head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head; using both hands to give and receive an object is a sign of respect, particularly with older people.
- Karen people: Karen people normally walk behind those who are their seniors and elders; Karen may answer a question with a no to be modest when an affirmative answer may seem more appropriate.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Belief in spells and black magic is thought to be widespread in Burma. When a person has an illness that cannot be cured by any kind of medicine, black magic is usually suspected, and a cure is sought from a healer experienced in dealing with illnesses. ■ **Buddhist:** Good and bad events can be attributed to actions committed in the past. The health of a person is controlled by the four elements of fire, water, air, and earth and any imbalance in these elements causes illness and disease. ■ **Animist:** Many Karen and Karenni who have retained their animist system believe a person possesses a number of souls called *kla* which might flee for various reasons – one way of keeping *kla* is by an elder or religious shaman tying sacred string around the wrist.



Labor and Delivery: **Buddhist:** After childbirth, the mother's body is susceptible to illness because it is *cold* from blood loss. The mother may want her body warmed with external heat and warm drinks and may want to eat foods with *hot* properties. Sour and bitter foods are also seen as important to reduce blood flow. ■ **Animist:** Many Karen and Karenni who have retained their animist belief system believe that a person possesses a number of souls called *kla* which might flee for various reasons – the *kla* are said to leave the body at death and reappear in the form of the *kla* of a newly born child.



Mental Health: Many Burmese [refugees](#) have experienced numerous traumatic events including the deaths of family members, prolonged separation from family, repressive measures and uncertainty about their future. In addition, they have been impacted in many cases by a lack of food and water and the widespread use of landmines.



Nutrition: Buddhist: Certain foods and medicines are classified as *hot* or *cold* and can adversely or positively affect health conditions and emotions. The classification of foods as *hot* or *cold* is unrelated to temperature. *Hot* foods are generally those foods which are salty, sour or high in animal protein, while *cold* foods are generally sweet or bitter. States of health seen as *hot* or *cold* are seen to require treatment with the opposite in medicine or foods.



Registration: Traditionally Burmese people do not have family names. Therefore, all members of a family may have names that bear no obvious relationship to each other. It is customary to use titles (e.g. Mr. and Mrs.) when addressing people other than small children.



Spirituality: Buddhist verses are important in curing illnesses, either being blown over the ill Burmese American or recited over water for the ill Burmese American to drink. When a Buddhist is dying, a Buddhist monk or minister should be notified to provide chaplaincy services. The monk will chant verses after the person has died to help release the person's good energies. The state of mind at the time of death is important in determining the deceased person's next rebirth. ■ Karen and Karenni: Many who have retained their animist belief system believe that a person possesses a number of souls called *kla* which might flee for various reasons (e.g. in connection with a mental breakdown). It is seen as vitally important to retain the *kla* and losing *kla* puts a person in danger of illness. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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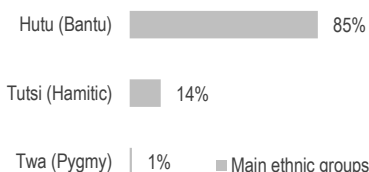
1

What are some quick facts?

Introduction

- In 1972, conflict between the ruling Tutsis and the majority Hutu population resulted in approximately 200,000 deaths and 150,000 people seeking refuge in Tanzania, Rwanda, and Zaire (now the Democratic Republic of Congo).
- In 1988, increasing tensions between the ruling Tutsis and the majority Hutus resulted in violent conflict between the army, the Hutu opposition, and Tutsis. As a result, an estimated 150,000 people were killed and tens of thousands of refugees fled to neighboring countries.
- In 1993, Burundi's first democratically elected Hutu president was assassinated leading to another wave of violence between the Tutsis and Hutus. This resulted in more than 100,000 deaths within a year, and another 100,000 more deaths and hundreds of thousands of refugees fleeing the country over the next 11 years. This civil war continued until 2005.
- Places of transition include Tanzania, Rwanda, Uganda, Zimbabwe, Malawi, and the Democratic Republic of Congo.

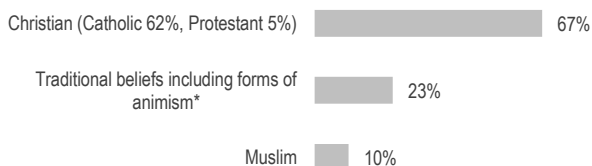
Ethnicity



Language

- The main and official languages are Kirundi and French. Swahili is spoken in some areas.

Religion and Spirituality



- *About 23 percent of Burundians, including most of the Twa and some Christians, have maintained traditional beliefs which include forms of animism. Animists believe inanimate and natural phenomena, as well as living creatures, have souls and spirits. Certain rituals are believed to control uncertainties and negative influences in life.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Handshakes are important to Burundians and the type of handshake varies by region. For example, one handshake involves touching one's left hand to the other person's elbow. Handshakes are often soft.
- People stand close together in conversation and often continue holding hands for several minutes after shaking.
- There is good to fair eye contact between people of equal stature but little eye contact otherwise. Avoiding eye contact is a way to show respect for the elderly or important people.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Many Burundians use traditional remedies to treat diseases. Potions made from leaves, roots, bark, fruit, and herbs may be taken orally or rubbed on the skin. Many Burundian Americans may be unable to use traditional remedies in the U.S., because of the unavailability of ingredients. Some people travel to Burundi to access traditional remedies.



Health Services: The healthcare system in Burundi is basic and medical facilities are limited, even in cities. About two million people in Burundi (one third of the population) have no access to formal healthcare. Burundian Americans unfamiliar with the healthcare system may benefit from orientation to the system, including how to make a health appointment, the importance of regular health checks and immunization, and how to access emergency departments.



Mental Health: Many Burundians have experienced traumatic and life threatening experiences including prolonged pre-trial detention, harsh and life threatening prison conditions, torture and beatings, witnessing killings, kidnap, rape, extortion, and forced labor. ■ Thousands of Burundian refugees have spent years in refugee camps in neighboring countries such as Tanzania, many for longer than a decade and some for almost their entire lives. Some Burundians have fled their country more than once. Living conditions in these overcrowded camps are primitive, water and sanitation inadequate, infectious diseases a continued threat and, with a mix of ethnicities and political orientations, many people have experienced insecurity and paranoia. ■ Settlement is often impacted by changing family dynamics and concern for family members who remain in refugee camps.

Pharmacy: Many Burundian Americans prefer injections to tablets.



Spirituality: Animist rituals may be performed to cure a person who is ill.

Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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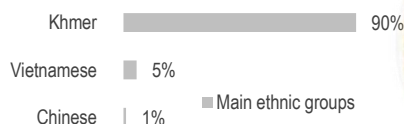
1

What are some quick facts?

Introduction

- A civil war began in 1970, led to a Communist Khmer Rouge takeover from 1975 to 1979. An invasion by Vietnam in 1979 ended the Khmer Rouge reign, but civil war continued until United Nations troops enforced a cease-fire in late 1991.
- Of an estimated population of 7.1 million people in 1975, approximately two million Cambodians were killed during the four-year Khmer Rouge reign. Approximately one million people were killed in the civil wars before and after this period.
- From 1975, Cambodian people began to seek refuge in other countries, including the U.S.
- Place of transition: Thailand

Ethnicity



Language

- Khmer is the official language and is spoken by 95 percent of the population. Other languages include French and English.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Traditionally, Cambodian Americans do not address each other by name, but according to relationship (e.g. brother or uncle). The titles Sir and Madam are used for strangers. It is advisable to use a person's title when addressing a Cambodian American person directly (e.g. Mr., Mrs., Doctor).
- It is considered disrespectful to sit with the legs stretched out and the feet pointed towards a person.
- The head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head.
- Cambodian people may consider direct eye contact to be inappropriate. Some people may be reluctant to maintain eye contact with people seen as deserving of respect, such as a senior person.
- A response of *yes* does not necessarily indicate agreement. The word *yes* is sometimes used to indicate that the listener is paying attention. It is important to obtain feedback from the person to ensure understanding, especially when gaining consent to treat.
- Cambodian American people rarely appear desperate or distressed, even when experiencing significant anxiety or pain.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: A belief in the *hot* and *cold* qualities of [food](#) and medicine is common. The body is seen as operating in a delicate balance between these two opposing elements. For example, diarrhea is thought to be due to an excess of *cold* elements and skin rashes to an excess of *hot* elements. ▀ Traditional healing can include *cupping*, *pinching* or *rubbing* (also known as *coining*). In *cupping*, a cup is heated and then placed on the skin, usually on the forehead or abdomen, which creates a vacuum. These treatments can often leave some redness or bruising. The marks resulting from *cupping* and other traditional treatments have sometimes been mistaken by healthcare providers for signs of a more serious illness or domestic abuse.



Health Services: Cambodian American people may have a fear of blood tests. Blood is thought to be replenished slowly, if at all, with any loss of blood seen as weakening the body.



Labor and Delivery: Many Cambodian American people believe the body of a woman is made *cold* by labor. Women who have recently given birth may want to be kept very warm and may not want to shower post-partum for up to three days, or may prefer a sponge bath. New mothers are often kept warm by being fed *hot* foods.



Mental Health: It has been shown two decades after seeking refuge in the U.S., the Cambodian population continues to have high rates of psychiatric disorders associated with trauma including post-traumatic stress disorder (PTSD) and depression.



Pharmacy: Some Cambodian American people may expect to receive medications for every illness, and injections are often seen as more effective than oral medications. It may be necessary to carefully explain why medication is not necessary. Medication is frequently taken only for as long as the individual feels ill. Compliance with medications for a chronic disease can be difficult.



Registration: Many Cambodia-born women prefer to be examined by female healthcare providers.



Spirituality: Spiritual healers may be sought for mental illnesses (i.e., depression) and chronic diseases (i.e., diabetes and hypertension), as these illnesses are thought to be caused by spirits. ▀ Cambodian American people may explain the causes of illnesses in terms of both the natural and supernatural. ▀ When a Cambodian Buddhist is *dying*, a Buddhist monk or minister should be notified to provide chaplaincy services. The monk will chant verses after the person has died to help release the person's good energies. The state of mind at the time of death is considered important in determining the deceased person's next rebirth.



Surgery: Some Cambodian American people may resist surgery or other invasive techniques. When such procedures are required, it may be necessary to explain the need for such treatment. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

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Discussion Questions



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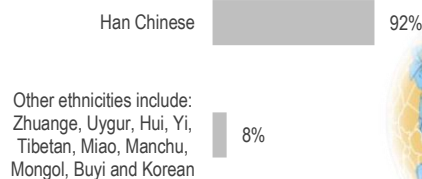
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What are some quick facts?

Introduction

- During the past 30 years, Chinese people have arrived in U.S. from Malaysia, Singapore, Hong Kong, Vietnam and elsewhere in Indochina. More recently, immigrants have arrived from Taiwan and the People's Republic of China (PRC).
- The term *Chinese* covers a diverse range of communities and individuals, sometimes having no more in common than ancestral heritage.

Ethnicity



Language

- Mandarin is the official language of China and is widely spoken in the PRC and Taiwan.
- Cantonese is spoken and widely understood in Hong Kong, the Guangdong province of the PRC, Vietnam, and among many people from Malaysia, Singapore and Christmas Island.
- Other languages include: Shanghaiese, Fuzhou, Hokkein-Taiwanese, Xiang, Gan and Hakka dialects.

Religion and Spirituality

- China is officially atheist.
- Ancestor worship is widely practiced.
- A small percentage of the population are Daoist (Taoist), Buddhist, Muslim and Christian.
- Confucianism, although not strictly a religion, has an important role in the Chinese way of living. Confucianism emphasises mercy, social order, and fulfilment of responsibilities.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Chinese American people usually greet each other by shaking hands.
- Chinese Americans may avoid saying the word *no* because they consider it impolite.
- Chinese Americans may commonly mask discomfort or other unpleasant emotions by smiling.
- Chinese Americans may be accustomed to being addressed by their title and surname (e.g. Mr. or Mrs.), job title (e.g. Manager), professional qualification (e.g. Engineer) or educational qualification (e.g. Bachelor).
- In many cases, family names are generally placed before first names. However some Chinese Americans have adopted the American style of naming and have changed the order of their names, placing their surnames last. Chinese surnames usually only have one syllable.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Many Chinese Americans will use traditional Chinese medical treatments including acupuncture, acupressure, and Chinese herbs. Dietary therapy and supernatural healing (through a fortune teller, *Feng Shui* practitioner or temple medium) may also be used. Modern versions of traditional medicines are widely available in all major U.S. cities. [Many Chinese Americans use traditional Chinese medicine in conjunction with U.S. medical treatments.](#)



Health Services: Many Chinese American people assume a sick role when they are ill or pregnant in which they depend heavily on others for assistance. As a result, healthcare providers may be seen as uncaring if they encourage independence rather than catering directly to the wishes of the person.



Language Services: Many distinct Chinese dialects are spoken by the Chinese. It is recommended before seeking an interpreter for a Chinese American, first find out the particular dialect spoken by the Chinese American.



Nutrition: Many Chinese classify food, illness, and medications as *hot* or *cold* according to the perceived effects on the body. A proper balance of these elements is required to maintain good health. The classification of [foods](#) as *hot* or *cold* is unrelated to temperature and not always related to taste. For example, seafood is classified as *cold* even if it served *hot* or with chili.



Oncology: Chinese Americans emphasize the importance of the role of the family in mediating between health professionals and patients or members with cancer. Chinese Americans with cancer prefer a confident and clear diagnosis and treatment recommendations.



Pharmacy: Many Chinese Americans visiting a healthcare provider will expect tangible evidence of treatment, such as a prescription.



Registration: Many Chinese Americans have a strong preference for Chinese-speaking general practitioner. Chinese people usually prefer to be examined by a doctor of the same sex; this is particularly true for women.



Spirituality: Some Chinese Americans may attribute illness to: disharmony of body elements (e.g., an excess of *hot* or *cold* foods); moral retribution by ancestors or deities for misdeeds or negligence; cosmic disharmony which may occur if a person's combination of year of birth, month of birth, day of birth and time of birth (the eight characters) clash with those of someone in their family; interference from evil forces such as malevolent ghosts and spirits, or impersonal evil forces; poor *Feng Shui* (i.e., the impact of the natural and built environment on the fortune and wellbeing of inhabitants). Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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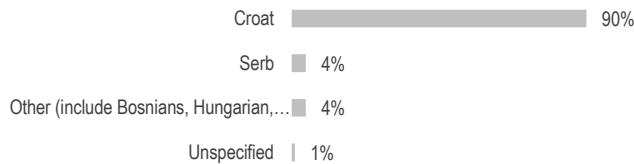
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What are some quick facts?

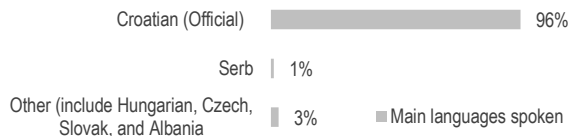
Introduction

- The Socialist Federal Republic of Yugoslavia (SFRY) was formed in 1945 and comprised the states of Bosnia-Herzegovina, Croatia, Macedonia, Montenegro, Serbia, and Slovenia.
- Within each state, there coexisted a diversity of ethnic groups as diverse as Croats, Gypsies, Albanians, Hungarians, and Serbians.
- In 1991, Slovenia and Croatia declared their independence from the federation of states, followed by Bosnia-Herzegovina and Macedonia. The subsequent civil war involved atrocities including rape, torture and murder, as ethnic communities fought each other for the right to self-determination.

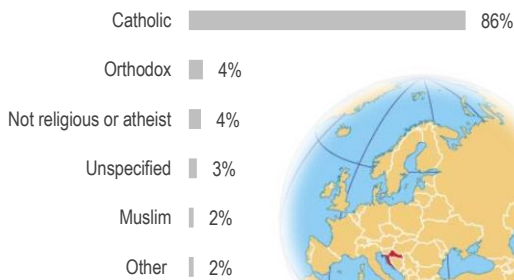
Ethnicity



Language



Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- The level of English proficiency among Croatian Americans varies according to age and education, with the younger people tending to be more proficient.
- It may be difficult to gain rapport with some Croatian Americans because of their recent trauma.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Health Services: Croatian Americans tend to openly discuss their suffering. The relatives give moral and physical support. ■ Healthcare providers may be expected to give high significance to discussions of symptoms and complaints. ■ Some Croatian Americans may have a fear of serious disease approaching a phobia. ■ Many Croatian Americans will want detailed explanations of tests and procedures. ■ It is expected that the Croatian Americans family will care for the elderly at home, and the suggestion of a nursing home may appear insulting. ■ Many recent Croatian refugees have had little health and dental care in the past five years and may require extra services initially. ■ Croats coming from camps and other difficult circumstances may have a higher incidence of TB. ■ Awareness of public health issues tends to be high but this is often not reflected in lifestyle choices. Exercise is uncommon, and there is a tendency towards being overweight. Smoking amongst men is relatively common. ■ Croatian American males tend to have a higher than average mortality from diseases of the digestive system.



Language Services: Although the Croatian language shares many of the features of Serbian, and the speakers can frequently understand one another, care needs to be taken to ensure that the patient's interpreter is from an acceptable ethnic group.



Mental Health: Croats may have witnessed horrific events in some cases torture and rape. Croatian Americans may also have survivor guilt and be worried about those left in Croatia. ■ Unemployment, in men particularly, may be associated with depressive illness. Alcohol may be used to compensate for feelings of inadequacy. ■ Psychological distress may be expressed as somatic symptoms, particularly gastro-intestinal or respiratory symptoms. ■ Mental health-seeking behavior is often limited by language proficiency and lack of knowledge of services. ■ There is a stigma associated with admitting to mental illness. ■ There may be the view that medication is the only treatment. Psychotherapy, group therapy, or occupational therapy maybe rejected.



Pediatrician: Croatian-American children may have unexplained behavioral problems related to previous traumatic experiences in Croatia. Children may have to cope with severe emotional problems among older family members.



Pharmacy: Treatment is often not considered complete without medication.



Social Services: Croatian-American parents of a disabled child may feel shame and isolate themselves from the rest of the community, thus not taking advantage of social services available. ■ Many of the aged Croatian Americans are in need of health and welfare services, but are not accessing them because of poor English, lack of mobility and lack of knowledge of the services. ■ It is expected that the family will care for the elderly at home, and the suggestion of a nursing home may appear insulting. Adapted from: [Queensland Health Community Profiles](#) and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include: 1 What brings you here today? 2 What do you call your illness, problem? 3 What do you think has caused the illness, problem? 4 What have doctors, nurses, other caregivers done so far? What have you or other family members done so far? 5 How has the illness affected your life? 6 How has it affected you and your family? 7 What worries you most about the illness and its treatment? 8 What would you like to have happen today? ➔ *Document the answers in the patient's records.*

Adapted from: *Cultural Competence in Healthcare*; A. Rundle, M. Carvalho, M. Robinson

1

What are some quick facts?

Introduction

- Two to four of every 1,000 people in the U.S. are "functionally deaf," though more than half became deaf relatively late in life.
- One out of every 1,000 people became deaf before 18 years of age.



Source: [Annual Survey of Deaf and Hard of Hearing Youth and Children: GRI](#)

- Two to three out of every 1,000 children are born with a detectable level of hearing loss in one or both ears.
- One out of three people at age 65 has a hearing loss.
- 48 million Americans report some degree of hearing loss.



Children with detectable level of hearing loss in one or both ears



People 65 years or older with hearing loss

Source: [Basic Facts about Hearing Loss: Johns Hopkins Medicine](#)

2

What is the difference between a person who is “deaf,” “Deaf,” and “hard of hearing”?



Deaf

- The uppercase Deaf is a term used when referring to a particular group of deaf people who share a language – American Sign Language (ASL) – and a culture.
- The members of this group have inherited their sign language, use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society.

deaf

- The lowercase deaf when referring to the audiological condition of not hearing.

Hard-of-hearing

- Hard-of-hearing (HOH) can denote a person with a mild-to-moderate hearing loss. Or it can denote a deaf person who doesn't have/want any cultural affiliation with the Deaf community. Or both. The HOH dilemma: in some ways hearing, in some ways deaf, in others, neither.

Source: [National Association of the Deaf](#)

3

Is referring to a person as “hearing-impaired” okay?

- For many people, the words “deaf” and “hard of hearing” are not negative. Instead, the term “hearing-impaired” is viewed as negative.
- The term “hearing-impaired” focuses on what people can't do. It establishes the standard as “hearing” and anything different as “impaired,” or substandard, hindered, or damaged. It implies that something is not as it should be and ought to be fixed if possible.

4

What is their communication style?

Communication Patterns and Value Orientation Sample

- For people who wear hearing aids, check to see if they are on before talking.
- Most deaf people communicate with hearing professionals through a combination of methods such as signing, writing, speech, and lip reading. Assess the best method for communication by asking the deaf person about their preference.
- Do not assume that when a deaf or a hard-of-hearing person nods their head in acknowledgment, that they have heard or understood you. Use open-ended questions to make sure they have understood.
- To express heightened emotions, the deaf person's signing may be made with larger, quicker, and more forceful motions. The deaf person's language conveys emotions such as urgency, fear, and frustration in this way.

5

How can I ensure optimal care?

Patient-and Family-Centered Care



American Sign Language (ASL): If the deaf person relies on ASL (which is not global, make sure that an interpreter is present. ■ Your own body language is an important way to enhance your communication. Use pantomime and facial expressions. Be aware that deaf people may use facial expressions to assess the gravity of the situation. ■ Demonstrate respect and understanding by attempting to learn a few key phrases in Sign Language. Become familiar with the manual sign language alphabet for when an interpreter is not available to communicate. ■ See <http://www.aslpro.com/cgi-bin/aslpro/aslpro.cgi> for an animated dictionary of ASL.



Health Services: Deaf people may have limited experience with medical terminology. Sometimes deaf people do not have the opportunity to gain incidental information, and may not have the same common knowledge that hearing people have. Topics such as causes of illness, prevention, allergy, average body temperature may not be familiar. ■ Deaf people may not have full knowledge of their medical history. They often do not receive adequate explanations about their illness or treatments. Remember to talk directly to the adult deaf person. Give thorough explanations, explaining terms and procedures. Ask open-ended questions to ensure understanding. Use pictures and diagrams when possible. ■ When performing procedures that place you out of view of the patient or the member, explain the procedure ahead of time. When possible, adjust your seat to improve the line of vision with your patient's or your member's face and/or make sure that there is a certified interpreter in the room who can help with communication. ■ Always have written materials to reinforce verbal information given to your patient.



Inpatient: Use the **hard-of-hearing kit** available to facilitate communication. Contact [language services](#) if you have any questions. ■ If signing is the preferred communication method, intravenous lines should be placed in the non-dominant side and arm restraints should be avoided. If arm restraints are necessary, release the dominant hand for communication when a patient is calm.



Speech or Lip Reading: For deaf or a hard-of-hearing people, who prefer speech or lip reading, make sure that you have their attention before speaking: tap them on the shoulder, wave, flick a light, or use another visual signal. ■ Be sure to speak clearly, using your regular voice volume and lip movement. Maintain eye contact when you speak. If you turn your head, you could obscure the view of your face. Taking notes or writing in the chart while talking with a deaf person can hinder their view. ■ When speaking to a deaf person, do not place things such as pencils, gum, or food in your mouth. Remove your facemask before speaking. ■ Avoid standing in front of a light or a window. Position yourself so that the light is shining on your patient. Overhead lighting limits shadows. ■ For patients who are hard-of-hearing, close the door to limit background noise. Be aware of equipment noises in the rooms and hallways and, when possible, find a quiet place to speak with your patient.



Writing: If writing is the patient's preferred communication: Writing can be fatiguing and time-consuming, resulting in communication that may be incomplete. ■ Note that ASL does not follow the order and syntax of written and spoken English. It may be helpful, therefore, to use short precise clauses, pictures, and diagrams. ■ Some deaf people consider English their second language after ASL. Always ask the deaf person about comfort with written language when you are using this mode of communication. ■ Be sure the deaf person is provided with writing tools. A small white or blackboard is useful tool for all communication modalities. Allow for the increased time needed. Adapted from: [Culture Clues: University of Washington Medical Center](#)

Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.

Learn from other sources:

- [Animated Dictionary of the American Sign Language](#)
- [Association of Medical Professionals with Hearing Loss](#)

- [Hard of Hearing Culture Clues: University of Washington Medical Center](#)
- [Language Services at Intermountain Healthcare](#)

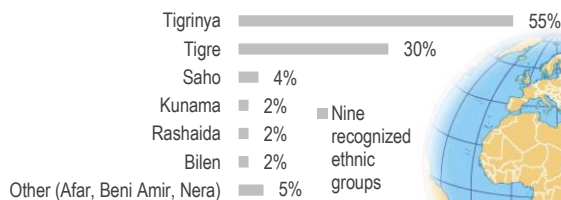
1

What are some quick facts?

Introduction

- Eritrea's history goes back to the days of the Pharaohs in Egypt, when they conducted trade with the chiefs of the Red Sea coasts. The region was invaded by Egypt, Turkey, and Italy. Italy lost the colony to the British in 1941 and after World War II the United Nations made Eritrea an autonomous region of Ethiopia.
- In 1961, the Eritrean war for independence began. The following year, under Emperor Haile Selassie, Eritrea was annexed into Ethiopia. The Eritrean flag was discarded and the people were forced to speak Amharic, the official language of Ethiopia. The armed struggle continued until 1991 when Eritrea was able to gain its independence. During the thirty years of fighting, the country was in a state of civil war.
- As Eritreans were fighting for their freedom, their country was devastated. The countryside was in ruins and many Eritreans left to escape the intense fighting. Many went first to refugee camps in neighboring countries such as Sudan and Zaire (now the Republic of Congo).
- There are two, and more recently three, main waves of Eritrean refugees: those from the 1980s and 1990s and recent immigrants escaping mandatory national service that can go on indefinitely.
- Most recent immigrants are young males because it is easier for them to physically leave the country. Many come illegally across the Mexico border, seeking asylum here. Some come from Egypt, Malta, and Ethiopia through resettlement programs as refugees.

Ethnicity



Language

- The official language of Eritrea, is Tigrinya (also spelled Tigrigna). Eritreans over the age of 50 may also speak Arabic, Amharic, and Italian, because they lived during the Italian and Ethiopian occupations.

Religion

- Most Eritreans follow Islam or Christianity (roughly 40 percent each), but indigenous religious beliefs are still widespread. Although Catholics and Protestants are found among the more affluent and Westernized Eritreans, most Christians are Orthodox.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Greeting styles vary by region and ethnic group. Eritrean highlanders greet with a handshake.
- Eritreans use the right hand for eating and making gestures. They also use it alone or together with the left hand to pass or receive items. A hand held high is a greeting, whereas a hand waved back and forth indicates a negative response.
- Snapping fingers shows agreement. To beckon, one waves all fingers with the palm facing out. Pointing with a finger to indicate location is fine, but pointing at people is impolite.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Eritrean Americans believe in the healing powers of different plants, although they generally see a medical practitioner first. ■ Eritrean Americans may not realize that large quantities of some plants may interact with pharmaceutical drugs, and therefore it should be explained that although herbs may not seem like medication to Eritrean Americans, providers should be informed if the patient is using them.



Health Services: Eritrean Americans may be concerned that too much blood is drawn for testing and would prefer to avoid this unless absolutely necessary. They may be resistant to blood transfusions but also understand that if absolutely necessary, they will comply. If blood is being drawn, providers should explain exactly what the purpose is and what tests are being done on the blood. It should also be explained that blood tests do not necessarily provide a total medical overview and sometimes blood tests are looking for one specific variable. ■ If an Eritrean American is diagnosed with a life threatening illness or is dying, it is advisable to first tell a family member or next of kin. This person will be able to offer advice on how to approach the person, or may serve as the informant. Often a group of close friends or family will go to the house of the person whose relative/spouse has died to inform them of the death and provide support and comfort.



Labor and Delivery: A high value is placed on natural childbirth and Eritrean-born women generally try to avoid using pain killers during birth. ■ Eritrean Americans may strongly feel that U.S. doctors perform too many unnecessary cesarean deliveries. Eritrean American women would prefer the doctor wait for the baby to come naturally. Women often wait to come to the hospital hoping to avoid interventions. ■ Traditionally Eritrean American men do not enter the birthing room, and only the female family members are present.



Language Services: Eritrean Americans strongly believe that Eritreans understand one another and prefer not to be equated with Ethiopians, even though some Ethiopians speak Tigrinya. However, since the end of the Ethiopian occupation, there is as strong a preference for a strictly Eritrean interpreter in the healthcare setting. With easing tensions between the Ethiopian and Eritrean population, an Ethiopian interpreter who speaks Tigrinya is an acceptable option for non-English speakers.



Mental Health: Post-traumatic stress disorder (PTSD) is an issue in the immigrant Eritrean community. Anyone over the age of 20 who immigrated to the U.S., is potentially at risk, especially if they were in the army.



Pharmacy: Chronic illnesses such as diabetes and hypertension are common in the elderly Eritrean American population due to advancing age. **Medication adherence** for these conditions is often poor among the elderly, as most do not understand the purpose of supportive treatments like cholesterol-lowering drugs. They do not understand the purpose of taking medication for conditions that do not present symptoms.



Registration: Many Eritrean American women prefer to be examined by female healthcare providers and if an interpreter is needed, a female is preferred. Adapted from: [EthnoMed](#), [State of Eritrea: Cultural Gram](#), and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include:

- What brings you here today?
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 - What do you think has caused the illness, problem?
 - What have doctors, nurses, other caregivers done so far? What have you or other family members done so far?
 - How has the illness affected your life?
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 - What worries you most about the illness and its treatment?
 - What would you like to have happen today?
- ➔ *Document the answers in the patient's records.*

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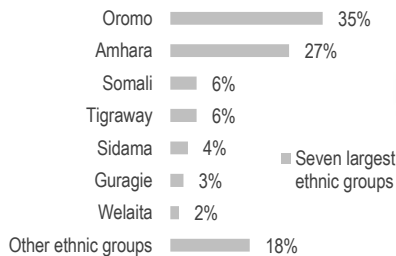
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What are some quick facts?

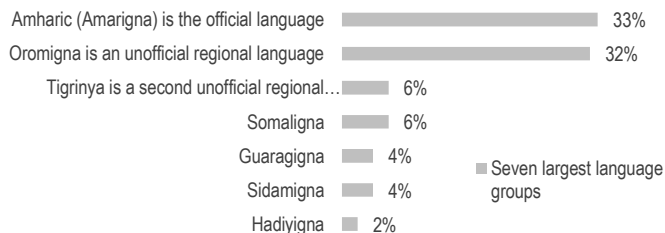
Introduction

- Ethiopia is located in the horn of Africa, a region that has experienced decades of natural disasters, political unrest, war, drought, and famine. This has forced millions of Ethiopians to seek refuge within their own and in other countries.
- In the 1970s, drought, the Ogaden War with Somalia, and an oppressive military regime caused the displacement of more than one million Ethiopians. In the 1980s, Ethiopia experienced another prolonged drought and a consequent famine that continued into the 1990s displacing hundreds of thousands of people.
- From 1998-2000, Ethiopia and Eritrea fought a war that killed more than 70,000 people and displaced more than 600,000 people from areas near the border.
- Ethiopia has provided refuge to displaced people from Sudan, Somalia and Eritrea who have fled war and famine in their own countries.
- Places of transition include: Somalia, Kenya, Sudan, Egypt, and Djibouti.
- Ethiopia is an ethnically complex and diverse country comprising more than 78 distinct ethnic groups.

Ethnicity

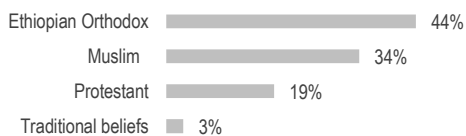


Language



- English and Arabic are also spoken by a small percentage of Ethiopians.

Religion and Spirituality



- Ethiopian Orthodox is a unique Coptic form of Christianity which has been practiced in Ethiopia since the fourth century AD.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Many Ethiopian Americans may be unfamiliar with the use of a surname. Most people have their own personal name and use their father's name in place of a surname. As a result, members of the same family may not have the same surname.
- Ethiopian Americans are generally formal and courteous in their greetings. The most common form of greeting is a handshake with direct eye contact. Handshakes are generally light.
- Ethiopian Americans usually address others by their title and first name.

- Elders are highly respected in Ethiopia and it is customary for Ethiopians to greet elders first and to bow when introduced to someone who is older or holds a more senior position.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Ethiopian Americans may use [traditional remedies in combination with U.S. medical treatments](#) for related or unrelated health conditions, without informing their doctor. Many Ethiopia-born people chew *chat*, a plant that contains an amphetamine like stimulant that can produce mild to moderate psychological dependence.



Health Services: In Ethiopia, [bad news](#) such as a terminal prognosis is first given to the family, or close friends and not directly to the ill person. This is done to maintain the person's hope, and avoid sudden shock that is seen as harmful to health. A family member or close friend will inform the ill person in a culturally appropriate manner.



Language Services: Ethiopian Americans may be uncomfortable with interpreters because of ethnic and political differences. As a result they may not openly express all of their health needs or trust prescribed medicines. Ethiopian Americans generally prefer interpreters of the same gender.



Mental Health: Prior to seeking refuge, many Ethiopians experienced persecution, harassment, torture, political imprisonment, death or disappearance of family members, threats to safety, lack of freedom of expression and will, and coercion to support the ruling political regime.



Pediatrician: In Ethiopia, children commonly undergo [uvulectomy](#) (to prevent suffocation during pharyngitis in babies), the extraction of lower incisors (to prevent diarrhea), and the incision of eyelids (to prevent or cure conjunctivitis) are common.



Pharmacy: Ethiopian Americans may prefer injections to tablets.



Spirituality: The use of prayer for spiritual healing is an important part of treatment for illness for many Ethiopian Americans.



Women's Health: [Female genital mutilation](#) (FGM) is practiced in Ethiopia. Complications of FGM may include incontinence, obstructed miscarriage and childbirth, vaginal and perineal damage at childbirth, and sexual difficulties including non-consummation and painful intercourse. Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include: 1 What brings you here today? 2 What do you call your illness, problem? 3 What do you think has caused the illness, problem? 4 What have doctors, nurses, other caregivers done so far? 5 How has the illness affected your life? 6 How has it affected you and your family? 7 What worries you most about the illness and its treatment? 8 What would you like to have happen today? → *Document the answers in the patient's records.*

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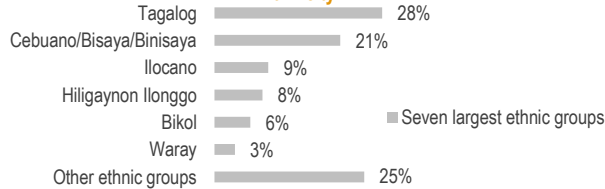
1

What are some quick facts?

Introduction

- Filipinos in North America were first documented in the 16th century, with small settlements beginning in the 18th century. Mass migration did not begin until the early 20th Century when the Philippines was ceded by Spain to the U.S.

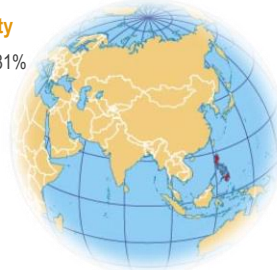
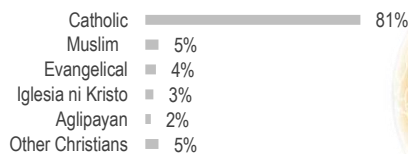
Ethnicity



Language

- Filipino and English are the official languages of the Philippines and both are spoken by many in the Philippines. Filipino is based on the language Tagalog which is a South-Asian language influenced by Spanish, Chinese, Malay and Arabic. In addition, there are eight major dialects spoken: Tagalog, Cebuano, Ilocano, Hiligaynon or Ilonggo, Bicol, Waray, Pampango, and Pangasinan. There are also more than 70 other regional dialects spoken in the Philippines.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- The word *Filipina* refers to a woman from the Philippines; *Filipino* may refer to a person from the Philippines in general, or a man from the Philippines.
- Older Filipino Americans prefer to be addressed by their title (e.g. Mr., Mrs.) and surname. People are familiar with using titles for professionals such as doctors in the Philippines and may be uncomfortable using first names.
- Filipinos take special care to avoid confrontation in any type of communication. Filipino Americans may be reluctant to show disagreement and may say *yes* even when they do not agree. They may maintain a smile when disagreeing or when feeling embarrassed and may say *maybe* or *I don't know* when they really mean *no* or *I can't*.
- Prolonged eye contact can be considered rude and provocative, especially if it involves people of different status or occurs between a man and a woman. Brief and frequent eye contact is recommended between healthcare providers and Filipino Americans.
- An important cultural value of Filipinos is *hiya*, which can be roughly translated as embarrassment, shame or face. It has been described as a kind of anxiety, a fear of being left exposed, unprotected and unaccepted. Having *hiya* means that people may feel very sensitive to social slight and as a result are very careful of the feelings of others.
- Questions such as *Do you understand?* or *Do you follow?* may be considered disrespectful. It is more appropriate to ask *Do you have any questions?*

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Filipino Americans originating from rural areas in the Philippines are often knowledgeable about home remedies, traditional healing techniques and faith healers. Traditional therapies such as *hilot* (traditional therapeutic massage), herbals, nutritional supplements and home remedies may be used in conjunction with U.S. medical treatments and prescribed medications. Filipino Americans may classify and explain illnesses using concepts of *hot* and *cold*. Foods, medicines and temperature/weather conditions are classified according to their heating or cooling quality and their effects on the body. Sudden changes in body temperature may be perceived as harmful.



Health Services: Filipinos generally expect their families to care for them and to be with them when they are sick. Fear of isolation from families is one reason for delayed presentation to hospitals and healthcare providers. Many Philippines-born people cope with illness with the help of family and friends, and by faith in God. Filipino families can greatly influence a patient's or a member's decisions about healthcare.



Inpatient: Beliefs about the relationship of water and bathing to health differ substantially. Bathing can be associated with a draining of strength from the body, particularly if a person is already ill.



Labor and Delivery: Traditional custom in the Philippines dictates that women should not bathe for about ten days after giving birth and during menstruation. Bathing during these times is seen as a cause of ill health and rheumatism in old age. Sponge baths and steam baths could be used as alternatives. Women may object to having a shower immediately after giving birth.



Language Services: Although many Filipinos can communicate in English, many prefer to speak their native language, particularly when ill or when in other high stress situations. However, sensitivity is required in introducing the need for an interpreter as many Filipinos take pride in their ability to speak, read, and write English and may feel offended.



Mental Health: Many Filipino Americans may not be willing to accept a diagnosis of mental illness. This can lead to the avoidance and underutilization of mental health services because of the associated stigma and shame.



Social Services: Power imbalances in relationships can in some cases escalate to domestic violence. Catholic beliefs and values may influence some women's decisions to remain in abusive relationships despite personal cost. In addition, women may be reluctant to seek help if they think that other Filipinas will find out about their marital difficulties, and they may not feel comfortable discussing issues of domestic violence with service providers.



Spirituality: Filipino Americans may believe in *anitos* (spirits) alongside their Christian faith. *Anitos* are sometimes seen as the cause of illness and, in certain areas of the Philippines, healers may be consulted to perform rituals to appease the invading spirits. Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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1

What are some quick facts?

Introduction

- The Hmong are a highland group from southern China, and resident in Laos, North Vietnam, and Thailand. The Hmong have migrated from their homeland since the end of the Vietnam War in 1975 when they faced persecution or death from the communist movement in Laos.
- From 1975 to 1997, approximately 138,000 Hmong escaped by crossing the hazardous Mekong River to refugee camps in Thailand. It is estimated that between 50,000 to 100,000 Hmong people died from fighting, disease and starvation. Many of the Hmong seeking refuge in West transitioned through a refugee camp in Thailand.
- Hmong is the main language.

Religion and Spirituality

Hmong religion is comprised of a cult of spirits, shamanism and ancestor worship. It is a pantheistic religion teaching that there are spirits residing in all things. According to Hmong religious beliefs there are two distinct worlds, the invisible world of *yeeb ceeb*, which holds the spirits, and the visible world of *yaj ceeb*, which holds humans, material objects and nature. The shaman is an important person because he has the ability to make contact with the world of the spirits.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Hmong people greet each other verbally. Older Hmong people and women may be unfamiliar with the practice of shaking hands.
- Hmong people may be reluctant to make direct eye contact. Traditionally looking directly into the face of a Hmong person or making direct eye contact is considered rude and inappropriate.
- Hmong people tend to be reserved and may not wish to show or express their true emotions in front of other people. They may say *maybe* or *I will try* instead of giving a definite positive or negative reply. If they feel pressured, they may say *ok* or *yes* when they actually mean *no*.
- Due to religious beliefs and personal values, many traditional Hmong elders, may object to a stranger touching their heads, or those of their children.
- Care may be required when explaining healthcare issues as many Hmong Americans have not completed any formal education.
- Hmong Americans often prefer for healthcare providers to take some time to discuss family or other pleasantries before asking direct questions about their physical health.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample

Alternative/Complementary: Hmong beliefs about the causes of illness can be divided into three basic categories:

- **Natural causes:** This includes imbalances of metaphysical forces (similar to the concept of yin/yang), changes in weather, bad food, heredity, aging and bacteria. The Hmong understanding of bacteria is similar to that of Western medicine.
- **Spiritual or religious causes:** Ancestors, nature and evil spirits are all thought to be able to cause illness to people in some cases.
- **Other causes:** There is a broad range of other causes of illness. For example, it is a common traditional Hmong belief that a person who has been wronged by another has the power to curse that person and bring about illness.

 ▪ **Headaches, muscle aches, swelling, tingling, back pains, chest pains and abdominal pains** are often interpreted as being caused by a build-up of pressure in the body that must be released. Traditional healing techniques used to *dim pa* (release the pressure) include *cupping*, *coining*, and *massage*.

- **Cupping** uses round glass cups, bamboo jars or water buffalo horns. These objects are placed on the location of the pain and a vacuum is applied to the skin by heat or mouth suction. *Cupping* can cause a bruise.

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- **Coining or spooning** involves applying medicated oil or balm and then rubbing the skin with a flat edged object such as a silver coin or a spoon.
- **Massage** is used to loosen the body (muscles, tendons and veins) and promote better circulation.
- Hmong people may grow, import and use herbs and other organic substances for healing a variety of ailments

Anesthesia: Some Hmong people may fear anesthesia and after a general anesthetic may feel it is necessary to perform a soul calling ceremony.

Health Services: Many Hmong people believe that blood maintains balance in the body and that the body may be weakened if blood is withdrawn.

- Hmong may have a limited understanding of the concept of chronic illness and may have a consistent impression that these illnesses can be cured rather than managed.

Adherence to long-term sustained treatment regimens may be low. Careful explanation to the decision maker in the family may be required to gain support.

Labor and Delivery: Many Hmong believe that the mother's body is susceptible to illness because it is *cold* from blood loss. It is believed that the new mother should follow a special diet for 30-days that includes *hot* as opposed to *cold* foods. The father and his mother will often cook these foods for the new mother.

- Hmong believe the placenta is required for reincarnation and is usually buried at the place of birth. Hmong women may wish to bury the placenta.

Language Services: There are two distinct dialects of Hmong language: White Hmong (*Hmong Der* dialect) and Green Hmong (*Mong Leng* dialect). The names of the languages originate from the colors traditionally used for women's clothing by the different groups. Although some Hmong people report difficulty in understanding speakers of another dialect, in general speakers of White and Green Hmong can understand each other.

Spirituality: Non-Christian Hmong may consult a Shaman to diagnose and treat the causes of illness.

- Many Hmong people believe illness can result from an individual losing one or more of the twelve souls that are thought to dwell in the human body. For good health, all twelve souls must remain intact in the body. Many aches and pains, depression and symptoms of mental illness are believed to be caused by a person having lost souls. Souls may be lost in a variety of ways including a sudden fright, excessive fear or grief, capture by an evil spirit, or a soul transferring to another being because they are unhappy.
- Traditional Hmong believe that an autopsy may hinder the reincarnation of the deceased person.

Surgery: Many Hmong people believe that surgery may interfere with reincarnation or may open access to the body for evil spirits to enter.

Women's Health: Same sex healthcare providers are preferred by Hmong Americans, particularly for women. Hmong women may refuse vaginal examinations, especially by male doctors. This may be a reason for late presentation for antenatal care and non-attendance at post-partum checks.

Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions

Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include:

- 1 What brings you here today?
 - 2 What do you call your illness, problem?
 - 3 What do you think has caused the illness, problem?
 - 4 What have doctors, nurses, other caregivers done so far? What have you or other family members done so far?
 - 5 How has the illness affected your life?
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 - 7 What worries you most about the illness and its treatment?
 - 8 What would you like to have happen today?
- ➔ *Document the answers in the patient's records.*

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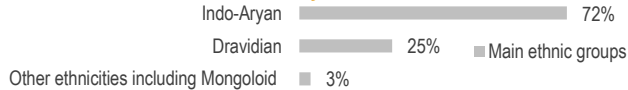
1

What are some quick facts?

Introduction

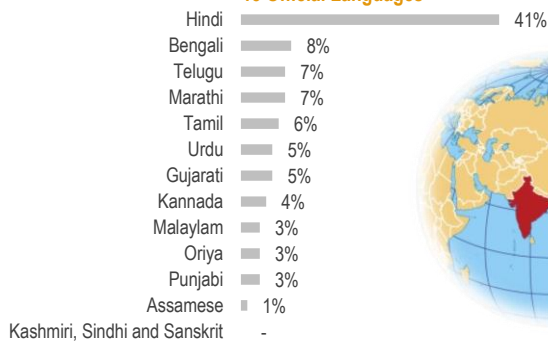
- In addition to India, the three major countries of immigration of India-born people to the U.S. are Pakistan, Bangladesh, and Sri Lanka. Immigrants from an Indian background also migrate from Fiji, United Kingdom, Australia, Canada, New Zealand, Singapore, Malaysia, Indonesia, Philippines, the Middle East, Mauritius, South Africa, East Africa, Madagascar, and the Caribbean.
- Many Indians arrive in the U.S. as skilled migrants and students.

Ethnicity



- India has 15 official languages. Hindi is the most widely spoken and the primary language of the population. However, more than 200 languages are spoken by people throughout India.

15 Official Languages



- Maithili is a non-official language spoken by 1.2 percent of the population. English has the status of subsidiary official language of India.
- Many Indians grow up learning several languages at once.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Indian Americans usually greet each other with the word *namaste* and a slight bow with the palms of the hands together. Some Indians may be uncomfortable with physical contact with strangers. In most cases, a handshake is appropriate. However, it is usually *not* appropriate to shake hands with the opposite sex. Handshakes are usually gentle, rather than firm.
- Sikh people use given names followed by either Singh (for men) or Kaur (for women). Muslim people are known by their given name followed by *bin* (son of) or *binto* (daughter of) followed by their father's given name. For older Hindus, the term *ji* (for both men and women) or *da* (meaning big brother for men) is added to the end of a person's name or title to indicate respect (e.g. *Anita-ji* or *Basu-da*).
- Indian Americans usually prefer minimal eye contact, and in India it is considered rude to look someone directly in the eye, especially where they feel deference or respect.
- In many cases, Indians will often avoid saying *no* and may prefer to avoid conflict by giving an answer such as I will try. In some circumstances, shaking of the head may indicate agreement.
- Indians may say *yes* in order to please a health professional, even if they do not understand the medical concept or treatment plan. It is advisable that health professionals ensure that the person understands all instructions.

Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.

- Indians may avoid the words *please* and *thank you*, believing that actions are performed from a sense of duty and do not require these courtesies.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Many Indian Americans use Western medicine in conjunction with traditional remedies including traditional medicine and spiritual practices such as *Ayurveda*, *Siddha*, *Unani*, *Tibbi*, homeopathy, naturopathy, and acupuncture. *Ayurveda* places emphasis on herbal medicines, aromatherapy, nutrition, massage, and meditation to create a balance between the mind and body.



Anesthesia: Some Indian American families may wish for sedation to be decreased for a dying person because it is considered important that the person is as conscious as possible at the time of death. Many people believe that individuals should be thinking about God at the time of death and that the nature of one's thoughts determines the destination of the soul.



Health Services: An Indian cultural practice that may influence healthcare is the designation of left and right hands for specific tasks. The right hand is typically used for sanitary tasks such as eating while the left hand is reserved for unsanitary tasks. This may affect a patient's or may affect a member's comfort with the use of one arm or the other for drawing blood or for the insertion of an IV. The involvement of family members in major and minor medical decisions is crucial for many Indian Americans. Disclosing a serious or terminal diagnosis is best undertaken with great care and with the consultation and help of family members. It may be appropriate to ask an Indian American his or her wishes about confidentiality and privacy before discussion of any sensitive issues.



Mental Health: Mental illness has severe negative connotations, especially among the older Hindu population. Some believe that mental illness is due to possession of the evil eye. Shame and denial are typical responses to any suggestion of mental illness. Because mental illness is concealed, it is often presented to a doctor as somatic complaints such as headaches or stomach pain rather than as anxiety or depression.



Registration: Many Indian American women, particularly older Hindus, may prefer to be examined by health professionals of the same gender. Having a female relative in attendance when examining an older Hindu woman is recommended as it may facilitate a more open interaction.



Spirituality: Married Hindu women of Indian background often wear the *Mangalsutra* (a sacred necklace) around their necks. Some Hindu men wear a sacred thread around their torso. Ritualistic armbands are also worn by Hindu men and women. These items are sacred and it is important that they are not cut or removed without the consent of the family. At the time of death, family members may request that the body be positioned in a specific direction. They may wish to drop water from the River Ganges or place a holy basil leaf in the mouth of the person and to audibly chant Vedic hymns. It is very important for family members to be at the bedside of a dying person.

Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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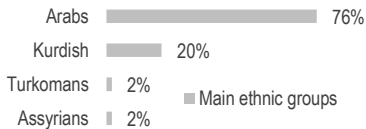
1

What are some quick facts?

Introduction

- Since the early 1980s Iraq has experienced successive wars, oppression, and political and economic sanctions resulting in the displacement of at least nine million people, with approximately seven million people leaving the country and two million being displaced within Iraq.
- The humanitarian crisis in Iraq has included sectarian violence between the two main Muslim groups, the Sunni and the Shi'a, and ethnic cleansing perpetrated against non-Muslim religious minorities including the Yazidis, the Chaldean-Assyrians, Iraqi Christians, Kurds and the Mandaean (a small pre-Christian sect).
- Places of transition include Syria, Jordan, and Iran.

Ethnicity

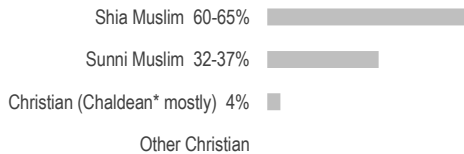


- The Kurds are a distinct group who live in an area in the north, located at the intersection of Turkey, Iraq, Iran, Syria, and Armenia. Turkomans comprise less than three percent of the population and Assyrians less than two percent.

Language

- Almost all Iraqis speak Arabic, the official language of Iraq.
- Kurdish (official in Kurdish regions) is spoken in northern Iraq.
- The Turkomans speak Turkish.
- The Assyrians speak Aramaic.
- Farsi is spoken by some groups in Iraq.

Religion and Spirituality



- * The Chaldean community is a very old Catholic sect who traditionally lived in what is modern Iraq.
- Other Christians include Assyrian (or Nestorian), Madaean (or Sabaeen), and Armenian.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- The most common form of greeting is a handshake coupled with direct eye contact and a smile. Handshakes may be prolonged. It is normal for people of the same gender (men/men, women/women) to kiss on the cheek as well as shake hands when greeting.
- For some Iraqi Americans, it is disrespectful for a man to offer his hand to a woman unless she extends it first. However, this is usually not the case for Christians and Kurds.
- A single, downward nod is the most common expression for yes.
- Many Iraqi Americans view outward signs of emotions in a negative manner because of the need to save face and protect honor.
- Many Iraqi American women who are Muslim wear a *hijab* (head covering) or *jilbab* (full body covering) in public.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample For Iraqi Muslims:



Alternative/Complementary: Some rural Iraqis have ancient traditional health beliefs and practices that can include supernatural agents such as *evil eye*, *jinni*, witchcraft, sin, envy and bad luck and often seek traditional healers. These beliefs may delay patients or may delay members and their families from seeking medical advice.



Anesthesia: Muslims may prefer to decrease sedation at the time of death so that the person is able to hear the final part of the same blessing he or she heard at birth. The blessing, which is the *Kalima* or confession of the faith, should be the last thing one hears at death.



Health Services: Iraqi Muslims may be reluctant to disclose personal information and may be embarrassed by personal questions, including their sexual relationships. Patients or members may not provide enough information for a comprehensive diagnosis. ■ It is common for a family member to stay with the patient and to help answer questions. Many Iraq-born people expect information about a diagnosis and prognosis to be first filtered through the family with the family deciding whether or not to tell the affected person.



Labor and Delivery: Religious rituals and customs at birth and death are important. A Muslim birth custom involves having an adult male be the first person to speak to a new born infant. This male, who becomes a special person in the infant's life, whispers a blessing in the infant's ear. This is usually the *Adhan* or what is usually recited as a call for prayer.



Language Services: It is recommended that gender is considered when matching an Iraqi American with a healthcare interpreter.



Mental Health: Mental illness is often stigmatized. A person with mental health problems may not seek advice from professionals or even family members. Many Iraqi [refugees](#) have experienced traumatic and life threatening experiences before fleeing Iraq. Common traumatic experiences include living in a combat or war zone, imprisonment and [torture](#) (especially common for Iraqi men), and the experience of an accident, fire or explosion. The fear of genocide has a major impact on the health of Kurds and non-Muslim minorities from Iraq.



Registration: Both male and female Iraqi Americans have a preference for a male doctor.



Spirituality: Muslims are required to pray five times a day and this may be particularly important when they are ill.



Women's Health: It is expected that decision making regarding procedures such as a tubal ligation or hysterectomy involve the woman's husband. ■ For gynecological needs, most women prefer to be seen by a female doctor. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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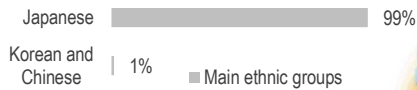
1

What are some quick facts?

Introduction

- From 1869 to 1924 approximately 200,000 immigrated to the islands of Hawaii, mostly laborers arriving to work on the islands' sugar plantations.
- Some 180,000 went to the U.S. mainland, with the majority settling on the West Coast and establishing farms or small businesses.

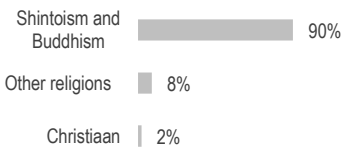
Ethnicity



Language

- Japanese is the official language and is spoken by the majority of the population.

Religion and Spirituality



- Shintoism is an ancient indigenous religion of Japan existing before the introduction of Buddhism. It lacks formal dogma and is characterized by a honor of nature spirits and ancestors. In Shintoism, the wind, sun, moon, water, mountains, and trees are all spirits (*Kami*).
- Confucianism as a code of ethics, has an influence on the lives of many Japanese people. High importance is placed on family values and social order.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Japanese Americans may bow as a greeting to show respect and gratitude. The depth of the bow depends on the occasion and social status of the individuals involved.
- The Japanese smile can be difficult to interpret as it can be used to convey happiness, anger, confusion, embarrassment, sadness, or disappointment.
- Japanese people nod their heads to show either agreement or concentration during a conversation.
- Japanese people make considerable effort to maintain harmony and may do so by expressing agreement, regardless of level of comprehension or genuine agreement, or simply by following instructions or recommendations.
- A negative response is signaled by holding a hand in front of the face and waving it backwards and forwards.
- It is usual to address Japanese people by their family names. Given names are used only for children or between close friends. *Sensei* or *san* may be added to the end of a name to indicate rank or position. *San* is the equivalent of the title Mr. or Mrs. *Sensei* is generally used for teachers or doctors.
- An older Japanese person may not volunteer information, so respectful inquiry may be helpful to elicit pertinent clinical information.
- It is advisable to avoid direct eye contact with a Japanese American when discussing their illness, including diagnosis and prognosis. Japanese people often focus on the other person's forehead when they are talking.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Japanese may combine traditional therapies with Western medicine. It is advisable to ask patients if they are using any other therapies for their medical conditions. Common traditional health practices include *Kampo*, *Moxibustion*, *Shiatsu* and *Acupuncture*. ■ *Kampo* uses herbal medicines which originated in China around the 7th Century. The herbs are usually in powdered or granular form. ■ *Moxibustion* involves burning dried mugwort on specialized points of the skin to stimulate life energy and blood flow. This can cause bruising on the skin. ■ *Cupping* uses round glass cups which contain a lit taper and are pressed into the skin to stimulate circulation. ■ *Shiatsu* is a form of massage therapy concentrating on pressure points of the body to redirect or reestablish energy flow and restore balance. ■ *Acupuncture* involves inserting needles into specific points on the body to eliminate toxins and relieve pain.



Health Services: Japanese Americans may find it awkward if sensitive medical information is given to them directly. Japanese Americans may not want to hear the name of their illness directly from a doctor and may prefer to be informed indirectly before their appointment so they can be prepared when speaking with the doctor. In Japan, medical information is usually shared with the family. The doctor may tell close family members about the situation first. ■ In many cases, Japanese Americans may not want their doctor to know that they are mentally upset by hearing bad news about their illness. Offering comfort to a Japanese American who has broken down with grief could be very embarrassing for them.



Inpatient: In Shintoism, the state of health is associated with purity. Japanese Americans may want to wash their hands frequently and use wet towels instead of washing.



Mental Health: Many Japanese people believe that weakness of character is a cause for mental illness and may be reluctant to openly discuss disturbances of mood as these are considered to be indicative of personal weakness rather than treatable medical conditions.



Spirituality: In Japan, it is a common saying that Japanese people are born Shinto but die Buddhist. ■ In Shintoism, there is an emphasis on purity and cleanliness. Terminal illness, dying and death are considered negative and impure. Therefore, frank and open discussions about death and dying may be difficult. ■ Many Japanese people embrace Buddhism later in life. For Buddhists, death is a natural process where life continues in the form of rebirth. Japanese, who are Buddhists, may be more open to discussion about death and dying. ■ A number of Japanese are Christians and embrace a Christian view of the meaning of death, dying, and end of life issues. Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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1

What are some quick facts?

Introduction

- In 1903, the first group of Korean laborers came to Hawaii on January 13th, now known annually as Korean-American Day.
- In 1945. After World War II, a democratic-based government (Republic of Korea, ROK) was set up in the southern half of the Korean Peninsula while a communist-style government was installed in the north (Democratic People's Republic of Korea, DPRK).
- During the Korean War (1950-53), US troops and UN forces fought alongside ROK soldiers to defend South Korea from a DPRK invasion supported by China and the Soviet Union.
- Discord with North Korea has permeated inter-Korean relations for much of the past decade, highlighted by the North's attacks on a South Korean ship and island in 2010,

Ethnicity

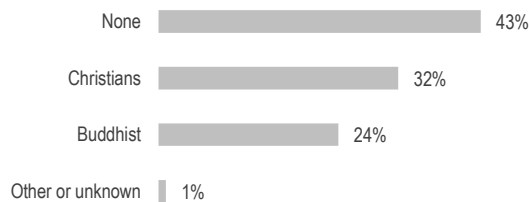
- Koreans except for about 20,000 Chinese.

Language

- Korean is the official language.



Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Koreans may not sustain direct eye contact with providers. Frequently Koreans may look at others when they are trying to become more comfortable.
- Handshakes are appropriate between Korean men; Korean women do not shake hands.
- Respect is shown to authority figures by giving a gentle bow.
- Korean Americans may highly value emotional self-control, appearing stoic. Be aware that the Korean Americans may not show pain or ask for pain medications. Instead of asking Korean Americans about pain, ask, "May I get you something for pain?"
- Respect Korean Americans' desire to keep emotions in control when asked about upsetting matters.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Health may be viewed as finding harmony between complementary energies such as *cold* and *hot*, these forces are called yin and yang. ■ Many Korean Americans seek medical care from *hanui*, a traditional herbal doctor. *Hanyak* or herbal medicines are widely used. Ginseng is a popular herb.



Health Services: Consult with the Korean American family in cases of serious or terminal illness. While decision making is family focused, the husband, father, eldest son, or daughter may have the final say. The eldest male is often the spokesperson. ■ Because of traditional Korean values of loyalty, the patient or the member may trust that the parents and family will make the best decision for them. Therefore, advance directives may seem unnecessary to the patient or the member and their family. The informed consent process may be a new experience for Korean Americans.



Mental Health: Physical complaints are readily accepted. Mental illness is viewed as stigmatizing and threatening among Korean Americans. As a result, psychological and social stress may be experienced bodily. ■ *Hwabyung* is an example of a Korean culture-bound illness, common in Korean women. The cause of this illness is suppressed anger or intolerable tragic situations. Symptoms of *hwabyung* include perceived stomach mass palpitations, heat sensation, flushing, anxiety, and irritability.



Pharmacy: Korean Americans may believe that Western medicine is too strong and may not take the full dose or complete the course of treatment. ■ Korean Americans may cut the dose in half or stop taking the medicine whether or not they feel better.



Spirituality: Korean American may follow Buddhist or Confucian doctrine, viewing illness and death as a natural part of life. ■ Symptoms may be seen as bad luck, misfortune or the result of *karma* – payback for something they did wrong in the past.



Women's Health: Consider the modesty of Korean American women and girls when giving a pelvic exam. Many young women are modest about having an exam and may prefer a female doctor to do it. In some cases, Korean American women may refuse a gynecologic exam from a provider of either gender.

Adapted from: [Culture Clues: University of Washington Medical Center](#) and [The World Factbook: CIA](#)

4

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Discussion Questions



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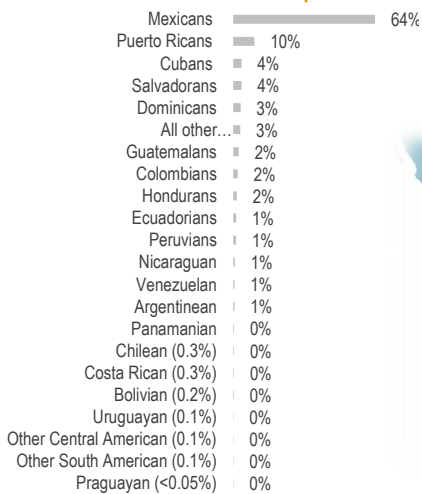
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What are some quick facts?

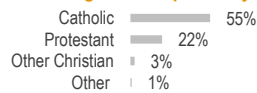
Introduction

- Latin Americans are the nation's largest minority group, representing over 17 percent of the U.S. population.

Statistical Portrait of U.S. Hispanics



Religion and Spirituality



Note: Hispanic origin is based on self-described family ancestry, lineage, heritage, national group or country of birth. Source: [Pew Hispanic Center tabulations of 2013 American Community Survey \(1% IPUMS\)](#) and Pew Research Center survey of Hispanic adults, May 24–July 28, 2013. Figures above based on FORM12 and FORMNCO, N=4, 080. Figures may not add to 100%, and nested figures may not add to total, due to rounding. [Pew Research Center](#)

Language

- Latin American countries where **Spanish is the sole official national language**: Mexico, Colombia, Argentina, Venezuela, Chile, Guatemala, Cuba, Dominican Republic, Honduras, El Salvador, Nicaragua, Costa Rica, Panama, Uruguay.
 - Latin American countries and regions where the **Spanish language is co-official**: Peru (Spanish, Quechua, and Aymara); Ecuador (Spanish, Quechua, and Shuar); Bolivia (Spanish, Quechua, Aymara, and Guarani); (Paraguay, Spanish and Guarani); Puerto Rico (Spanish and English); Equatorial Guinea, (Spanish and French).
 - English is the official national language in Belize. However, the country shares land borders with Spanish-speaking Mexico and Guatemala. Spanish is spoken by a sizable portion of the population there.
 - In Brazil, **Portuguese** is the official national language. In Venezuela and Guyana, there are communities of Portuguese immigrants and their descendants who speak Portuguese as their native language.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Latin Americans value relationships. They prefer a polite and friendly encounter before a therapeutic relation. Take time to develop relationships. Shake hands and greet Latin Americans by name, or ask Latin Americans what they prefer to be called. An older person may prefer to be called *Señor* (Mr.) or *Señora* (Mrs.).
- When a Latin American nods his or her head, it does not necessarily signify agreement, but that he or she is listening to you. Silence is more likely a sign of not understanding or disagreement.
- Latin American people tend to experience intense feelings and often express them. People can appear to be sensitive and may be easily hurt, but also easily react positively if treated with respect and friendliness.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample

Alternative/Complementary: Latin Americans may see illness as an imbalance. The imbalance may be between internal and external sources (for example, hot and cold, natural vs. supernatural, the soul is separate from the body).

- There are folk-defined diseases such as *empacho* (stomach ailment) and standard western medically-defined diseases such as measles, asthma, and TB.
- Many Latin Americans seek medical care from *Curanderos* or other folk healers. Ask about use of pharmaceuticals or home therapies such as herbal remedies or certain foods. Screen for possible patient use of injectables, especially antibiotics or vitamins. Ask if you can see the home treatment if the patient or the member cannot identify the substance.



Health Services: The ill person is seen as an innocent victim, and will be expected to be passive when ill.

- The mother determines when a family member requires medical care; the male head of the household gives permission to go to the medical center.
- Head of household, often oldest adult male is the decision-maker, but important decisions often involve the whole family. The family spokesperson is usually the father or oldest male. When possible, engage the whole family in discussions that involve decisions about care.
- The family would prefer to hear about bad medical news before the ill person is informed. The family spokesperson usually delivers information about the severity of illness. The family may want to shield the ill person from the bad news.



Inpatient: *La familia*, the family, is an important source of emotional support during recovery. Be aware of the importance of this and consider extending visiting hours.

- Explain the visitation policy at the time the patient or the member is admitted or before a surgery, so that the family knows what to expect.
- The family may want to allow the person to remain passive during recovery while they provide complete support for activities of daily living. Educate family members about the importance of the patient's or the member's active participation during recovery.



Labor and Delivery: According to the *hot* and *cold* theory of illness, during childbirth heat is lost, and the mother must be protected from *cold* by physical confinement, restrictions on bathing, eating *hot* foods and avoiding *cold* foods.



Language Services: Ask your client if they prefer to use an interpreter. Even if the client's English is adequate at the beginning of the interview, an interpreter may be appropriate, particularly for stressful health discussions.

- The client may prefer an interpreter of their nationality but when confidentiality is an issue, they may prefer another nationality.



Mental Health: Depression may not be seen as an illness. It is often seen as a weakness and an embarrassment to family.

- Susto* is a culturally specific disorder which manifests in several forms, including anxiety and over-conforming to social roles.



Pediatrician: *Mal ojo* or evil eye is caused by a person with a strong eye and occurs when someone admires a child without touching them.

- A plump baby may be seen as healthy and a mother will find it hard to believe her child is overweight.



Social Services: Latin Americans are often not recognized for their professional qualifications, or insufficient English to work in their professional capacity. Laboring or production process work may be all that is available to them in the U.S. As a result, they may lose self-esteem and dignity which can lead to depression.



Spirituality: Latin Americans may believe that God determines the outcome of illness.

- For some Latin Americans, eye contact may be related to evil spirits. An illness may be attributed to receiving an "evil eye" or *mal ojo*.

 Adapted from: [Culture Clues: University of Washington Medical Center](#) and [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions

Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include:

- 1 What brings you here today?
- 2 What do you call your illness, problem?
- 3 What do you think has caused the illness, problem?
- 4 What have doctors, nurses, other caregivers done so far? What have you or other family members done so far?
- 5 How has the illness affected your life?
- 6 How has it affected you and your family?
- 7 What worries you most about the illness and its treatment?
- 8 What would you like to have happen today?

 Document the answers in the patient's records.

Adapted from: *Cultural Competence in Healthcare*; A. Rundle, M. Carvalho, M. Robinson



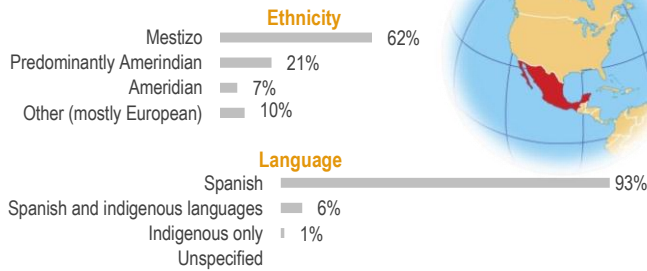
Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.

1

What are some quick facts?

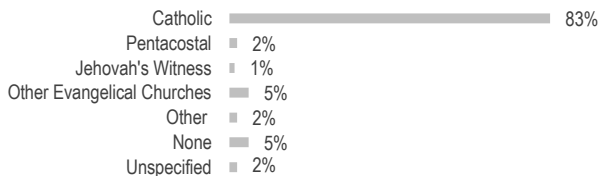
Introduction

- Mexico was originally inhabited by many different ethnic groups including the Mayas, Zapotec, Aztec, and others. Mexico, like much of South and Central America, was colonized by the Spanish, being occupied from 1521-1810.
- Mexican independence occurred September 16, 1810 and was sparked by the Napoleonic threat to acquire what was then "New Spain".
- Afraid of losing their emerging culture, the *criollos* (descendants of the Spaniards born in Mexico) and the *mestizos* (descendants of the Spanish and Indian intermarriages) united in a movement known as "Los Insurgentes", which eventually overthrew Spain.



- Indigenous languages include various [Mayan](#), Nahuatl, and other regional languages (2005)

Religion and Spirituality (2010 Census)



- Many Mexican Americans living in the U.S. practice Catholicism. The Aztec religion, as it was practiced before colonization, is all but gone. They believed in a vital force of *tona* that separated living from non-living matter. They were animists with multiple gods. They also had a strong belief in balance and in supernatural powers which can still be seen today in some of the traditional medical beliefs.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Respect is very important in Mexican culture. The way in which a healthcare provider greets and addresses Mexican Americans may convey respect or disrespect.
- Mexican Americans may prefer their providers greeting them in a manner that conveys respect. Use a title and the full name, such as saying, "Hello Señor Julio Perez."
- Studies indicate that Mexican Americans expect a caregiver to show warmth and the encounter should not be strictly business.
- Mexican Americans prefer their provider be attentive, take their time, show respect, and if possible, communicate in Spanish.
- Mexican Americans may also have more respect for care givers if they exhibit confidence.

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Learn from other sources:

[Culture Clues](#) are one-page tip sheets for healthcare providers

[EthnoMed](#) includes information about cultural beliefs, medical issues, and other pertinent healthcare issues

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample

Alternative/Complementary: Illness is believed to result from an imbalance of *hot* and *cold* forces in the body. For example, when a Mexican American person is sick, it is because they are out of balance, having either too much heat or cold. Correction of this balance is by consumption of foods or herbs of the opposite quality. *Cold* diseases are ones that have invisible symptoms and include earaches, arthritis, stomach cramps and a chest cold. *Hot* diseases have more visible symptoms and include *empacho* (indigestion), *colico* (nausea, vomiting and abdominal cramp), stomach ulcers, fever, headache, and sore throat. Since these categories may vary depending on where the patient or the member is from, it is often best just to ask if there is any contraindication to taking a medicine according to their beliefs. ■ Supernatural powers are also believed to cause disease. An example of this is *mal de ojo* or the *evil eye*. With diseases caused by supernatural forces, non-supernatural cures are not believed to be helpful and often have poor compliance. It is important providers point out the natural cause of the disease and why the prescribed treatment will be beneficial.

Mental Health: *Susto* or fright sickness is caused by a traumatic or frightening experience. Symptoms include lethargy anxiety, depression, insomnia, and irritability.

Nutrition: *Empacho* is a form of stomach upset which is believed to be caused by a bolus of undigested food. This can happen by eating the wrong foods at the wrong time of the day or eating undercooked foods. Symptoms include anorexia, vomiting, diarrhea bloating, indigestion, and constipation. The most common treatment is massaging the stomach or back, pinching the skin of the back and pulling it until it pops.

Pediatrician: *Caida de mollera* means sunken fontanel and is believed to be caused by pulling a baby away from the breast or bottle too quickly, having the baby fall to the ground or carrying the baby incorrectly. Symptoms include poor suck, irritability, sunken eyes, vomiting, and diarrhea. The treatments include pushing up on the baby's palate with a finger, holding the baby upside down over a pan of water and slapping the bottoms of his feet, and apply a poultice to the fontanel. ■ *Mal ojo* or *evil eye* is caused by a person with a strong eye and occurs when someone admires a child without touching them. The cure involves passing an egg over the body and then placing it in a bowl under the child's pillow overnight. If the egg is cooked in the morning then the child had *mal de ojo*.

Spirituality: The main traditional healer is known as a *Curanderas* and is believed to get her power from God. Less used traditional healers include the *Yerberos* (herbalists) and *Sobadores* (masseuses). *Curanderas* view illness in a religious and social context, and are used more for diseases that have a supernatural cause. ■ One study showed 72 percent of people who receive care from a folk healer do not tell this to their physician. Although most of the folk cures are harmless and even sometimes helpful, it is important to know if a patient or a member is using a folk cure because some remedies such as *greta* and *azarcon* contain lead and can be harmful. ■ *Mal puesto* is when someone uses witchcraft to put a bad disease on a person. The hex can be placed by a *bruja* (witch) or someone who knows about witchcraft. Symptoms can be varied and the cure involves prayers, massages, and herbs, making crosses on the arms with olive oil and chili powder, and medicinal enemas. Adapted from: [Ethnomed](#) and [The CIA World Factbook](#)

4

How can I ensure optimal care?

Discussion Questions

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Adapted from: *Cultural Competence in Healthcare*; A. Rundle, M. Carvalho, M. Robinson

1

What are some quick facts?

Introduction

- The terms Native American, American Indian, and Alaska Native (AI/AN) refer to a group that consists of descendants of the original people indigenous to the North American continent. The U.S. Census Bureau defines American Indians and Alaska Natives as “people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.”
- AI/AN community members make up more than 500 different tribes. Among the tribes reported in the 2000 US census include the Ute, Paiute, Goshute, Shoshone, Navajo, Nez Perce, Kalispel, Kootenai, Coeur d’Alene etc.
- Urban Indian communities can be found in most major metropolitan areas. These populations are represented by members of a large number of different tribes and cultures that have different degrees of traditional culture and adaptation to Western culture norms. They form a sense of community through social interaction and activities, but are often “invisible,” geographically disbursed, and multi-racial.
- Some AI/AN individuals have converted to Christianity, some retain their American Indian spirituality, and some practice a mixture of both Christianity and American Indian spirituality.



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- AI/AN people communicate a great deal through non-verbal gestures. Careful observation is necessary to avoid misinterpretation of non-verbal behavior.
 - AI/ANs may look down to show respect or deference to elders, or ignoring an individual to show disagreement or displeasure. A gentle handshake is often seen as a sign of respect, not weakness.
 - AI/AN people may convey truths or difficult messages through humor, and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much direct clarification about sensitive topics.
 - Establishing trust with members of an AI/AN community may be difficult. Many Tribal communities were destroyed due to the introduction of European infectious illnesses. Similarly, many treaties made by the U.S. government with Tribal nations were broken.
 - Getting messages across through telling a story (traditional teachings and personal stories) is very common and sometimes in contrast with the “get to the point” frame of mind in non-AI/AN society.
 - Adapt your tone of voice, volume and speed of speech patterns to the local community member to fit their manner of communication style. Preferred body language, posture, and concept of personal space depend on community norms and the nature of the personal relationship. Observe others and allow them to create the space and initiate or ask for any physical contact.
 - Be careful about pointing with your finger, which may be interpreted as rude behavior in many tribes. Avoid jargon, a person may nod their head politely, but not understand what you are saying.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Purification is used to maintain harmony with Nature and to cleanse body and spirit. Purification can be accomplished by total immersion in water or by use of sweat lodges, herbal medicines, and special rituals. Sometimes sage, cedar, or other materials are burned to purge a hospital room or area of evil spirits and disease. Work with patients and their family members to suggest non-fire based ways for purification, such as sprinkling ground sage or cedar around a hospital bed and/or room.

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Health Services: Many health and wellness issues are not unique to AI/AN communities, but are statistically higher than in the general population.

- AI/ANs may be stoic about expressing pain. This stoicism can lead to ineffective treatment for pain. Be alert to nonverbal cues and physiological indicators of pain. Nonverbal cues could include grimacing, becoming immobile, withdrawing from activity and socialization, holding the painful area, breathing with increased effort, and becoming restless. Physiological responses could include muscle tension; tachycardia; rapid, shallow respirations; increased blood pressure; dilated pupils; sweating; and paleness.
- Be careful how the words “positive” and “negative” are used. The statement “your tumor test was positive” could be misconstrued to be good news that no cancer cells were present.
- Do not touch sacred items, such as medicine bags, other ceremonial items, hair, jewelry, and other personal and cultural things. If a patient must go to surgery, the medicine bag could be placed in a clean or sterile bag and taped to the patient’s body or otherwise sent with the patient.
- Some American Indians adhere to Western medical regimens when ill, some rely on traditional Indian medicine, and some use a mixture of both.



Mental Health: It is easy to be challenged by the conditions in AI/AN communities and to not see beyond the impact of the problems or crisis. Recognizing and identifying strengths in the community can provide insight for possible interventions. Since each community is unique, look to the community itself for its own identified strengths, such as: extended family and kinship ties; long-term natural support systems; shared sense of collective community responsibility; physical resources (e.g., food, plants, animals, water, land); indigenous generational knowledge/wisdom; historical perspective and strong connection to the past; survival skills and resiliency in the face of multiple challenges; retention and reclamation of traditional language and cultural practices; ability to “walk in two worlds” (mainstream culture and the AI/AN cultures); and community pride.



Spirituality: Specific practices such as ceremonies, prayers, and religious protocols will vary among AI/AN communities.

- A blend of traditions, traditional spiritual practices, and/or mainstream faiths may coexist. It is best to inquire about an individual’s faith or beliefs instead of making assumptions, but be aware that many AI/AN spiritual beliefs and practices are considered sacred and are not to be shared publicly or with outsiders.
- Social/health problems and their solutions are often seen as spiritually based and as part of a holistic world view of balance between mind, body, spirit, and the environment.

 Adapted from: [Culturally Competent Nursing Care for American Indian Clients in a Critical Care Setting: D.L. Flowers and Culture Card A Guide to Build Cultural Awareness: DHHS, CDC](#)

4

How can I ensure optimal care?

Discussion Questions



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 Document the answers in the patient’s records.

Adapted from: *Cultural Competence in Healthcare*; A. Rundle, M. Carvalho, M. Robinson

Learn from other sources:

[MedlinePlus](#) has information on health issues that affect Native Americans

[Indian Health; Utah Department of Health](#) offers reports and more resources

[Think Cultural Health](#) offers free E-learning courses

[AAFP Quality Care for Diverse Populations](#) has seven 3 to 8-minute videos showing clinicians thoughtfully communicating

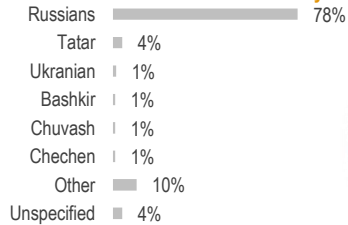
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What are some quick facts?

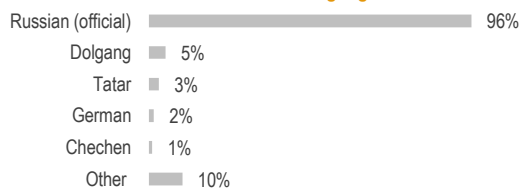
Introduction

- General Secretary Mikhail Gorbachev introduced openness and restructuring in an attempt to modernize communism, but his initiatives inadvertently released forces that by December 1991 splintered the USSR into Russia and 14 other independent republics.
- President Vladimir Putin, foreign policy focused on enhancing the country's geopolitical influence, particularly in the former Soviet Union, and continued economic growth
- Russia has severely disabled a Chechen rebel movement, although violence still occurs throughout the North Caucasus.

Ethnicity

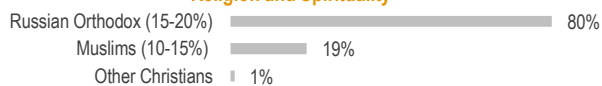


Language



- Note: shares sum to more than 100% because some respondents gave more than one answer

Religion and Spirituality



- Note: estimates are of practicing worshippers; Russia has large populations of non-practicing believers and non-believers, a legacy of over seven decades of Soviet rule.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Decisions are made by the Russian American parents or the oldest child. There are no major gender issues; decisions could be made by the Russian American mother, father, or eldest son or daughter.
- Direct eye contact with Russian Americans is acceptable.
- A handshake is welcome from the healthcare provider.
- Among Russian Americans there are expressions of grief however, efforts are made to not openly grieve in front of the dying person. The dying person is allowed to freely express grief.
- Russian Americans may be demonstrative or expressive when discussing quality of care issues as a way to draw attention and get the best from the healthcare system. Assure the patient or the member they are getting the best care, the same care given to all patients or all members regardless of nationality or financial status.
- Russian Americans appreciate talking with clinicians as long as possible, and may prefer that the conversation occur in a private setting such as a doctor's office or consult room.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Health Services: Russian Americans may believe that illness is caused by weather or social experiences, such as stress from the living situation or because of arguing with the family. Spend time with the patient or the member to show that they are cared for. Bad medical news is often shielded by the family in the belief that telling the patient or the member will only make the condition worse. The doctor, not the nurse, is expected to transmit the medical news to the family or to the patient or the member. Before touching the patient, always explain what will be done and why. They may prefer that opposite gender family members leave the room. The doctor is typically regarded as the ultimate authority in all medical matters. The doctor is expected to orchestrate the work of the healthcare team. Whenever possible the doctor should introduce each member of the care team to the patient or the member and to the closest relatives, stressing their credentials. If another team member is the designated lead for care management, this should be explained and assurances given that the doctor is kept informed. In general, Russian Americans want to understand the cause of their disease and they have a strong tendency for self-diagnosis using medical books and other sources. Try to explain the possible causes of their condition and how the treatment affects them. Encourage self-directed learning however, encourage the use of credible sources of information, and welcome opportunities to discuss their findings and conclusions.



Inpatient: Russian Americans may prefer sponge baths to daily baths or showers. Russian Americans may not wash hair as frequently when sick, especially when in the hospital, for fear of catching a cold or headache. Russian Americans may prefer to keep the room warm and the window shut. Hygiene may be performed by the patient, the family, or with the help of a nurse or aide. Maintain modesty and privacy issues with opposite-gender family members present.



Mental Health: Mental health does not receive due respect in the former Soviet Union. Even the word "mental" has negative connotations because it is connected with "mental illness." Use the term *depression*, not mental health or mental illness.



Pharmacy: Russian Americans may not like to take excessive medications. When there is an option, ask the patients or the members if they prefer over-the-counter or homeopathic medicine. Adapted from: [Culture Clues: University of Washington Medical Center](#) and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



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1

What are some quick facts?

Introduction

- Samoa and Tongans are both Polynesians however there are many differences between the two groups.

Ethnicity (Samoa)



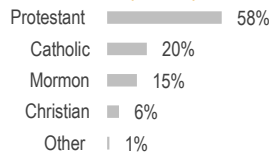
Ethnicity (Tonga)



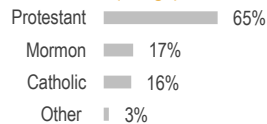
Language (Samoa and Tonga)

- Samoa and English are both official languages of Samoa. Tongan and English are both official languages of Tonga.

Religion and Spirituality (Samoa)



Religion and Spirituality (Tonga)



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Most people from Samoa and Tonga speak English, although new immigrants and older people may not be very proficient and an interpreter may be required.
- It is appropriate to address Tongan Americans by their first name "Mr." and "Mrs." are not used in their culture. This does not apply to Samoan Americans.
- Samoa and Tongan Americans tend to be shy and tend not to ask questions or question a health professional's authority.
- The handshake is a common greeting for Samoan Americans and appropriate for both men and women.
- Samoa and Tongan Americans may say yes when they do not necessarily understand or agree with what is being said. Healthcare providers may need to check for understanding.
- Among both Samoan and Tongan-American men and women, a high level of body contact is natural and normal.
- Samoa and Tongans are very respectful of health workers; however, they may feel uncomfortable and need reassurance.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: If Western medicine is perceived as ineffective, Samoans may use traditional healers. Tongans will tend only to use traditional medicine if the illness is terminal and they can find the right plant to use locally.

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Health Services: Some Samoan Americans, particularly women, may be reluctant to discuss health issues openly with a health practitioner. Encourage Samoan and Tongan Americans to ask questions. Samoan Americans are very family oriented. When explaining a serious illness, a patient may prefer to have at least one family member present or their whole family. It may be preferable for a healthcare provider to explain the diagnosis first to a close family member and they will both tell the patient together. Samoan and Tongan Americans may not be aware they have a choice of treatment options, so it may be necessary to make the alternative treatments explicit. It may be useful to link up patients or members with someone from their community who understands the hospital system. Explain clinical terms simply and slowly. Rephrase questions if Samoan and Tongan Americans do not understand. Avoid questions phrased in the negative, such as "You didn't go to hospital, did you?" which they may answer with "yes" when they mean "no". A visual explanation of the problem may be more effective than written or oral explanations.



Inpatient: Samoan and Tongan Americans like to have relatives and friends staying there too and feel discriminated against when they can't. If this is not possible, then an explanation of your reasons will help them.



Language Services: Ask if Samoan and Tongan Americans need an interpreter or assistance to fill in forms, especially the elderly.



Mental Health: Because of shame and stigma, mental health problems are not easily talked about with people from outside of the person's family, with consequent delays in seeking professional help.



Social Services: Research suggests that domestic violence may be prevalent in Pacific Islander communities in the U.S. There is some evidence to suggest that living conditions away from Samoa may increase the occurrence of domestic violence as a result of changes in gender roles with increased opportunities for education and employment for women and decreased opportunities for men, and an absence of extended family buffering and social support.



Registration: The gender of the health provider may be an issue for Samoan Americans, particularly for younger people, and women may appreciate being asked if they have a preference for a female healthcare provider.



Spirituality: Some Samoan Americans believe that illness (including cancer, musculoskeletal, and neurological problems) is caused by spirits, or retribution for not adequately helping family members in Samoa. Prayer is an important element of the healing process for many Samoans.



Women's Health: Church-based mobile health prevention programs, including breast and cervical cancer screening programs, have proven effective in increasing cancer screening in Samoa-born women in the U.S. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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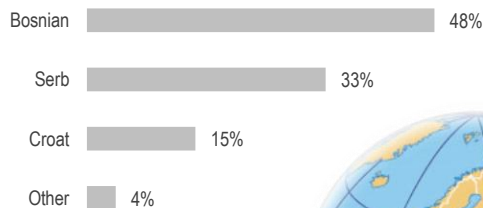
1

What are some quick facts?

Introduction

- The Socialist Federal Republic of Yugoslavia (SFRY) was formed in 1945 and comprised the states of Bosnia-Herzegovina, Croatia, Macedonia, Montenegro, Serbia, and Slovenia.
- Within each state, there coexisted a diversity of ethnic groups as diverse as Serbians, Bosnian Muslims, Romani (Gypsies), Albanians, Hungarians, and Croats. It was not until the late 1960s that the government of the SFRY formerly recognized the Bosnian Muslims as a distinct “nation” with a separate ethnic identity.
- In 1991, Slovenia and Croatia declared their independence from the federation of states, followed by Bosnia-Herzegovina and Macedonia. The subsequent civil war involved atrocities including rape, torture, and murder, as ethnic communities fought each other for the right to self-determination.
- Many recent Serbian Americans have come from Bosnia-Herzegovina and have had horrific experiences. They have suffered expulsion from their homes, imprisonment, torture, rape, and life in concentration camps.

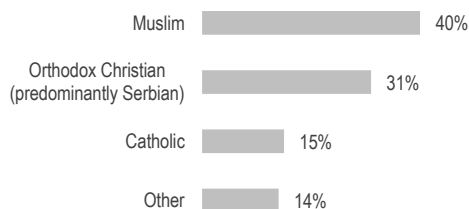
Ethnicity



Language

- The official languages for Bosnia-Herzegovina are Serbian, Bosnian, and Croatian.

Religion and Spirituality



Note: This community profile provides an overview of some of the cultural and health issues that may concern this community. This description may not apply to all members of this community as individual experiences may vary. However, the profile can be used as a pointer to some of the issues that may concern the person and family.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- The level of English proficiency among Serbian Americans varies according to age and education, with the younger people tending to be more proficient.
- It may be difficult to gain rapport with some Serbian Americans because of their recent trauma.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Health Services: Serbians who are sick are encouraged openly discuss their suffering. The relatives give moral and physical support. ■ Some Serbian Americans may have a fear of serious disease approaching a phobia. ■ Many Serbian Americans will want detailed explanations of tests and procedures. It may be hard for a Serbian patient or a member to trust the provider or the interpreter, which may make communication difficult.



Labor and Delivery: In childbirth, it is accepted that women may be expressive of the pain rather than stoical.



Mental Health: Serbians may have witnessed horrific events in some cases torture and rape. ■ Unemployment, in men particularly, may be associated with depressive illness. Alcohol may be used to compensate for feelings of inadequacy. ■ Psychological distress may be expressed as somatic symptoms, particularly gastro-intestinal or respiratory symptoms. ■ Mental health seeking behavior is often limited by language proficiency and lack of knowledge of services. ■ There is a stigma associated with admitting to mental illness. ■ There may be the view that medication is the only treatment. Psychotherapy, group therapy or occupational therapy may be rejected. ■ Often members of the older generation are non-English speaking and experience frustration and isolation.



Pharmacy: Treatment is often not considered complete without medication.



Social Services: Serbian-American parents of a disabled child may feel shame and isolate themselves from the rest of the community, thus not taking advantage of social services available.



Women's Health: In women, musculoskeletal problems are more common than in the Anglo-American population.

Adapted from: [Queensland Health Community Profiles](#) and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



Medical Records: You can elicit information about the person's beliefs and preferences to assist in the development of individualized, comprehensive plan of care. Certain questions can help you establish a relationship and exchange important information with the family. Questions to ask include: ① What brings you here today? ② What do you call your illness, problem? ③ What do you think has caused the illness, problem? ④ What have doctors, nurses, other caregivers done so far? What have you or other family members done so far? ⑤ How has the illness affected your life? ⑥ How has it affected you and your family? ⑦ What worries you most about the illness and its treatment? ⑧ What would you like to have happen today? ➔ *Document the answers in the patient's records.*

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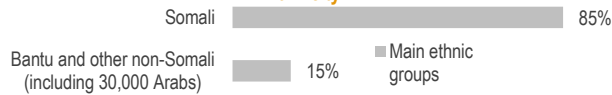
1

What are some quick facts?

Introduction

- Colonial rule began in the mid-1800s and divided the land inhabited by ethnic Somalis into several territories.
- In 1960 British Somaliland and Italian Somaliland peacefully obtained independence and were united to form the current borders of Somalia. The inland region of the Ogaden, controlled by the British after World War II, was designated as part of Ethiopia in a United Nations mediated agreement in 1948. This has been a source of heated contention between the Somali and Ethiopian governments ever since.
- In 1964 and again in 1977, military conflict arose between the Somali and Ethiopia over control of the Ogaden, resulting in many lost lives on both sides. The land is currently controlled by Ethiopia, though many Somalis believe the region should be reunited with Somalia.
- Places of transition include Ethiopia, Kenya, Djibouti, Yemen, and Burundi.

Ethnicity



- [Somali Bantus](#) were brought as slaves from Tanzania and Mozambique to Somalia in the 18th and 19th centuries. They were marginalized in Somalia. During the 1991 civil war in Somalia, 12,000 Bantu were displaced to Kenya.

Language

- Somali and Arabic are the official languages (according to Transitional Federal Charter), and Italian and English are spoken.

Religion and Spirituality

- Nearly all Somali are Sunni Muslims. A small number are Christians.



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- Somali American children and elders share mutual respect. When addressing another family member or friend, words for “aunt,” “uncle,” “brother,” “sister,” and “cousin” are used depending on the person’s age relative to the speaker.
- When addressing Somali culture, it is considered disrespectful to refer to “clans” or “tribes.” It is a very sensitive issue that is best avoided when in the U.S. and some in the community will deny their existence. Tribes were names originally given in order to place families and locate people, but now they reinforce prejudices produced by the civil war.
- A person can give someone else an *evil eye* either purposefully or inadvertently by directing comments of praise at that person, so causing harm or illness to befall them. For example, one does not tell someone else that they look beautiful, because that could bring on the *evil eye*.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Somali traditional doctors are responsible for helping to cure illnesses caused by spirits. The illness is cured by a healing ceremony designed to appease the spirits. These ceremonies involve reading the Koran, eating special foods, and burning incense. ■ Somali traditional medicine includes fire-burning, herbal remedies, casting, and prayer. Fire-burning is a procedure where a stick from a special tree is heated till it glows and then applied to the skin in order to cure the illness.

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Health Services: Somali Americans feel it is important to tell the immediate family first if there is a poor prognosis so they can be prepared in order to work together and comfort the patient or the member. They may also seek to protect the patient or the member, so as not to scare them with a poor prognosis and cause them to lose hope and die, as a result. Some Somali Americans believe supernatural causes such as the *evil eye* cause illness but may not share this with providers. Religious leaders are contacted when a serious illness is diagnosed. ■ Generally the right hand is considered the clean and polite hand to use for daily tasks such as eating, writing, and greeting people.



Inpatient: There is much discussion about the acceptability of life support in Somali culture and religion. While Somalis appreciate every effort to preserve life, there is controversy regarding at what point life support may interfere with God’s will and extend life artificially. Yet, some Somalis don’t feel they can make the decision to remove life support because that too would be interfering with God’s will. As a result, Somalis may have complicated spiritual issues surrounding life support.



Labor and Delivery: Newborn care includes warm water baths, sesame oil massages, and passive stretching of the baby’s limbs. An herb called *malmal* is applied to the umbilicus for the first 7 days of life (*malmal* is available in the U.S. in some Asian markets). ■ When a child is born, the new mother and baby stay indoors at home for 40 days, a time period known as *afatanbah*.



Pediatrician: Somali American mothers cringe when providers tell them that their babies are big and fat, out of fear the *evil eye* will cause something bad to happen to their child. ■ Somalis practice circumcision for both males and females. It is viewed as a rite of passage, allowing a person to become a fully accepted adult member of the community. ■ [Female genital mutilation \(FGM\)](#) is an important yet sensitive issue for Somali Americans and healthcare providers need to strive to keep the lines of communication open in order to best serve the needs of their patients.



Registration: Somali names have three parts. The first name is the given name, and is specific to an individual. The second name is the name of the child’s father, and the third name is the name of the child’s paternal grandfather. Thus siblings, both male and female, will share the same second and third names. Women, when they marry, do not change their names. ■ Somali Americans may prefer same-gender medical staff when available, and appreciate it when providers provide information in detail about medications and procedures.



Spirituality: Important religious holidays include Ramadan, Id al-Fitr, Id Arafa, and Moulid. Ramadan is the 9th month of the lunar calendar. During the 30 days of the holiday, people pray, [fast](#) and refrain from drinking during the day and eat only at night. An important aspect of this holiday for medical providers to be aware of is that medications will often be taken only at nighttime. Pregnant women, people who are very ill, and children (usually interpreted as under 14-years old) are exempted from the fast. Some religious observance of Ramadan extends the fast for an additional 7 days.

Adapted from: [Ethnomed](#) and [The World Factbook: CIA](#)

4

How can I ensure optimal care?

Discussion Questions



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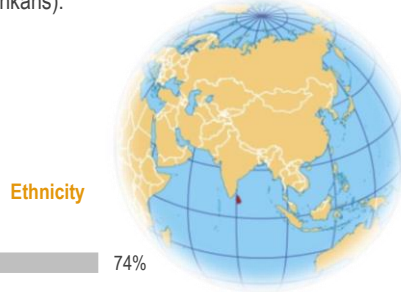
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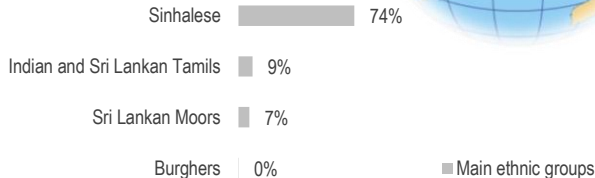
What are some quick facts?

Introduction

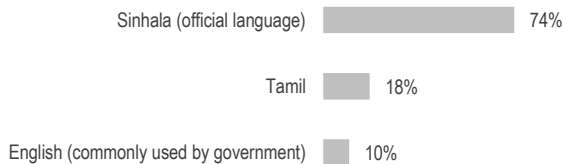
- Sri Lanka (formerly known as Ceylon when under British rule) gained independence in 1948. As a result of the political ascendancy of the Sinhalese, the dominant ethnic group, many members of minority groups, including Tamils and Burghers (people of Sri Lankan and European descent), felt threatened, resulting in increasing numbers migrating to other countries.
- In 1983, civil war broke out between the majority Sinhalese and minority Tamils. The war continued for 26 years until 2009. Sri Lankan Tamils increasingly settled in U.S. as refugees or skilled migrants. Sinhalese Sri Lankans continued to migrate to the U.S., along with Sri Lankan Moors (also known as Muslim Sri Lankans).



Ethnicity



Language



Religion and Spirituality

- Sinhalese: The majority of Sinhalese are Buddhists.
- Tamil: Most Tamils are Hindus, but some are Muslims or Christians. The majority of Christians are Catholics.
- Sri Lankan Moors: The majority are Muslim.
- Burghers: The majority are Christians.

2

What is their communication style?

Communication Patterns and Value Orientation Sample

- When addressing a person from Sri Lanka, particularly the elderly, it is important to use the appropriate title (e.g. Mr., Mrs.) followed by their family name.
- Younger Sri Lankan Americans generally shake hands and are socialized towards soft rather than firm handshakes. A firm handshake may surprise a newly arrived Sri Lankan American.
- Sri Lankan Americans usually avoid eye contact in interactions where they feel deference or respect.

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- Although many South Asians nod their heads to indicate yes and shake their heads to indicate no, this is not always true. A horizontal head swing can mean yes for some Sri Lankan Americans.
- The following communication issues are particularly important for Sri Lankan Buddhists: it is disrespectful for legs to be stretched out with feet pointed towards a person, the head is considered the spiritually highest part of the body and sensitivity is advised if it is necessary to touch the head, and using both hands to give and receive an object is a sign of respect, particularly with older people.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Many Sri Lankan Americans value and use Western medicine in conjunction with traditional remedies, including traditional medicines and spiritual practices such as *Ayurveda* and *Sinhala*. *Ayurveda* places emphasis on herbal medicines, aromatherapy, nutrition, massage and meditation to create a balance between the mind and body.



Health Services: The involvement of family in major and minor medical decisions is crucial for many Sri Lankans. Disclosing a serious or terminal diagnosis is best undertaken with the consultation and help of family members. It may be appropriate to ask a patient or a member his or her wishes about confidentiality and privacy before discussing any sensitive issues. ■ A Sri Lankan cultural practice that may influence healthcare is the designation of left and right hands for specific tasks. The right hand is typically used for sanitary tasks such as eating, while the left hand is reserved for unsanitary tasks. This may affect a patient's comfort with the use of one arm or the other for drawing blood or for the insertion of an IV.



Mental Health: Mental illness has strong negative connotations and stigma. Shame and denial may be the normal response to any suggestion of mental illness.



Registration: Sri Lankan Americans have various naming conventions dependent on their ethnic group. In most cases, the family name comes first, and given name second.

Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

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Discussion Questions



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1

What are some quick facts?

Introduction

- Sudan's first civil war began shortly after independence from joint British-Egyptian administration in 1956 and continued until 1972. A second civil war broke out in 1983 and continued until 2005.
- Sudan experienced major famines largely as a result of extended periods of drought in the 1980s and 1990s.
- The toll from war and famine is estimated at almost two million deaths and four million displaced people.
- Drought, famine, and war have caused large numbers of Sudanese refugees to seek refuge in neighboring countries.
- Most Sudanese refugees arrive from Egypt, Kenya, Ethiopia, and Uganda. Other places of transition include: Eritrea, Lebanon, Malta, Sweden, and Syria.



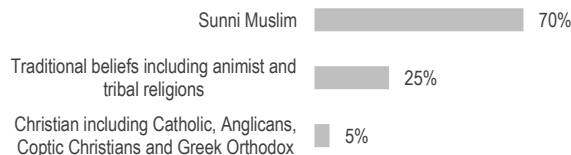
Ethnicity

- Although Sudan is a country of considerable ethnic diversity, the Sudanese are often characterized into two major groups: Arabs (in the north) comprising 39 percent of the population and black Africans (in the south) comprising 52 percent of the population. However, there are hundreds of ethnic and tribal divisions within the two major groups.
- Arab groups include the Kababish, Ja'alin and Baggara and African groups include the Dinka, Nuer, Shilluk, Azande (Zande), Madi, Acholi and Bari. The Beja (a semi-nomadic group distinct from both Arabs and Africans) make up 6 percent of the population.
- The concept of ethnicity in Sudan is complex, and it is often based on cultural affiliations. Sudanese also identify by region such as Nuba and Equatorian, and these groups are comprised of many different ethnicities and languages.

Language

- Arabic is Sudan's official language and is the most widely spoken. English is the language of instruction for schools of South Sudan. A Sudanese Government policy in 1990 forced South Sudanese schools to use Arabic rather than English.
- Many other languages are spoken in the south including varieties of Dinka, Fur, Nuer, Ma'di, Acholi, Bari, and Zanda. Many Sudanese are bilingual or multilingual. Sudanese refugees may have a preference for using their own language rather than Arabic, which was forced on them.

Religion and Spirituality



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- There are distinctions in communication style between North Sudanese Muslims and South Sudanese people:
 - Northern Sudanese greetings tend to be formal with a handshake only extended to members of the same sex. There may be a reluctance of Muslim men and women to shake hands with the opposite sex and prior to interaction with a woman, it is advisable that acknowledgement be afforded to the man as the head of the household.
 - Typically, South Sudanese greetings are less formal. People greet friends and relatives with handshakes and men and women shake hands. Women can be addressed directly.
- The right hand is used for greeting and eating and all other activities. The left hand is generally only used for bodily hygiene.
- People are called by their first name, except for elders, teachers and religious leaders who are addressed by their title and surname.

3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: Many Sudanese refugees practice herbal and traditional health remedies. These practices are often limited by a lack of availability of herbs and a lack of specialists to prepare them.



Family Practice: Polygamy is common across Sudan and is considered a sign of wealth and prestige. The practice is decreasing in South Sudan.



Health Services: Sudanese refugees may be unfamiliar with a formal health system, U.S. medical practices, or being treated by a doctor of the opposite gender.



Language Services: There are many different names for languages spoken in South Sudan and speakers of a particular language may not recognize the English name for the language they speak.

- It is advisable when contracting the services of an Arabic interpreter for a Sudanese person that a Sudanese-Arabic interpreter is requested. The Sudanese Arabic dialect is distinct and the person may not understand an interpreter using another Arabic dialect.



Registration: Members of the same family may appear to have different surnames in the U.S. as a result of confusion in the transfer of names during immigration. In Sudan, family names are silent and considered other names, and as a result many Sudanese Americans will have their middle name recorded as their surname on official documents.



Social Services: Sudanese refugees settling in the West have been shown to have high rates of depression, anxiety, and post-traumatic stress disorder. However, many Sudanese are more concerned with current acculturative stressors such as family problems, employment issues, housing and transport than they are about past trauma.



Women's Health: [Female genital mutilation \(FGM\)](#) is practiced in Sudan, particularly in the north. Complications of FGM may include: incontinence, obstructed miscarriage and childbirth, vaginal and perineal damage at childbirth and sexual difficulties including non-consummation and painful intercourse. Some families may want their daughters to undergo FGM, even if this means undertaking the operation outside the country. Adapted from: [Queensland Health Community Profiles for Healthcare Providers; Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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- 5 How has the illness affected your life?
- 6 How has it affected you and your family?
- 7 What worries you most about the illness and its treatment?
- 8 What would you like to have happen today?

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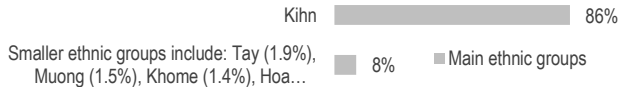
1

What are some quick facts?

Introduction

- Large numbers of Vietnamese people fled their country during the Vietnam War after Saigon fell to the Communist Government in the north in 1975, and the Socialist Republic of Vietnam was declared in 1976.
- From 1975 to 1985, an estimated two million people fled Vietnam. People initially fled by sea to refugee camps in South East Asia before seeking refuge in countries including the U.S., Canada, France and Australia.
- Places of transition include Thailand, Malaysia, Singapore, Indonesia, the Philippines, Hong Kong, and Cambodia.

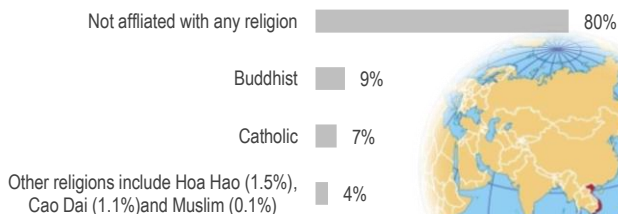
Ethnicity



Language

- Vietnamese is the official language and is spoken by the majority of the population. English is becoming increasingly favored as a second language. Other languages include French, Chinese (usually Cantonese), Khmer, and the mountain languages of Mon-Khmer and Malayo-Polynesian.

Religion and Spirituality (1999 Census)



2

What is their communication style?

Communication Patterns and Value Orientation Sample

- In addressing others, Vietnam-born people often use a person's title (e.g. Mr., Mrs.), followed by their first name.
- Some Vietnamese Americans may appear to answer *yes (da)* to all questions. This may be a polite way of saying "Yes, I am listening," or "Yes, I am confused."
- Vietnamese people can use a smile to show many different emotions including happiness, anger, embarrassment or grief.
- Vietnamese Americans may prefer to speak about sensitive subjects indirectly.
- Traditionally, Vietnamese people greet each other by joining hands and bowing slightly. The handshake has been adopted in Vietnamese cities. In public, men often hold hands as an expression of friendship. In Vietnam, women rarely shake hands with each other or with men.
- Outside of Vietnamese cities, making direct eye contact when talking is considered impolite particularly with people senior in age or status.

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3

What are some health beliefs and practices?

General Health Beliefs and Practices Sample



Alternative/Complementary: [Traditional medicine](#), which incorporates traditional Chinese and Vietnamese medicine, is important in Vietnamese culture. Emphasis is placed on the balance of yin and yang and *hot* and *cold*, and a proper balance is required to maintain health. Vietnamese Americans may use traditional remedies, including medicines, in conjunction with U.S. medical treatments. It is common to use two types of medicine to treat a disease in Vietnam, and some Vietnamese Americans may consider prescribed and traditional medicines to be compatible. Many Vietnamese may be reluctant to inform their doctors about their use of traditional medicines because of fear of disapproval. Two common treatment methods of *wind illnesses* are *coining* and *cupping*: *cupping* uses round glass cups which contain a lit taper and are pressed into the skin and, coining involves rubbing medicated oils onto the chest and back in parallel lines in order to release *poisonous wind*.



Health Services: Traditional beliefs regarding shame and guilt are important in understanding how older Vietnamese adults report symptoms. Since Vietnamese culture is oriented towards the family and the group, the individual is thought to represent the family as a whole. If an individual loses respect or status in the community, the whole family loses respect and status as well. The concept of loss of face may be why some older Vietnam-born adults and their families are reluctant to report distressing symptoms. Illness may be considered a result of environmental influences such as wind and spirits that can offset the internal balance of a person. For example, a Vietnam-born person may refer to a cold or flu as being exposed to *poisonous wind* or *catching the wind* instead of catching a cold. To prevent stress for older adults, some Vietnamese American families may prefer that the diagnosis of a serious or terminal illness is not disclosed directly to the older family member. There is considerable variation in beliefs among the Vietnamese, including between earlier migrants and those who migrated more recently. Providers should acknowledge these variations and seek the preferences of patients or of members, and their families.



Mental Health: Mental illness is generally considered shameful and is often associated with wrong-doing in a previous life. It is often not discussed in the family or the community. Somatization is a common response to problems of psychogenic origin. For example, a Vietnamese American male is more likely to explain psychological difficulties as physical symptoms such as abdominal pains or headaches.



Nutrition: Illness is believed to result from an imbalance of Yang (male, positive energy, *hot*) and Yin (female, negative energy, *cold*) forces in the body. Self-control of emotions, thoughts, behavior, diet and [food](#) and medication intake are all important in maintaining balance and health. For example, excess eating or worrying can lead to an imbalance or excess of heat, thus resulting in mental and physical illness. For example, an excess of *cold* food is believed to be related to coughing and diarrhea.



Registration: Many Vietnamese Americans women prefer a female practitioner, particularly for procedures such as breast and cervical cancer screening. Adapted from: [Queensland Health Community Profiles for Healthcare Providers: Dr. Samantha Abbato](#)

4

How can I ensure optimal care?

Discussion Questions



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1

Who needs language services?

Patients or members and their family members who are limited English proficient (LEP) and those who use American Sign Language (ASL) need this important service.



LEP

- a legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter
- a person with the inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with healthcare providers or social service agencies.

2

How many people do not speak English well?

From 2011 – 2013, an estimated 2,599,481 Utahns spoke languages other than English at home, and 1,481,887 Idahoans spoke languages other than English at home.

Top Five Languages “Speak English Less Than Very Well” in Utah, 2011-2013

Language	Speakers	Speak English Less Than Very Well
1. Spanish or Spanish Creole	256,563	97,823
2. Chinese	11,559	5,197
3. Vietnamese	6,403	3,653
4. Tongan, Samoan, and Other Pacific Island languages	13,978	3,096
5. Korean	4,764	1,971

Source: [U.S. Census Bureau, American Community Survey](#)

3

When does a person need an interpreter?

Signs a Patient or a Member and Their Family Need an Interpreter

- Difficult verbal exchanges in English
- Patient or a member and/or family are using hand gestures and/or signs to communicate
- A family member or friend speaks for the patient or the member
- A family member or friend is used as an interpreter to make an appointment over the phone
- Patients, members, or family member requests an interpreter

4

What is important to know about choosing an interpreter?

To help people live the healthiest lives possible, the use of *trained* healthcare interpreters results in more accurate diagnoses and better patient compliance; thus the use of untrained interpreters (unqualified bilingual staff, friends, or family) is highly discouraged.

And while *free* interpreting is provided to people, do not decide on the kind of interpreting to provide based on any actual costs of the service alone. Do choose the best method of interpreting based on

the particular needs of the provider and patient for each healthcare encounter (see table provided). Speak directly to the provider and patient if you are not sure on the best method of interpretation for their specific healthcare encounter. See [Language Services](#) to learn more.

Methods of Interpretation



Onsite: Preferred method for conversations that are sensitive or complex in nature or are clinically significant (e.g., obtaining informed consent, end of life conversations, care planning and conferences, complicated discharge instructions, etc.), and for patients that require additional communication assistance on top of a language barrier (e.g., deaf, hard of hearing, sight impaired, patients who are recovering from brain injury, or who have any temporal or permanent impairment in their ability to understand or process information).



Video Remote Interpretation (VRI): An effective communication aid for short conversations, such as follow-up or routine care (assessing pain level, bedside report, etc.), to avoid delay in care in emergency situations (e.g., triage in the Emergency Department, patient needs that require immediate attention and can't wait until an on-site interpreter becomes available), and whenever on-site interpretation is not an option or is not available.



Phone: Simple conversations that do not require face-to-face interaction (e.g., pre-registration, scheduling). It's a reasonable accommodation for instances when on-site interpretation and/or video remote interpretation are not available. Telephonic interpreters in over 200 languages are available 24/7.

6

How can I partner with language services?

Essential Steps to Partnering with Healthcare Interpreters

- Recognize the value of qualified interpreters** The use of trained healthcare interpreters results in more accurate diagnoses and better patient compliance.
- Never use minors as interpreters** If bilingual hospital staff will be interpreting, they should be trained as Qualified Bilingual Employees (QBEs) just like other healthcare interpreters. If needed, use male interpreters for male patients or male members, and female interpreters for female patients or female members.
- Take time to prepare a short meeting with the interpreter** It is useful to have a short preconference with the interpreter before seeing a patient or a member to clarify the goals of the appointment and what will occur.
- Speak directly to the patient or the member** Even though an interpreter is in the room, on screen or on the phone, speak directly to the patient or the member, not the interpreter.
- Use short, simple sentences** Speaking in short sentences allows for complete and accurate interpretation. You should avoid using complicated medical terminology. Although trained healthcare interpreters can interpret that information, technical jargon can be confusing.

Learn from other sources:

[BRYCS \(Bridging Refugee Youth & Children's Services\)](#) offers information for empowering immigrant children and their families

[Intermountain.net](#) see [Patient Rights and Responsibilities](#), [Language Services](#), [Communications Assistance Policy](#)

[Think Cultural Health](#) offers free E-learning courses

[COR Refugee Backgrounders: Cultural Orientation Resource Center](#) provides key information about various refugee populations

[AAFP Quality Care for Diverse Populations](#) has seven 3 to 8-minute videos showing clinicians thoughtfully communicating

1

What does LGBT mean?



LGBT

LGBT stands for “lesbian, gay, bisexual, and transgender” and is a term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation (also, “LGBT community”). Sometimes the acronym is depicted as “LGBTQ” to include those who may be questioning their sexual orientation or gender identity. There is no right or wrong way to order the letters (for example, GLBT or GLBTQ), and some people and organizations add additional letters, “Q” for queer and/or questioning, including “I” for intersex, and “A” for non-LGBTQ allies (for example, LGBTQQIA).

queer

In modern usage, queer refers to an inclusive unifying sociopolitical, self-affirming umbrella term for people who are gay, lesbian, bisexual, pansexual, transgender, transsexual, intersexual, gender queer, or any other non-heterosexual sexuality, sexual anatomy, gender identity. This was historically a term of derision for LGBT people. Queer has been reclaimed by many (although not all) in the LGBT community.

two spirit

A current term that references historical multiple-gender traditions in many First Nations cultures. Many Native/ First Nations people who are lesbian, gay, bisexual, transgender, intersex, or gender nonconforming identify as Two-Spirit; in many Nations, being Two-Spirit carries both great respect and additional commitments and responsibilities to one’s community.

questioning

A person, often an adolescent, who has questions about his or her sexual orientation or gender identity. Some individuals eventually come out as LGBT, while others do not.

2

Is there a large LGBT community in Utah?

One report analyzes data from a Gallup ranking of the 50 most populous U.S. metropolitan areas, based on their percentage of residents who identified as LGBT in surveys conducted from 2012 to 2014 and 1990. Census data ranks the same metro areas by the number of same-sex couples per 1,000 households. Salt Lake City ranked 39th in the 1990 rankings and 7th in the 2012-2014 data.

Top 10 U.S. Cities

Rankings of large metropolitan statistical areas by same-sex couples per 1,000 households (1990 US Census) and percent of LGBT (2012-2014 Gallup Daily tracking survey).

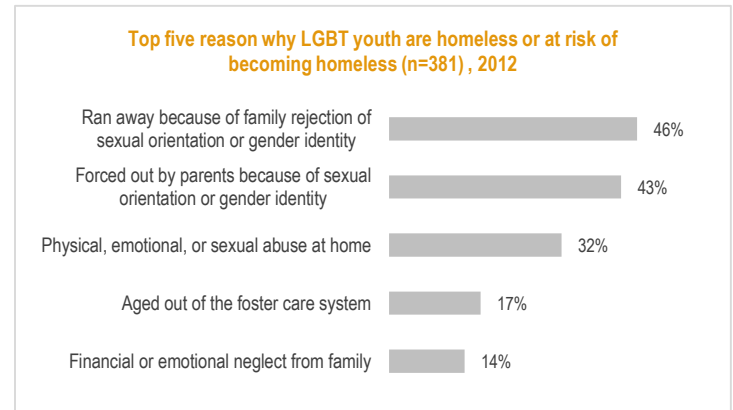
	Rank by same-sex couples per 1,000 households (1990 US Census)	Ranked by percent of LGBT (2012-2014 Gallup Daily tracking)
Salt Lake City	39	7
New Orleans	25	4
Harford	23	10
Portland (OR)	11	2
Boston	10	6
Denver	13	9
San Francisco	1	1
Austin	2	3
Seattle	3	5
Los Angeles	6	8

Source: [Comparing LGBT Rankings by Metro Area: 1990 to 2014: The Williams Institute](#) (P.1)

3

What is a fact about LGBT youth?

Over the past ten years, the percentage of providers serving LGBT homeless youth has increased from 82 percent to 94 percent. Nearly seven in ten (68 percent) respondents indicated that family rejection was a major factor contributing to LGBT youth homelessness, making it the most cited factor. More than half (54 percent) of respondents indicated that abuse in their family was another important factor contributing to LGBT homelessness. Additionally, more than 75 percent of responding agencies worked with transgender youth in the past year.

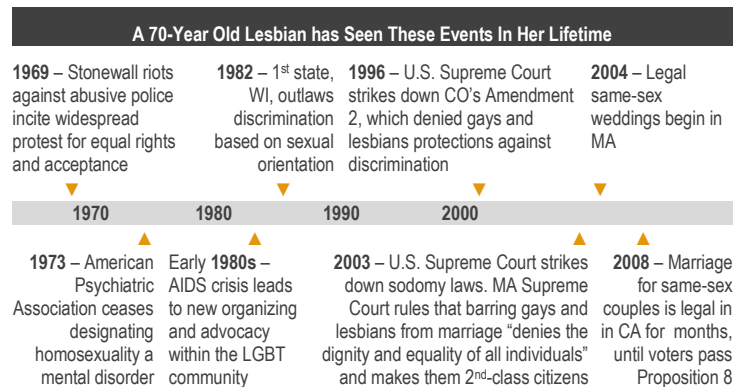


Source: [Ninety-four percent of Homeless Youth Service Providers Report Serving LGBT Youth: The Williams Institute](#) (P.4)

3

What is a fact about older LGBT adults?

Social isolation affects many LGBT older people around the country as they deal with stigma and discrimination in their daily lives (see the timeline provided) and in our country's aging system. The primary risk factors for social isolation affect LGBT older adults in unique and disproportionate ways. For example, one primary risk factor is living alone. LGBT older people are twice as likely to live alone, twice as likely to be single, and three to four times less likely to have children – and many are estranged from their biological families



Adapted from: [Services & Advocacy for LGBT Elders](#); [InfoPlease.com](#); [Map analysis](#)

Learn from other sources:

[It Gets Better Project](#) includes videos in response to the suicide of teenagers who were bullied

[Utah Pride Center](#) provides services, events, and activities to LGBT people

[Intermountain.net](#) see [Patient Rights and Responsibilities](#), [Visitation Hospital Policy](#), and [Spirituality and Diversity](#)

[National LGBT Health Education Center](#) provides video, free webinars, publications and suggested readings

To make this information stick: Share what you learned here, including your insights, at work today or later this week.

1

Why is LGBT health important?

Introduction

- Reaching out to the LGBT community not only contributes to better patient and better member care, it makes good business sense. Studies of LGBT purchasing decisions have demonstrated that the majority of gay and lesbian adults will choose brands that have a reputation for being friendly to LGBT individuals. This is an important consideration as healthcare consumers have more access to information through the Internet and social media, and as healthcare reform efforts increase availability and choice.
- Like many other populations identified as at-risk or disadvantaged, research has demonstrated that LGBT individuals experience disparities not only in the prevalence of certain physical and mental health concerns, but also in care due to a variety of factors, including experiences of stigma, lack of awareness, and insensitivity to their unique needs.
- These disparities include the following: Less access to insurance and healthcare services, including preventive care (such as cancer screenings).
 - Lower overall health status.
 - Higher rates of smoking, alcohol, and substance abuse.
 - Higher risk for mental health illnesses, such as anxiety and depression.
 - Higher rates of sexually transmitted diseases, including HIV infection increased incidence of some cancers.



family

Two or more persons who are related in any way – biologically, legally, or emotionally. Patients and families define their families.

surrogate healthcare agent/surrogate decision-maker

Someone appointed to make decisions on behalf of another. A surrogate decision-maker makes decisions when an individual is without decision-making capacity, or when an individual has given permission to the surrogate representative to make decisions. Such an individual is sometimes referred to as a legally responsible representative. – The Joint Commission

2

How can I best communicate?

Effective Communication and Value Orientation Sample

- Use neutral and inclusive language in interviews and when talking with all patients or all members. Interactions with patients or with members that are sensitive and nonjudgmental will pave the way for more effective patient-provider communication and can make people more comfortable with disclosing information relevant to their care. How a question is phrased can communicate acceptance and consideration for a range of partner or family relationships. Be aware of language or questions that assume heterosexuality, such as “*Are you married?*” or references to husbands or wives. When asking about family relationships, ask “*Who are the important people in your life?*” or “*Who is family to you?*”
- Listen to and reflect patients’ or reflect member’s choice of language when describing their own sexual orientation and how the patient or the member refers to their relationship or partner. Notice the language LGBT patients or LGBT members use to describe sexual orientation, gender identity, partner(s), and relationships and reflect the choice of terminology when appropriate. Never assign a label to a person’s sexual orientation by inference.
- Facilitate disclosure of sexual orientation and gender identity but be aware that this disclosure or “coming out” is an individual process. As providers make it as easy as possible for patients or for members who choose to self-identify, but need to remember that this decision is up to the individual person.
- Avoid assumptions about sexual orientation and gender identity. Remember that any patient or any member can be LGBT, regardless of appearance, behavior, age, self-identification, socioeconomic status, religion, race, ethnicity, ability/disability, or culture.
- Be prepared with information, guidance, screenings, and referrals for the conditions that affect the group as a whole and those that disproportionately affect each subpopulation.

3

How can I ensure optimal care?



Administration: Prominently post the nondiscrimination policy or patient bill of rights in registration, waiting, or high traffic areas.

- Ensure the [visitation policy](#) is implemented in a fair and nondiscriminatory manner.
- Foster an environment that supports and nurtures all patients or all members, and families. A welcoming environment is one in which all patients or all member, and families feel comfortable expressing love and support for one another. The healthcare encounter can be a time of considerable stress, fear, and anxiety. Be aware that visible discomfort on the part of staff or other patients or other members in the presence of displays of affection or support can exacerbate an already difficult situation for LGBT families. Determine mechanisms for handling patient-to-patient discrimination while preserving the dignity of all involved.
- Identify opportunities to collect LGBT relevant data and information during the healthcare encounter.
- Collect feedback from LGBT patients or LGBT members, and families and the surrounding LGBT community: engage LGBT patients or engage LGBT members, and families and the surrounding LGBT community in discussions regarding available services and programs to determine whether these existing services meet LGBT needs.
- Support forums for employees to freely and openly discuss any LGBT related questions or concerns in a group setting to encourage learning.



Health Education: Provide information and guidance for the specific health concerns facing lesbian and bisexual women, gay and bisexual men, and transgender people. Although LGBT individuals may share some of the negative health consequences associated with the experience of being stigmatized and/or reluctance to seek medical care, each subpopulation has unique health concerns.

- Incorporate LGBT patient care information in new or existing employee training.



Mental Health: Understand many LGBT youth live with bullying as a part of their daily lives at school. Bullying puts their mental health and education at risk, not to mention their physical well-being. Gay, lesbian, and bisexual youth are up to four times more likely to attempt suicide than their heterosexual counterparts.



Registration: Facilitate disclosure of sexual orientation and gender identity but be aware that this disclosure or “coming out” is an individual process. Hospitals and providers should make it as easy as possible for patients or for members who choose to self-identify, but need to remember that this decision is up to the individual patient or the individual member.



Waiting Area: Waiting rooms and other common areas should reflect and be inclusive of LGBT patients or of LGBT members and families.

- Brochures and other available reading material should include topics relevant to LGBT patients and LGBT members as well as general brochures. LGBT– relevant magazines, posters, and information about local LGBT resources should be available. LGBT resources should be available. Décor and images depicting couples and families should include same-sex partners, same-sex parents, and LGBT families.
- Create or designate unisex or single stall restrooms. Patients or members whose appearance might not conform to gender stereotypes may feel more comfortable and safe in a single-stall or unisex restroom. Design or clearly identify at least one such restroom. These single-stall or family restrooms can also serve parents caring for opposite-sex children, disabled people accompanied by opposite-sex caregivers, and any other patients or any other members wishing to use them. Note: Although making a unisex restroom available is an important signal of acceptance, patients or members should be permitted to use restrooms that comport with their gender identity and should not be required to use the unisex restroom.

Adapted from: [Advancing Effective Communication, Cultural Competence, and Patient-and-Family-Centered Care for the LGBT Community: The Joint Commission](#)

➔ Learn from other sources:

[It Gets Better Project](#) includes videos in response to the suicide of teenagers who were bullied

[National LGBT Health Education Center](#) provides video, free webinars, publications and suggested readings

[Utah Pride Center](#) provides services, events, and activities to LGBT people

[Intermountain.net](#) see [Patient Rights and Responsibilities](#), [Visitation Hospital Policy](#), and [Spirituality and Diversity](#)

1

What is transgender?

Introduction

- A transgender person is someone who feels strongly that their gender is not the same as the sex they were assigned at birth. Transgender people feel and express their gender in many different ways. Many transgender people feel they were born as the wrong gender; for example, people born with the outward manifestations of a female who feel very strongly that they are a male. Some transgender people feel they are both female and male, or neither male nor female, but somewhere along the spectrum of male and female. These feelings begin very early in life for many and later for others.



transgender

People whose gender identity or gender expression differ from their birth sex or prevailing ideas of masculinity and femininity are often called transgender. Although transgender is an umbrella term that includes people who cross-dress and people who otherwise express themselves in unconventional ways for their birth sex, it is often used to refer to transsexuals – people who live as a sex not associated with their birth sex, after a process known as transitioning. While some transsexuals describe themselves as “trans,” others simply say they are male or female, depending on the sex to which they have transitioned.

transition

The period of time when a transgender or transsexual person is learning how to cross-live socially as a member of the sex category different from the individual's birth-assigned sex, or is engaged in early hormone use. Some people use this term to describe their medical condition with regard to their gender until they have completed the medical procedures that are relevant for them.

transsexual

A medical term applied to individuals who seek hormonal and (often, but not always) surgical treatment to modify their bodies so they may live full time as members of the sex category different from their birth assigned sex (including legal status). Some individuals who have completed their medical transition prefer not to use this term as a self-referent. Avoid using this term as a noun: A person is not “a transsexual”; the individual may be a transsexual person.

transman

This usually means that the person was assigned female at birth but identifies as a man (sometimes referred to as female-to-male or FTM).

transwoman

This usually means that the person was assigned male at birth but identifies as a woman (sometimes referred to as male-to-female or MTF).

Note: Do not use terms considered offensive: she-male, he-she, it, tranny, “real” woman or “real” man

- Most transgender people will dress and behave in a way that matches their inner sense of gender. For example, people born male who feel their true gender is female may grow their hair long and start wearing dresses and makeup. A person who feels they are neither male nor female may dress and do their hair in a way that is not traditionally male or female. Transgender people often change their name to match the gender they feel. They often want people to call them by the pronouns that feel right to them (e.g. he/him, or she/her). Some, but not all, change their bodies to more closely resemble how they think of themselves by getting medical (hormone) and surgical treatments. As is true for all people, it is very important for transgender people's mental health and well-being to be able to live the way they feel about their gender, and to be accepted.

Learn from other sources:

[It Gets Better Project](#) includes videos in response to the suicide of teenagers who were bullied

[Utah Pride Center](#) provides services, events, and activities to LGBT people

[National LGBT Health Education Center](#) provides video, free webinars, publications and suggested readings

[WPATH \(World Professional Association for Transgender Health\)](#) offers a standards of care publication

Differentiating Sexual Orientation and Gender Identity

Sexual Orientation: Is about how people identify their physical and emotional attraction to others. It is not related to gender identity. Transgender people can be any sexual orientation (gay, lesbian, bisexual, heterosexual /straight, no label at all or some other self-described label).



Gender Identity: A person's internal sense of being a man, woman, or other gender for example, transgender or gender queer

Birth Sex: The sex (male or female) assigned a child at birth, based on a child's genitalia.

Gender Expression: The way a person acts, dresses, speaks, and behaves in order to show their gender as feminine, masculine, or other gender (for example, transgender or gender queer).

2

How can I best communicate?

Effective Communication and Value Orientation Sample

- See the applicable information from the previous page for LGBT patients.
- Show respect by being relaxed and courteous, avoid negative facial reactions. Speak to transgender people as you would any other person.
- Refer to transgender persons by the name and pronoun that corresponds with their gender identity. Use “she” for transgender women and “he” for transgender men, even if you are not in the patient's presence.
- Ask politely, “How would you like to be addressed?” “What name would you like to be called?” “Which pronoun is appropriate?” if you are unsure about the person's identity.
- Do not ask questions about a person's transgender status if the motivation for the question is only your own curiosity and is unrelated to care, it is inappropriate and can quickly create a discriminatory environment.

3

How can I ensure optimal care?



Administration: See the applicable information from the previous page for LGBT patients.



Health Education: Provide information and guidance for the specific health concerns facing transgender people. See the more information from the previous page for LGBT patients.



Health Services: Keep in mind that the presence of a transgender person in your treatment room is not always a “training opportunity” for other health care providers. However, like in other situations where a patient has a rare or unusual finding, ask a patient's permission before inviting providers or trainee. ■ It is inappropriate to ask transgender patients about their genital status if it is unrelated to their care. ■ Never disclose a person's transgender status to anyone who does not explicitly need the information for care. Just as you would not needlessly disclose a person's HIV status, a person's gender identity is not an item for gossip. If disclosure is relevant to care, use discretion and inform the patient whenever possible. ■ Become knowledgeable about transgender health care issues. Get training, stay up to date on transgender issues, and know where to access resources.



Mental Health: Understand for many transgender individuals, the lack of congruity between their gender identity and their birth sex creates stress and anxiety that can lead to severe depression, suicidal tendencies, antisocial behavior, and/or increased risk for alcohol and drug dependency. ■ Be aware, transitioning is the process that many transgender people undergo to bring their outward gender expression into alignment with their gender identity is a medically necessary treatment strategy that effectively relieves this stress and anxiety.



Registration: Ask politely, “How would you like to be addressed?” “What name would you like to be called?” “Which pronoun is appropriate?” if you are unsure about the person's identity. Once a patient has given a preferred name, use this name in all interaction.



Waiting Area: See applicable information in the previous page for LGBT patients. Adapted from: [Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: The Joint Commission, Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff; the Fenway Institute; the Fenway Institute](#) and 10 Tips for Working with Transgender Individual; Transgender Law Center

1

What are some ideas for staff development?

Intermountain identified six Healing Commitments that, if adopted, should help lead to extraordinary patient or superior member experiences. The commitments are based on local and national research, surrounding patient or member satisfaction.

Department leaders can assess their teams' strengths and weaknesses with regard to these commitments to help employees improve their performance.

Healing Commitments

Each person at Intermountain Healthcare is committed to creating a healing environment in every way we can – with our skills, our attitudes, and our service.

1. I help you feel safe, welcome and at ease.
2. I listen to you with sensitivity and respond to your needs.
3. I treat you with respect and compassion.
4. I keep you informed and involved.
5. I ensure our team works with you.
6. I take responsibility to help solve problems.

Teams can also learn from *reflection* on their experiences with diversity and inclusion. Provided are some ideas:

Inspire Learning

An employee can choose a diversity-related resource such as a film, book, biographic, etc., and give a brief presentation about what they learned to their team. In the presentation planning, the employee can reflect on the following:

- Why did you choose this medium?
 - Who was characterized in it?
 - What kind of person was s/he?
 - How did the person relate to the idea of diversity and inclusion?
 - What problems did the person face?
 - Were the problems solvable? If so how?
 - What was the moral stance if any, of the person?
 - Did you gain some insight and/or sympathy? If so how?
- ⇒ Record the *development activity* in the Talent Management system and consider posting a brief summary of what was learned to the Patient Engagement Community site on Intermountain.net.

For lists of resources refer to the Library of Congress at loc.gov (see the [Books That Shaped America](#)) the American Film Institute at afi.com (see the [100 Most Inspiring Films of All Times](#) or [100 Cheers](#)) and the [Presidential Medal of Freedom](#) at whitehouse.gov.

Facilitate Engagement

- Show respect for all views and perspectives in your diversity planning efforts with your team.
- Start meetings with a team member sharing a story about diversity and inclusion. Remember, these can be the “big stories” or the “small things” you do every day. See a [sample Intermountain story just to the right](#).
- Present diversity related facts/information (e.g., health disparities, policies, etc.) to further assess strengths/opportunities.
- Ask, “*What will we do today to show our commitment, both individually and as a team, to provide Extraordinary Care and/or Superior Service to our diverse patients or our diverse members and customers?*”
- Discuss the impact/progress the team has made to diversity and inclusion at Intermountain and thank people for their contributions.

Intermountain Stories, March 1, 2010

The pain of a teenage trauma shows the importance of cultural competence – and Intermountain Medical Center's new Diversity Council is here to increase our ability to deliver it - By David Grauer, Administrator

Here's one reason why we've established a Diversity Council at Intermountain Medical Center: When I was 17, I worked as a valet parking attendant at Henry Ford Hospital in Detroit, and one of the things I did was monitor a parking lot we reserved for community leaders and VIPs. One day a guy pulled into the lot without a pass, and when he got out of his car, I told him, “You can't park here – these spots are reserved for very important people.” As soon as those words left my mouth I knew I'd said something incredibly insensitive and thoughtless (stupid too!) – and the man politely taught me a lesson I've remembered ever since. He said, “Well, ain't nobody more important than me.” He was right, of course, and 25 years later, his words are still very vivid in my memory. The lesson he taught me: Every individual deserves to be treated with respect, dignity, and sensitivity. Everyone is a VIP. Among the objectives of our new Diversity Council are to help prevent anyone here from ever feeling as dumb as I felt then and, more importantly, to ensure that we're sensitive to the unique needs of every individual who comes to us. One of our goals is **cultural competence**, or the ability to be aware of the unique needs of everyone we encounter; to interact effectively with people of different cultures and backgrounds.

The idea for the Diversity Council came from Dr. Joan Abele, our Medical Staff president, who asked me last summer, “What can we do to help us better meet the needs of everyone in the community?” Joan and I kicked the idea around a little. Then we brought in Dave Henricksen and Barbara Ohm of Administration and Brenda Voisard of Human Resources and did some research on what we should do. Some details about what happened: ■ We found best practices and case studies from other hospitals, including Mayo Clinic and — I love this irony — Henry Ford Health System (which probably saw a need to begin their initiative right after I left). One lesson we learned was the need for a council to direct our efforts. ■ The Diversity Council's members represent a broad section of perspectives, including our Medical Staff, Department of Nursing, Language Services, our Employee Advisory Council, and a representative from the community. We meet every month. ■ Our work is starting with an assessment to help us see how well we understand the diverse needs of the people we serve and the effectiveness of our HR and management practices. Then we'll put an action plan together to help us improve. Please be watching for details.

Cultural competence supports our goal to provide extraordinary care – as Connie Dangerfield exemplifies. Being sensitive to the individual needs of the people we serve is part of every one of the dimensions of care: Clinical excellence, service excellence, employee engagement, physician engagement, operational effectiveness, and community stewardship. A story I heard last year about Connie Dangerfield, a nurse in PACU, provides a perfect example. One of her patients was Muslim; she came into the OR wearing a burka.

Connie says, a few hours later, she came into PACU and the burka, of course, was off due to protocol in the operating rooms. As I was getting her packed up and ready to go down to Same Day Surgery, I remembered that we go through public hallways and asked if she wanted the burka back on before going out into the public's eye. She said, “Yes.” As we went out into the hallway, two of her family members were standing there waiting. I looked at both of them and they got tears in their eyes. So I looked at the patient and she was crying too.

This happens on occasion coming from PACU so I thought nothing of it. I asked the patient if she was okay. She looked at me, grabbed my hand, and said thank you. I of course responded, “No problem, I'm here to help you.” Then she said something to her family in another language. They looked at me and said no one from her previous surgeries asked if she wanted the burka back on before going out into the public. After I dropped off the patient, both the family members gave me a hug and thanked me again. That's cultural competence. I'm thrilled that our Diversity Council will help us improve our ability to deliver it — so all of us can follow the example of stars like Connie.

⇒ Learn from other sources:

[EthnoMed](#) includes information about cultural beliefs, medical issues, and other pertinent healthcare issues
[Intermountain.net](#) see [Patient Rights and Responsibilities](#), [Language Services](#), [Spirituality and Diversity](#)

[Think Cultural Health](#) offers free E-learning courses
[AAFP Quality Care for Diverse Populations](#) has seven 3 to 8-minute videos showing clinicians thoughtfully communicating

coming out: “coming out of the closet,” or “coming out,” is a figure of speech that refers to lesbian, gay, bisexual, and transgender people disclosing their sexual orientation and/or gender identity.

cultural competence: the ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and language needs brought by the patient to the healthcare encounter. Cultural competence requires organizations and their personnel to do the following: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served.

culture: integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

curandero: a traditional folk healer in some Latin American cultures dedicated to curing physical and/or spiritual illnesses.

disparities: racial and ethnic differences in healthcare that are not attributable to other known factors.

effective communication: the successful joint establishment of meaning wherein patients or wherein members and healthcare providers exchange information, enabling patients and members to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients or members and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients or from members, and when patients or members comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.

family: two or more persons who are related in any way – biologically, legally, or emotionally. Patients and families define their families. *See also* patient- and family-centered

gender identity: a person’s innate, deeply felt psychological identification as male or female, which may or may not correspond to the person’s body or assigned sex at birth (meaning what sex was originally listed on a person’s birth certificate). A person’s gender identity is distinct from his or her sexual orientation.

interpreter: a person who renders a message spoken/signed in one language into one or more languages.

language services: mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing. These services can include in person interpreters, qualified bilingual employees (QBEs), or remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation.

LGBT: the acronym LGBT stands for “lesbian, gay, bisexual, and transgender” and is a term that generally refers to a group of people who are diverse with regard to their gender identity and sexual orientation (also, “LGBT community”). Sometimes the acronym is depicted as “LGBTQ” to include those who may be questioning their sexual orientation or gender identity. There is no right or wrong way to order the letters (for example, GLBT or GLBTQ), and some people and organizations add additional letters, “Q” for queer and/or questioning, including “I” for intersex, and “A” for non-LGBTQ allies (for example, LGBTQQIA).

limited English proficient (LEP): a legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter; the inability to speak, read, write, or understand English at a level that permits an individual to interact effectively with healthcare providers or social service agencies.

patient-and family-centered care: an innovative approach to plan, deliver, and evaluate healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families. Patient- and family-centered care applies to patients of all ages, and it may be practiced in any healthcare setting. *See also* family.

patient rights and responsibilities: the patient Rights and Responsibilities have been adopted to promote quality care with satisfaction for patients, families, physicians, and staff. Intermountain prohibits discrimination of these rights and responsibilities based on age, race, color, ethnicity or national origin, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, veteran status, and/or the ability to pay. The physicians and staff of this Intermountain Healthcare facility are committed to provide quality healthcare at a reasonable cost and maintain the dignity and integrity of all patients.

qualified bilingual employee (QBE): is an Intermountain Healthcare employee that has been identified as proficient in a second language – Spanish in most cases – and is allowed to interpret for basic encounters when a staff interpreter is not available.

queer: in contemporary usage, queer refers to an inclusive unifying sociopolitical, self-affirming umbrella term for people who are gay, lesbian, bisexual, pansexual, transgender, transsexual, intersexual, gender queer, or any other non-heterosexual sexuality, sexual anatomy, gender identity. This was historically a term of derision for LGBT people. Queer has been reclaimed by many (although not all) in the LGBT community.

questioning: a person, often an adolescent, who has questions about his or her sexual orientation or gender identity. Some individuals eventually come out as LGBT, others do not.

refugee: is an individual who is unable or unwilling to return to their country of origin or nationality because of persecution or a well-founded fear of persecution.

sexual orientation: the preferred term used when referring to an individual’s physical and/or emotional attraction to the same and/or opposite gender. Heterosexual, bisexual, and homosexual are all sexual orientations. A person’s sexual orientation is distinct from a person’s gender identity and expression.

shaman: a member of certain tribal societies who acts as a medium between the natural and supernatural world.

surrogate decision-maker: someone appointed to make decisions on behalf of another. A surrogate decision-maker makes decisions when an individual is without decision-making capacity, or when an individual has given permission to the surrogate to make decisions. Such an individual is sometimes referred to as a legally responsible representative.

telephone interpreting: interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through speakerphones or headsets. In healthcare settings, the principal parties (e.g., doctor and patient or member) are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone.

transgender: people whose gender identity or gender expression differ from their birth sex or prevailing ideas of masculinity and femininity are often called transgender. Although transgender is an umbrella term that includes people who cross-dress and people who otherwise express themselves in unconventional ways for their birth sex, it is often used to refer to transsexuals people who live as a sex not associated with their birth sex, after a process known as transitioning. While some transsexuals describe themselves as “trans,” others simply say they are male or female, depending on the sex to which they have transitioned.

transition: the period of time when a transgender or transsexual person is learning how to cross-live socially as a member of the sex category different from the individual’s birth-assigned sex, or is engaged in early hormone use. Some people use this term to describe their medical condition with regard to their gender until they have completed the medical procedures that are relevant for them

transsexual: a medical term applied to individuals who seek hormonal and (often, but not always) surgical treatment to modify their bodies so they may live full time as members of the sex category different from their birth assigned sex (including legal status). Some individuals who have completed their medical transition prefer not to use this term as a self-referent. Avoid using this term as a noun: A person is not “a transsexual”; the individual may be a transsexual person.

transman: this usually means that the person was assigned female at birth but identifies as a man (sometimes referred to as female-to-male or FTM).

transwoman: this usually means that the person was assigned male at birth but identifies as a woman (sometimes referred to as male-to-female or MTF).

two spirit: a contemporary term that references historical multiple-gender traditions in many First Nations cultures. Many Native/ First Nations people who are lesbian, gay, bisexual, transgender, intersex, or gender nonconforming identify as Two-Spirit; in many Nations, being Two-Spirit carries both great respect and additional commitments and responsibilities to one’s community.

video medical interpreting: interpreting carried out remotely using a video camera that enables an interpreter in a remote location to both see and hear the parties for whom he or she is interpreting via a television monitor. The interpretation is relayed to the principal parties by speakerphone or through headsets. Two-way interactive television can also be used so that the other parties can interact with the interpreter as though face-to-face.

Adapted from: Intermountain Healthcare and The Joint Commission