

ETHNIC COMMUNITY PROFILES



For more information, please contact the:
Governor's Office of Energy and Community Services
57 Regional Drive, Suite 3, Concord, NH 03301-8519
p(603)271-5822 f(603)271-2615

FOREWORD

The following is a compilation of selected underserved ethnic community profiles that are intended to provide example approaches taken by various health and human service organizations in an effort to better understand the diverse needs of their constituents. It is strongly recommended that the reader examine his/her own cultural values and evaluate their interpersonal strengths and weaknesses prior to using this information. It is also important to recognize that differences in language, age, culture, socioeconomic status, political and religious beliefs, sexual orientation, and life experience add challenging dimensions to the dynamics of cross-cultural interactions. Therefore, this information is considered to be a supplement to cultural competency training and understanding and not a substitute to this process.



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Why Is There A Compelling Need For Cultural Competence?

The rationale to incorporate cultural competence into organizational policy are numerous. The National Center for Cultural Competence has identified six salient reasons for review:

1. **To respond to current and projected demographic changes in the United States.**

The make-up of the American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Health care organizations and programs, and federal, state and local governments must implement systemic change in order to meet the health needs of this diverse population.

Data from the 1990 census reveal that the number of persons who speak a language other than English at home rose by 43 percent to 28.3 million. Of these, nearly 45 percent indicate they have trouble speaking English.

The results of a March 1997 survey conducted by the Census Bureau reveal that one in every ten persons in the United States is foreign-born. Currently, the US foreign-born population comprises a larger segment than at any time in the past five decades. This trend is expected to continue.

The Children's Defense Fund predicts that early in the first decade following the year 2000, there will be 5.5 million more Latino children, 2.6 million more African-American children, 1.5 million more children of other races and 6.2 million fewer white, non-Latino children in the United States.

2. **To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.**

Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States. Despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders as compared with the US population as a whole. In recognition of these continuing disparities, the President of the United States has targeted six areas of health status and committed resources to address cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS and child and adult immunizations aggressively.

3. **To improve the quality of services and health outcomes.**

Despite similarities, fundamental differences among people arise from nationality, ethnicity and culture, as well as from family background and individual experience. These differences affect the health beliefs and behaviors of both patients and providers

have of each other.

The delivery of high-quality primary health care that is accessible, effective and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. Culturally competent primary health services facilitate clinical encounters with more favorable outcomes, enhance the potential for a more rewarding interpersonal experience and increase the satisfaction the individual receiving health care services.

Critical factors in the provision of culturally competent health care services include understanding of the:

- beliefs, values, traditions and practices of a culture;
- culturally-defined, health-related needs of individuals, families and communities;
- culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and
- attitudes toward seeking help from health care providers.

In making a diagnosis, health care providers must understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions are indispensable to the design of treatment and interventions. Health care services must be received and accepted to be successful.

Increasingly, cultural knowledge and understanding are important to personnel responsible for quality assurance programs. In addition, those who design evaluation methodologies for continual program improvement must address hard questions about the relevance of health care interventions. Cultural competence will have to be inextricably linked to the definition of specific health outcomes and to an ongoing system of accountability that is committed to reducing the current health disparities among racial, ethnic and cultural populations.

4. To meet legislative, regulatory and accreditation mandates.

As both an enforcer of civil rights law and a major purchaser of health care services, the Federal government has a pivotal role in ensuring culturally competent health care services. Title VI of the Civil Rights Act of 1964 mandates that no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Organizations and programs have multiple, competing responsibilities to comply with Federal, state and local regulations for the delivery of health services. The Bureau of Primary Health Care, in its Policy Information Notice 98-23 (8/17/98), acknowledges that: *"Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socioeconomic status, housing status and regional differences.*

Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff."

The Maternal and Child Health Bureau, through its program efforts related to state accountability and **Healthy People Year 2000/2010 Objectives** includes an emphasis on cultural competency as an integral component of health service delivery. The **National Health Promotion and Disease Prevention Objectives** emphasize cultural competence as an integral component of the delivery of health and nutrition services.

State and Federal agencies increasingly rely on private accreditation entities to set standards and monitor compliance with these standards. Both the **Joint Commission on the Accreditation of Healthcare Organizations**, which accredits hospitals and other health care institutions, and the **National Committee for Quality Assurance**, which accredits managed care organizations and behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care.

5. **To gain a competitive edge in the market place.**

The provision of publicly financed health care services is rapidly being delegated to the private sector. Issues of concern in the current health care environment include the marketing of health services and the cost-effectiveness of health care delivery. The potential for improved services lies in state managed-care contracts that can increase retention and access to care, expand recruitment and increase the satisfaction of individuals seeking health care services.

To reach these outcomes, managed care plans must incorporate culturally competent policies, structures and practices to provide services for people from diverse ethnic, racial, cultural and linguistic backgrounds.

6. **To decrease the likelihood of liability/malpractice claims.**

Lack of awareness about cultural differences may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand health beliefs, practices and behavior on the part of providers or patients breaches professional standards of care. In some states, failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. A 1994 study appearing in the journal of the American Medical Association indicates that the patients of physicians who are

frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. When physicians treat patients with respect, listen to them, give them information and keep communication lines open, therapeutic relationships are enhanced and medical personnel reduce their risk of being sued for malpractice.

Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Health care organizations and programs must address linguistic competence--insuring for accurate communication of information in languages other than English.

References used to prepare this document: "A Vision for America's Future: An Agenda for the 1990s." (policy statement). Washington, D.C., [Children's Defense Fund](#) (1990).

"Health Care Rx: Access For All." (chart book). Washington, D.C., [U.S. Department of Health and Human Services](#), 1998.

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["The Initiative To Eliminate Racial and Ethnic Disparities in Health."](#) (policy statement). Washington, D.C., U.S. Department of Health and Human Services, 1998.

The HIV/AIDS Epidemic in the United States, 1997-1998. (fact sheet). Atlanta, GA., Centers for Disease Control and Prevention, 1998.

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Like, R. "Treating and Managing the Care of Diverse Patient Populations: Challenges for Training and Practice." (paper presented at national conference on Quality Health Care for Culturally Diverse Populations: Provider and Community Collaboration in a Competitive Marketplace.) New Brunswick, N.J., Center for Healthy Families and Cultural Diversity, Robert Wood Johnson Medical School, 1998.

Mason, J. "Rationale for Cultural Competence in Health and Human Services," Training and Technical Assistance Resource Manual, (paper presented at national conference on Culturally Competent Services and Systems: Implications for Children With Special Health Needs.) Rio Grande, Puerto Rico, 1998.

Section One:

Bosnian

Bosnian Refugees

Bosnian Refugees in New Hampshire

Resettlement of Bosnian Refugees in New Hampshire began in 1993 and reached its peak in 1998 with the arrival of 345 refugees. Since 1998 agencies have resettled some 300 Bosnians a year primarily in Hillsborough, Merrimack and Belknap Counties. Some 77% of Bosnians were initially resettled in the Manchester area with smaller populations being received in Concord (56 people), Laconia (74 people) and Franklin (59 people).

Background

The dissolution of the Soviet Union led to the creation or re-creation of a number of eastern European or Balkan states, including Bosnia, Croatia, and Macedonia. Borders and populations changed, in some cases leading to or renewing conflict among ethnic and religious groups. Conflict was most pronounced between Serbia (the former Yugoslavia) and Bosnia (formerly part of Yugoslavia). The roots of the conflict lie in the past history of the areas (e.g., forced assimilation and different allegiances in World War II), in religious differences (Christian and Muslim), and in nationalism. The Bosnian population has traditionally been more mixed than other Balkan countries (40% Serb, 38% Muslim, and 22% Croatian) and with the capital, Sarajevo, seeming at one time to be a model of religious and ethnic tolerance. Most Serbs are Greek Orthodox, most Croats are Catholic, and most Bosnians are Muslim; with Bosnians tending to be more diverse with respect to religion than Serbs or Croats.

Conflict began in 1991 and in 1992, Bosnia (the Federation of Bosnia-Herzegovina) declared independence from Yugoslavia. The conflict included "ethnic cleansing" of Muslims in Bosnia by Serb military and police. This genocide was characterized by concentration camps, mass murders (especially of men), and a Serb policy of raping Muslim women. The vast majority of casualties (approximately 250,000 killed) were civilian. An outflow of refugees resulted with approximately 800,000 Bosnians displaced to other countries and more than 200,000 coming to the United States.

The language of Bosnia is Serbo-Croatian (Bosnians now refer to their language as Bosnian), and many people also speak German, English, or another second language. In most respects, Serbo-Croatian is similar enough to English that Bosnians are able to learn English without exceptional difficulty. A relatively high level of education (at least eighth grade) helps in learning English. Some have difficulty with question formation and recognition of gender-specific names (many Bosnian women have a name ending in "ica" or "a").

Religion

Virtually all Bosnian refugees are Muslim. Islamic influences on health care beliefs and practices are discussed in the section Religions. As discussed in that section, there are many factors that influence the extent to which a religion impacts health-related behavior. In the case of Bosnian refugees, generally a cosmopolitan group, Islam may have less of an impact on health beliefs and practices than among others from rural middle-eastern backgrounds. Bosnian women, for example, tend to be less intent on maintaining extreme modesty and are more willing to report gynecological problems than women from some other groups. At most, women will wear a scarf over their head and conservative dress. A Church World Service report noted that many

Bosnians have a relationship with Islam similar to the relationship many Americans have with Christianity: "something restricted to the Sabbath and major religious holidays."

Family Structure

Although there are extended families living together in rural Bosnia, most Bosnian refugees live in nuclear family groups. Many families have a history of both wife and husband employed outside the home. Men usually have greater authority than women. Although polygamy is sanctioned in the Quran ("marry of the women, who seem good to you, two or three or four . . . " Women: 4), it is only rarely practiced in Bosnia.

One of the more touching scenarios during the Bosnian war was a couple in love, with one person being Muslim and the other Christian. We see such couples among Bosnian refugees, and though they do not seem to romanticize the situation, still, they stand as testimony to the power of love.

Health care Beliefs and practices

Except that the health care system in Bosnia is socialized, basic health care is similar in many respects to that in the United States. There is a greater emphasis on primary care and some sophisticated tests and procedures are generally unavailable. However, except for conflict and war-related shortages, primary care, at least, care is similar. Nearly all Bosnians are familiar with western conceptions of hypertension, coronary disease, diabetes, treatment of infections, and so on. Some arrive in the U.S., with histories of treatment for thyroid deficiency, cancer surgery, and other sophisticated procedures.

Our research and experience have uncovered no specific health risks other than those related to war experiences, i.e., risk for post-traumatic stress disorder (PTSD), combat stress disorder (CSR), depression, and other sequelae of psychological trauma ñ including, despite Islamic prohibitions against alcohol, alcoholism. Reactions to war-trauma are discussed in detail in the section on Mental Health. Readers are strongly encouraged to refer to that section, as many Bosnians of all ages have lived through genocidal experiences and thus will have a very high risk for delayed reactions. Readers should also note that these experiences are essentially the same as holocaust experiences, hence reactions may continue through at least a second generation. Like other refugees, Bosnian refugees tend have a poorer "global health" status than other people in the host country. Poor global health is characterized by poor appetite, decreased memory, little leisure time; and decreased or poor energy, patience, sleep, mood, and health.

Health Risks in Refugees from Eastern Europe or Russia

- Nutritional deficit
- Hepatitis B
- Tuberculosis
- PTSD (Bosnia)

Recommended Laboratory and Other Tests for Refugees from Eastern Europe or Russia

- Hepatitis B surface antigen
- PPD

Nutritional assessment, hemoglobin or hematocrit, and (for Bosnians) stool for ova and parasites should be considered.

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- Maners, L. (1993). The Bosnians. New York: Church World Service.
- Sundquist, J., Behmen-Vincevic, A., & Johansson, S. E. (1998). Poor quality of life and health in young to middle aged Bosnian female war refugees: A population-based study. Public Health, 112(1), 21-26.

Links to Bosnian Sites and Other Resources

- <http://www.geocities.com/CapitolHill/Lobby/4634/> a home page that gives some background on Bosnia
- <http://www.public.usit.net/michaela/index.html> International Bosnian Student Homepage includes links
- <gopher://gopher.igc.apc.org/11/peace/yugo/crimes> Comprehensive gopher site (focus on genocide) in Bosnian and English
- <http://www.students.haverford.edu/vfilipov/home2.html> The Community of Bosnia Foundation an extensive and recommended site. See their list of "Recommended Books on Bosnia" below.
- <http://www.phrusa.org/about/index.html> Physicians for Human rights site. Focuses on genocide and related.
- <http://www-cgsc.army.mil/chap/courses/w-rel/bosnia.htm> Some in-depth information on religion in Bosnia.
- <http://www.its.caltech.edu/~bosnia/> More on war crimes and related.

Recommended Books on Bosnia

From the Community of Bosnia Foundation (address above)

With No Peace to Keep: United Nations Peacekeeping and the War in the Former Yugoslavia (London: Grainpress, 1995). ISBN: 0952711400. Grainpress Ltd.

Four Panton Street, London SW1Y 4DL, United Kingdom

Tel: +44 (0) 171 - 930 5363, Fax: +44 (0) 171 - 839 1228, email: icu@gn-apc.org

Andras Riedlmayer, *Killing Memory: Bosnia's Cultural Heritage and Its Destruction* (Haverford, Pa: Community of Bosnia Foundation, 1994). Videocassette, 48 minutes. (Community of Bosnia Foundation, Haverford College, Haverford, PA 19041-1392. Price, \$52.50, includes postage and handling). e-mail: msells@haverford.edu. Phone orders: 610-896-1027.

Kemal Kurspahic, *As Long as Sarajevo Exists* (Stony Creek, Ct.: Pamphleer's Press, 1997). ISBN: 0614957575 or 0963058770, \$25.00, cloth.

Michael Sells, *The Bridge Betrayed: Religion and Genocide in Bosnia* (Berkeley: University of California Press, 1996). Cloth: ISBN 0520206908; \$19.95. Orders: (609) 883-1759. Fax Orders: 1-800-99-1958

Ed Vulliamy, *Seasons in Hell* (New York: St. Martin's Press, 1994). Cloth, ISBN 0312113781, \$22.95.

Roy Gutman, *Witness to Genocide* (New York: Macmillan, 1993). Cloth, ISBN 0025467506, \$25.00; Paper, ISBN 0020329954, \$12.00.

Norman Cigar, *Genocide in Bosnia: The Policy of Ethnic Cleansing*. 247pp. College Station, TX: Texas A and M University Press. \$29.95. ISBN 0 89096 638 9

Rabia Ali and Lawrence Lifschultz, *Why Bosnia: Writings on the Bosnian War* (Stony Creek, Ct.: Pamphleteer's Press, 1994). Paper, ISBN 0963058797, \$19.95; Cloth, ISBN 0963058789, \$35.00

Mark Almond, *Europe's Backyard War* (London: Mandarin, 1994), ISBN: 0749316594. London: Heinemann, 1994. ISBN: 0434000035 : 0434001058 (pbk)

Laura Silber, *Yugoslavia: Death of a Nation* (New York: Penguin, 1995 and 1996). *Yugoslavia death of a nation Discovery Channel, 1995, Audiovisual*, 5 pts. in 3 videocassettes (250 min.) : sd., col. ; 1/2 in. Originally produced for television broadcast.

Peter Maass, *Love Thy Neighbor* (New York: Knopf, 1996). Cloth, ISBN 0679444335; \$25.00. Paper, Random House, 0679763899, \$13.00.

Tom Cushman and Stjepan Mestrovic, [*This Time We Knew*](#) (New York University Press, 1996). Price, Paper: \$18.95, ISBN: 0814715354; Cloth: \$40.00, 0814715346

G. Scott Davis, [*Religion and Justice in the War over Bosnia*](#) (New York: Routledge, 1996). Cloth, ISBN, 0415915198, \$55.00; Paper, ISBN 0415915201, \$17.95 Retail Price.

David Rohde, *Endgame: The Betrayal and Fall of Srebrenica, Europe's Worst Massacre since World War II* (New York: Farrar, Straus and Giroux, 1997). Order information: 212-741-6900. Fax: 212-741-6973.

Section two:

Cambodian

CAMBODIAN HEALTH

CAMBODIAN REFUGEES AND HEALTH CARE IN AN INNER-CITY SETTING

Note: Generalizations about Cambodians (Khmer) are about as accurate as generalizations about any other large group. Nevertheless, to better understand Cambodians or other groups or cultures, it is necessary to deal in generalizations to some extent. The following is written in a spirit of respectfully seeking to understand and to serve.

Cambodian Refugees in New Hampshire

Resettlement of Cambodian Refugees began in 1982 at the start of the state refugee program. Resettlement reached its peak in 1983 with the arrival of 109 refugees. Between 1982 and 1990 agencies have resettled some 212 Cambodians. Of the 212 refugees resettled approximately 35% were received in the Manchester area. Many of the Cambodian refugees were resettled through church sponsored programs creating small population pockets throughout the state. Since 1990 the Nashua – Manchester area has received many secondary Cambodian migrants through the expansion of the large Cambodian population in Lowell, Massachusetts.

Background

Once the dominant military and economic force of Southeast Asia, Cambodia was, by the late 1800's, a part of French Indochina. From the beginning of colonial rule, there was resistance to the French. With the Geneva Convention of 1954, Cambodia became independent with a government ruled by Prince Norodom Sihanouk. Communist and other dissident activities were repressed from that point until the late 1960's when the Khmer Rouge, led by Maoist extremists, in particular a man named Pol Pot, became active. A brutal and complex armed struggle ensued, resulting in many deaths. In 1970, a *coup d'état* replaced Prince Sihanouk with right wing military rulers. Fighting escalated and on April 17, 1975, a deeply divided Cambodia fell to the Khmer Rouge.

Within days of victory, the Khmer Rouge initiated a radical restructuring of Cambodian society. Liquidation of all non-communist leaders began immediately and eventually encompassed not only military and political leaders, but also monks, teachers, people who wore glasses, and anyone else judged to be a "new person" or corrupted by capitalism. The cities were totally emptied of all residents, who then were put to work on agricultural communes. Families were separated according to the needs of working units and a deliberate effort was made to replace traditional relationships and structures such as family, village, and Buddhism with absolute obedience to the communist party or *Angka*. By 1979, when the Khmer Rouge were overthrown by the Vietnamese army, approximately 1.5 million people out of a population of seven million had been murdered or allowed to die from starvation or disease.

That night Robona, Ton Ny's six-year-old sister, had a dream in which she saw someone very much like an angel who carried an armful of five lotus blossoms and spoke to her, "Don't be afraid my little girl, I'm keeping your Mama with me. But you shall go on living." In fact, one would have said that all the children were hurrying to join their mother. The first to die were the two five- year-old twins, three days apart, lying silently on a bamboo pallet; then two other brothers, Youthevy and Vouthinouk, nine and seven

years old, the first at the hospital, the second when he came home from the hospital. Kosol, the four-year-old, and Robona died three months later, on the same day. All of them starved to death. After they died, Mitia Mir dreamed that he saw four columns still standing from a house in ruins. I thought that they were my uncle and his three surviving children, but now I know that the fourth column was myself . . . No one had the strength to work, so we were given no more food . . . from The Stones Cry Out

Like Jews who survived Nazi terror, many Khmer experience significant and long-term effects from the years under Khmer Rouge terror. Note that many feel that, "For us its too late" (as a man said to me at this year's New Year ceremony) to deal with the long-term effects of these traumas - which, of course, is not so. **It is not too late, my brother.**

Beginning in late 1978, Cambodian refugees began fleeing to the relative safety of Thailand. From 1981-1985, approximately 150,000 Khmer were resettled in the U.S.

Once in the U.S. the Khmer have tended to follow one of several paths. Some have enjoyed financial success (usually through salaried jobs rather than entrepreneurship) and have become homeowners in mixed middle-class neighborhoods. Others have scattered to suburban apartments. Still others have stayed in the neighborhoods in which they were originally resettled and have become a generally hidden part of inner-city urban life. In many cases, there has been little assimilation. In most cases, regardless of external appearances, there is great pain related to past trauma and current difficulties.

RELIGION

Most adult Khmer in America are Buddhist. Buddhism is based on the teaching of Siddhartha Gautama, The Buddha. Central to Buddhism is belief in the Four Noble Truths. These are:

- All sentient beings suffer. Birth, death, and other separations are inescapably part of life.
- The cause of suffering is desire. Desire is manifested by attachment to life, to security, to others, to being itself, etc.
- The way to end suffering is to cease to desire.
- To way to cease to desire is to follow the Eightfold Path: (1) right belief (2) right intent (3) right speech, 4) right conduct (5) right endeavor or livelihood (6) right effort (7) right mindfulness (8) right meditation.

Following the path leads to cessation of desire and to nirvana or emancipation from rebirth and the endless cycles of suffering. The picture is of the Buddha meditating, protected by Naga. Worship is at a temple or *wat*, and at alters in individual homes. Worship at temples is usually led by one or more monks, often with assistance by a lay elder or *achar*. Worship includes monks and congregation chanting in *Pali*, a liturgical language, burning incense, and prayer. Worship may be concluded by the monks eating food (always before midday) brought by the congregation. The congregation then eats and gradually disburses. Overall, there seems to less structure in Buddhist worship or ceremonies than in western religions.

Buddhism teaches tolerance of others, acceptance of life (non-attachment), and lays out a strong moral code. The principle of karma or *kamma* is central to the practice of Buddhism. Karma is popularly interpreted as a moral precept: Follow Buddhist or other moral teachings and one will be reborn in a higher state; or practice evil and one will be reborn to a lower state. Another view of karma is that it is neither reward nor punishment, but simply cause and effect. Many

Buddhists attribute misfortune or accomplishment to actions in this or a past life. Despite assertions to the contrary (by often hostile interpreters of non-Christian religions), Buddhism does offer hope to its followers. Hope is leavened with acceptance or passivity, but hope for a better life now, a better next life and hope for a better life for (one's) children is strong. Further, Buddhism is explicitly based on the hope for cessation of suffering; even as the inevitability of suffering is accepted.

Evangelical Christian churches and The Church of Jesus Christ of Latter Day Saints are active in most Khmer communities. The success of such churches is due in part to the presence of missionaries in refugee camps and the effectiveness and compassion of those missionaries in caring for refugees. Another factor that helps Christian churches is their willingness to go into the community and take an active and ongoing part in the lives and difficulties of refugees. This active outreach and caring is in sharp contrast to the more detached Buddhist groups. Readers should note that many Khmer are comfortable with attending both Christian and Buddhist worship.

HEALTH CARE BELIEFS AND PRACTICES

(focus on Khmer from rural backgrounds)

Background: In general, the Khmer are comfortable with cosmopolitan or western medicine and with traditional or indigenous healing practices, both spiritual and medicinal (and often both). Illness may be attributed to imbalance in natural forces, i.e., a humoral theory of causation. However, many Khmer will not directly express this concept. A common expression of the concept(s) is for people to note the influence of "wind" or *kchall* on blood circulation and thus on illness. There may also be discussion of body conditions called "cold" or "hot." These are not necessarily temperatures, but rather are body states leading to or caused by illness or other changes such as childbirth.

For a variety of reasons, many Khmer are slow to seek healthcare from western practitioners and traditional measures may be tried first. Reasons for delaying healthcare include:

- Acceptance of the illness or discomfort
- Difficulty accessing public or private health providers
- Difficulty traversing the healthcare system (especially, in our experience, dealing with business/eligibility aspects, appointments, prescription refills, etc.)
- Other factors related to culture, language, poverty, and the healthcare system itself

The effects of delaying health care are well known, and include increased morbidity and mortality.

Traditional healing or indigenous practices: Some of the following procedures are carried out by family members and some by traditional healers or *kruu Khmer*. Some *kruu Khmer* specialize in medicinal practice with a spiritual component, while others specialize in magic with a medicinal component. Regardless of who carries out the below or other procedures, they are often accompanied by prayer and other spiritual activities.

- *Kooi*(rub) *kchall* (wind) is used to treat a variety of ailments, including fever, upper respiratory infection, nausea, weak heart, and malaise. A coin is dipped in Tiger Balm, Monkey Holding a Peach, Vick's Vapor Rub, or similar mentholated medicine. The coin is rubbed in one direction (away from the center of the body) on the patient's chest, back,

and/or extremities. *Kooŕkchall* is usually referred to in western literature as "coining" or "dermabrasion." We recently encountered a woman with diabetic neuropathy who was coining her feet to treat the pain of the neuropathy!

- *Jup* (pinch) *kchall* is used to treat headache and malaise. The first and second fingers are used to pinch and thus bruise the bridge of the nose, neck, or chest. *Jup* also refers to the practice of "cupping" or placing a small candle on the forehead, lighting the candle, and placing a small jar over the candle. The flame consumes the oxygen and creates a vacuum, thus causing a circular contusion. As many as three contusions may be seen on a person's forehead.
- *Oyt pleung* (known as "moxibustion" in the literature) is used to treat gastrointestinal and other disorders. *Oyt pleung* is seldom done in the U.S., but the abdomens of many adults will have four to six 1-2 cm round scars resulting from the procedure.
- Massage or manipulation is practiced by *kruu* Khmer and others.
- Traditional or natural medicines are available in stores and from individuals. Such medicines include a wide variety of plant (leaves, bark, extracts) and other substances. Some are brought to America (or even, occasionally, gathered in America) by individuals. Others are found pre-packaged and imported from Thailand or other Southeast Asian countries. These are often taken or applied topically in some combination of medicines and/or mixed with "wine" (usually vodka). We also sometimes encounter substances that may be classified as "Chinese medicine" such as those medicines/substances sold in Chinese pharmacies worldwide. It sometimes happens that *kruu* will give medicines (often topical or magic in nature) to hospitalized patients.

Spiritual healing practices: As noted above there are often both spiritual and medicinal elements in healing practices, hence classifying a particular practice as spiritual or medicinal may not give a completely accurate picture of the practice. However, some illnesses or conditions are viewed as primarily or even only due to spirit problems or possession.

- Magico-religious articles such as amulets, strings, and Buddha images are common. *Katha* (amulets or what appears to be a piece of string) are commonly worn around the neck by children or around the waist by adults. Types of amulets include a small piece of metal inscribed with sacred words written in Pali and rolled around string, Buddha images attached to a gold chain, and braided knotted string (with the knots incorporating magical substances). Amulets attain their power from prayers or incantations, from the words inscribed in the metal portion, from the material from which they are made, or from other attributes.
- *Yuan* are magical pictures/words placed over doors or sometimes folded in pockets. They usually are written in *Pali*.
- Buddha images may be seen as above or as statues or pictures in homes. They are found on altars placed high on a wall. Incense, flowers, food, cigarettes, or fetishes such as hair may also be placed on the altar.
- Tattoos are an older means of protection against harm or illness. Magical designs and/or words written in Pali are found on the chest, back, neck, and arms of some men (see below - also note *Oyt pleung* scars on abdomen).
- Other spiritual or magical means of treating illness include blowing on the sick person's body in a prescribed manner and showering or rubbing with lustral or blessed water.

As noted earlier, many Khmer see no conflict in practicing or using traditional or magic means of treating illness simultaneously with western medicine. Many would further see no conflict in adding Christian prayer to the mix.

Response to western or cosmopolitan medicine: Many Khmer take a syncretic approach to health care as well as other issues in life. Often traditional measures will be tried in the home before seeking health care outside the home and/or be used simultaneously with western medicine. Major issues in providing quality care are accurate and complete assessment, compliance with medications and treatment, and a reluctance to be involved in preventive measures.

Communication is a major issue in assessment and all other phases of care. Communication barriers may be due to language or to cultural issues. The latter include attempting to use a translator who, for gender, age, social status, or past relationship incompatibilities, may be rejected or not listened to.

Assessment is complicated first by a reluctance to complain or express negative feelings. It is common for patients to not report or even to deny symptoms or problems. This may be a cultural issue or may be due to past difficulties in obtaining health care. In other cases, symptoms or problems may be reported to several sources or to one source and not another.

Non-compliance may be due to several factors. The patient may not believe that he or she has communicated the problem and thus have little faith in the solution. A common Khmer orientation to symptoms (vs. cause) of illness may result in discontinuation of treatment as soon as symptoms are resolved. Treatment through dietary measures is very difficult because of difficulty in food substitutions, differences in perceptions of foods, and in some cases, financial issues. Often there is an erroneous assumption on the part of health providers that the patient will be able to independently obtain refills or reappointments. At the first of this paper we noted that Khmer (and others) have great difficulty negotiating the business aspects of the health care system. Upon receiving a large bill, some will react by simply not going back and thus be non-compliant. Some patients, rather than report a less than efficacious response to treatment, will report "no problem" or "its okay." There have been several recent deaths in Dallas due to non-compliance.

Most Khmer are oriented more to illness than prevention of illness. Childhood immunizations are accepted, but adult immunizations (influenza, pneumonia) are of little interest until illness strikes. Most Khmer do not value early detection or disease screening. We have enjoyed some success in cancer screening (mammograms), but have seen small results from attempts to teach women to perform breast self exam.

SOCIAL ROLES: FAMILY AND COMMUNITY

Extended families living together or in close proximity are the cultural ideal, but nuclear families are common. Men are the heads of the household, but increasing numbers of households are headed by widowed or divorced or separated women. In reality, the power in some families is with the wife rather than the husband.

Extended families usually are headed by an older parent or grandparent. Because of the inevitable adjustments and changes resulting from living in a foreign land, decision-making may fall to younger family members. However, even when it is clear to healthcare staff that a younger

son or daughter is making important decisions, it will benefit all concerned to go out of the way to show respect to the older family members.

Khmer youth are matter of concern to many community leaders and workers. Self-destructive behavior such as involvement in gangs is increasingly common. This is due at least in part to the destruction of much of the Cambodian culture by the Khmer Rouge and the long-term effects of the war and holocaust on individuals and families. Living in poor inner-city neighborhoods is part of the problem, but gangs and related behavior are a problem for many Khmer living in suburbs as well.

In many respects Khmer society in Cambodia and overseas is deeply divided and has been so for more than a quarter of a century. The pressures on individuals and families are profound and have a marked effect on individual and community health. While few Khmer will say to an American, "I am overwhelmed and lost," there is little doubt that many are exactly that.

INTERACTING WITH KHMER

As with most other cultures, respect is essential. Older people should be greeted first and last. Communication is often indirect and requests or questions may be couched in seemingly vague terms. It is unusual for older people to make a direct "no" response to a question or request. Responses that may mean "no" include no response, a change in subject, or statements such as "its okay" or "no problem," or even an unconvincing "yes." When an answer is not forthcoming it is of little value to continue to press for a response.

Paying attention to what others are doing is important. For example, when there is a pile of shoes at a door, visitors should also remove their shoes before going through the door. Offers of food and drink should be accepted ñ as should an offer of the only chair in a room. Note that while Khmer appreciate children as least as much as others, they do not gush over babies or children. In fact, complementing and praising babies and children may bring bad luck to the child. Effusive, loud, or over-familiar behavior toward others is seldom in good form; nor is showing anger or involvement in confrontation.

It is difficult if not impossible to learn and follow all the proper cultural patterns of a culture not one's own. The best one can do is to (1) maintain both an inner and outer respect for others (2) pay attention to what others are doing and how they are reacting to a situation, and (3) learn about the culture attempt to implement that knowledge.

Health Risks in Refugees from Asia

- Nutritional deficits
- Hepatitis B
- Tuberculosis
- Parasites (roundworm, hookworm, filaria, flukes, amoebae, giardia)
- Malaria
- HIV
- Hansen's disease
- PTSD

Recommended Laboratory and Other Tests for Refugees from Asia

- Nutritional assessment
- Stool for ova and parasites
- Hemoglobin or hematocrit
- PPD

VDRL should be considered.

Section three:

Cuban

Cuban Refugees

Introduction

This work focuses primarily on Cubans who are recent immigrants or who tend to hold more traditional values, i.e., older, from rural backgrounds, or who otherwise may be more isolated than the many Cuban-Americans who are well-assimilated in the United States. Although Cuba's proximity to the United States gives many Americans a sense of familiarity with Cuba and Cubans, it will be helpful in understanding Cubans to briefly review some recent Cuban history. From 1511 to 1898 Cuba was a Spanish colony populated largely by Spanish and black African slaves (slavery was abolished in 1886). Once free of Spanish rule, the Cuban republic came quickly under the rule of dictators such as Gerardo Machado and Fulgencio Batista y Saldívar. Despite significant corruption and repression under these regimes, a relatively large middle and professional class developed. After years of guerilla war, communist revolutionaries led by Fidel Castro overthrew the Batista regime in 1959. Castro and the communist government have remained in power since 1959.

Communist changes in government and society led to shifts (but no lessening) in repression, increased literacy rates, changes in land ownership, and increased access to basic health care. The country remains impoverished, especially after the collapse of the Soviet Bloc in the early 1990s.

History of Immigration

One outcome of communist victory in Cuba was a flood of middle and professional class refugees to the United States. Many of these refugees established large Cuban communities in Miami, Tampa, and New York City.

In 1980, the Cuban government allowed 125,266 Cubans, including a number of criminals as well as persons with mental illness, to leave Cuba in the "Mariel boat lift." While most "Marielitos" were healthy and guilty only of wanting to leave a repressive system, this extraordinary event is often seen only as a means of Cuba ridding itself of the mentally ill and criminals. In the 20 years since the Mariel boat lift, 1,425 of the Marielitos have been sent back to Cuba and 1,750 remain in the custody of the U.S. Immigration and Naturalization Service (Ojito, 2000). Most Marielitos have enjoyed success in the U.S., while others have had greater difficulty than earlier Cubans in establishing themselves. The most recent large influx of Cubans was in 1994, when about 30,000 "rafters" reached the U.S. Since then, the INS has sent all Cubans stopped in the water back to Cuba, while allowing those who reach land to stay. From the beginning of modern Cuban immigration of refugees in 1959 and continuing until today, there have been large numbers of family reunification cases.

Most early Cuban refugees to the U.S. were of Spanish origin, while later refugees and immigrant groups have included more people of mixed or African origin.

Culture

It is almost as difficult to characterize Cuban culture as it is to characterize American culture. Differences exist according to social class, background, ethnicity, and other factors. Although many Cuban refugees are from urban backgrounds, significant numbers will have lived in the city for less than one generation, hence may have more rural than urban outlook on life. Almost

forty years of communist rule have resulted in a culture that is definitely Latino in nature, yet to some extent has moved away from such traditional influences as the Catholic Church. For example, in a startling testimony to the power that necessity and Marxism can exert over religion, large numbers of Cuban women have had multiple abortions as a means of birth control.

Communications

The language of Cuba is Spanish, though there may be differences between Spanish spoken by Cubans and the Spanish of Mexicans, for example. Many new refugees and immigrants speak only Spanish. Conversation tends to be animated, fast, and may seem loud. We have noted in our refugee screening clinic that communications within families and among friends often seem warm and affectionate. Direct eye contact is the norm in almost all interactions. Men greet one another with hand shakes and women are often physically affectionate with one another. Both women and men tend to be passionate and express themselves in a way that seems demanding to others. This may result in negative perceptions by health care providers who sometimes expect docility in refugees.

Religion

Cubans traditionally are Catholic, but many younger recent refugees and immigrants have had little exposure to religion of any sort. We have noted fewer Cuban refugees wearing crucifixes, religious medals, or similar items than other Hispanic groups. Protestant missionaries (often of "Bible church" or Pentecostal orientation) are active in Cuban communities in the U.S. *Santeria* is practiced by some Cubans (and others from the Caribbean) in Cuba and the U.S. There is evidence that *Santeria* is practiced by persons from middle and upper-class backgrounds as well as those with less education. *Santeria* is based on the *Lacumi* beliefs of the Yoruba people who came to Latin America as slaves. *Santeria* incorporates Yoruba gods (the "Seven African Deities") or *orishas*, Catholic saints, and variations on Catholic ritual. *Santeria* rituals, a few including animal sacrifice, are conducted by *Santeros* (priests) or less commonly, by *Babalawos* (high priests). Herbal formulations and prayer are most commonly used. Healing by blessing rituals (*santiquo*) include supplications to one of the following *orishas* and corresponding saint.

- Chango/Saint Barbara (Although S. Barbara is female, Chango is male)
- Oggun/Saint Peter
- Orunla/Saint Francis
- Yemaya/Our lady of Regla
- Oshun/Our Lady of Charity of Cobre
- Obatala/Our Lady of Mercy
- Elegua/Saint Anthony

Santeros intervene in both physical and mental illnesses; and seldom operate in conflict with biomedical treatments. When treating mental illness *Santeros* may ascribe the problem as a special attribute or strength (*facultade*) of the person being treated. Readers interested in *Santeria* are referred to the excellent Pasquali article listed in references.

Social Structure

The extended family is idealized, but in many cases, the nuclear family is the basic unit of social structure. Men usually have the dominant role, but many Cuban women are outspoken and

assertive in public and private. Age, social status, and education are respected. Both within and without families, deference may be given to the elderly, persons of higher social status (especially male), and those with higher education.

Health Beliefs and Practices

Traditional Cuban culture holds mind, body, and spirit are inextricably intertwined. Health is viewed as a sense of well-being, freedom from discomfort, and a robust appearance.

Traditionally, many Cubans believe that moderate obesity indicates good health and thinness indicates poor health. Traditional diet (fried foods, beans, sweets) contributes to obesity and the wide availability of colas, sweets, and fast foods in the U.S. promotes obesity and attendant health problems. Meat is a valued part of the Cuban diet. Meat was less available in Cuba, but of course is affordable in the U. S., hence large quantities may be consumed ñ again, with attendant health problems. Infants and children are often comforted with food and plump infants are viewed as healthy.

While biomedical or allopathic medical practices are widespread in Cuba and germ theory is accepted and understood by most Cubans, traditional and other theories of illness causality are also incorporated in health beliefs and practices. Stress is thought to cause a variety of physical and mental health problems. Supernatural forces (e.g., *mal de ojo* or evil eye) or a lack of balance are thought by some, especially the less educated, to cause or contribute to physical and mental health problems. Among people who understand germ theory, imbalance may still be seen as the reason why some people become ill from microorganisms and some do not.

Amulets may be worn as protection against supernatural harm. *Santeros* are utilized in some cases to treat or prevent illness, especially those related to supernatural forces (see discussion under religion above). Regardless of a person's faith (Catholic, Protestant, *Santeria*, or a blend of these), spiritual care/belief is often incorporated in treatment or explanation of illness. Children, pregnant women, and postnatal women are thought to be especially vulnerable to supernaturally influenced health problems.

Childhood immunizations are a bright spot in Castro's Cuba. The Pan American Health Organization notes that "vaccine-preventable diseases are not responsible for any mortality among children under age five." Most Cubans arrive in the U.S. with vaccinations up-to-date or near up-to-date. Home visits by nurses and in some cases, physicians are common in Cuba. Despite significant success in efforts to improve health by the Cuban government, shortages of medications, poor diet, and other factors result in a variety of untreated chronic illnesses especially among middle-aged and older Cubans arriving in the U. S.

Overall life expectancy at birth for the period 1990-1995 was 76.1 years vs. 75.4 years in the U.S. overall. It is unclear what long-term effects will result from the collapse of the Soviet bloc and the sharp decrease in aid to Cuba (coupled with the U. S. embargo of Cuba).

Persons who are sick tend to take on a passive and dependent role. Self-care is poorly understood and little accepted. The physician is highly respected and expected to be in a more directive than partnership role. Decision-making usually includes older or more respected family members. Some expect bad news such as a poor prognosis to be shared with the family (oldest immediate family member) before the patient is told. HIV/AIDS diagnosis should be shared only with the patient and only with staff (vs. family or community) translators. Women are expected to provide and be in charge of sick care within the family, including when the patient is hospitalized.

The desire for family to be informed about a terminal illness or poor prognosis before the patient has at least the potential to lead to conflict. To avoid conflict it is best to clarify with the patient and family in early contacts that such information is given to the patient unless she or he expressly requests otherwise. It is difficult for patients and families to agree to DNR orders as such orders and acceptance of terminal status may represent giving up and abandonment of the patient.

Hospitalized patients are likely to be attended by family around the clock. Hygiene is important and is best given by the patient her or himself, or by family members. Some will resist shampooing during an illness. Patients will struggle to use the toilet rather than a bedpan. Although Cubans are not excessively modest, modesty for persons who are ill may be an important issue.

Both men and women express pain openly ñ though both may tolerate painful procedures without complaint.

Health risks for Cubans in the U.S. and in Cuba include cardiac and cerebrovascular diseases, diabetes, malignant neoplasms. Optic and peripheral neuropathies of unknown etiology are common in Cuban adults ages 25-64 years. Poor dental health is also common among Cuban refugees and immigrants.

Pregnancy and Childbirth

Pregnant women are expected to stay inside if possible and avoid over-exertion. Contact with persons who have deformities or health problems, as well as discussion of these should be avoided during pregnancy. In general, it is best to avoid any potentially stressful or negative discussion with a pregnant woman. Cubans in America are well aware of the value of prenatal care and tend to be early seekers of care. Men may be surprised at the prospect of participating or being present at delivery ñ and the pregnant woman's mother may be surprised at not being allowed to direct the proceedings.

The traditional postnatal practice is for the new mother and infant to remain inside the home for 41 days after delivery. Women from the family or neighbor women are responsible for caring for both (and providing food for the father as well) during this time. Potentially stressful or negative discussions should be avoided. Breastfeeding is common.

Many Cubans prefer circumcision, which is available in public hospitals in Cuba, but is not in some public hospitals in the U.S. Families in which a woman is pregnant should be made aware of this potential problem.

A Final Note

Discerning the truth about Cuba is difficult. The government is communist and although not as totalitarian as some, still exerts iron and repressive control over the lives of Cubans. In the U.S., many Cuban exiles are passionately anti-Castro; and hold inflexible positions on continuation of the U.S. embargo of Cuba.

In spring 1998 I was talking with a man who had just come from Cuba a few days before the Pope made his historic visit. I remarked that it was a wonderful thing that the Pope was coming to Cuba and asked the man if he was sorry to have missed the Pope. He replied that he would rather see Bill Clinton than the Pope.

Health Risks in Refugees from Latin America (except Cuba, where the primary risks are malnutrition, tuberculosis, and dengue fever)

- Malaria
- Intestinal parasites (helminthic, amebiasis, giardiasis)
- Hepatitis B
- Low immunization rate (risk for measles, mumps, rubella, diphtheria, pertussis, tetanus)
- Chagas disease (trypanosomiasis)
- Filariasis, Leishmaniasis, onchocerciasis, lymphatic filariasis, cysticercosis, schistosomiasis, echinococcosis
- Typhoid fever
- STDs, including HIV

Recommended Laboratory and Other Tests for Refugees from Latin America (except Cuba, where recommended tests are nutritional assessment, PPD, and consider hemoglobin or hematocrit)

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD

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Ojito, M. (April 23, 2000). 'You are going to El Norte.' *The New York Times Magazine*. 68-73, 78.

Pasquali, E. A. (1994). Santeria. *Journal of Holistic Nursing*, 12(4), 380-390.

Varela, L. (1996). Cubans. In J. G. Lipson, S. L. Dibble, & P. A. Minarik (Eds.). Culture & nursing care. San Francisco: UCSF Nursing Press.

<http://www.paho.org/> Pan American Health Organization.

Links Related to Cuba

<http://www.paho.org/> Pan American Health Organization ñ an immensely helpful site.

<http://www.healthnet.org/> I have not completely explored this site it looks like a helpful means of exchanging information.

<http://cuba.tulane.edu/index.html> Tulane's Cuban Studies Institute.

Section four:

Ethiopian and Eritrean

Ethiopian and Eritrean Refugees

Ethiopian Refugees in New Hampshire

From 1999 to the present, New Hampshire has resettled eight Ethiopian Refugees who currently reside in the Concord Laconia area.

Background on Country of Origin

Ethiopia is an arid country located on the Horn of (East) Africa at the Red Sea. Ethiopia was never colonized, but in 1935 suffered terribly at the hands of Italy's army as a prelude to WWII. The country was ruled from 1930 until 1973 by the Emperor Haile Selassie. In 1973, the Emperor was overthrown by a group of army officers who established a repressive marxist military regime. Along with the repression came drought, famine, a secessionist movement in Eritrea, and other conflicts.

Ethiopia and Eritrea are now separate countries, but culturally are similar, and considered the same by some sources. Major cultural groups living in Ethiopia include the Amhara and in western Ethiopia, the Oromo. In Eritrea, Tigreans are the most common group. Other groups living in Ethiopia/Eritrea include the Afad-Isas, Somalis, Wolaitas, Sidamas, Kimbatas, and Hadiyas.

History of Immigration

Prior to the 1973 coup, there were very few Ethiopians living in the West. Out-migration began immediately after the coup. A common experience was for a small group of 5-20 people to travel across the desert by night and hide by day. The journey to the country of first asylum was dangerous and many died on the way. Migration to the West began in 1980, with the greatest number of Ethiopians coming to the U.S. from 1983-1993. Estimates of the number of Ethiopians in North America range as high as 250,000 (Hodes, 1997). This probably is inflated. There were major airlifts of more than 55,000 Ethiopian Jews to Israel in 1985 and 1991 (Operations Moses and Solomon). Most of these were illiterate farmers.

Ethiopians/Eritreans living in the West are most often from urban backgrounds and many came with or obtained college degrees in their host countries. Most live in large urban areas on the East and West coasts as well as in Houston and Dallas. As noted in the section on families, Ethiopians/Eritreans living in the West are disproportionately male and young.

Culture

Influences operational to varying degrees in the lives of Ethiopians/Eritreans include traditional thinking (especially among the Ormoro and those from rural backgrounds), the Coptic Church, and Islam.

Foods are spicy and tend to be "heavy" and served in large portions, especially late in the day. A thin spongy bread is served and is used in place of utensils. Ethiopians tend to be very conscious of the need for hand washing before meals (and perhaps at other times as well).

Communications

Amharic is the national language of Ethiopia (the Amhara people) and Tigrinya the language of Eritrea (the Tigrean people) - though both languages may be used in either country. A third language, Oromigna is used by the Oromo people living mostly in western Ethiopia. Most Ethiopians/Eritreans prefer translations and other assistance be provided by persons from their

own ethnic or linguistic group - thus translation by an Amhara person for a Tigrean will not be as effective as a Tigrean translating for a Tigrean.

Communication tends to be direct, with most people usually speaking softly. Among those who live in the West, eye contact is usually direct. Little emotion or affect is shown to strangers, but physical affection is common between friends.

Religion

Most Ethiopians/Eritreans are Coptic Christians (or Ethiopian Orthodox). Some are Muslim and some Jewish - with many of the later immigrating to Israel 1985 & 1991. This branch of Christianity views the spiritual and physical worlds as similarly sacred and makes wide use of icons. Intercessory prayer is used to obtain God's healing in physical and mental illness.

Both Muslims and Coptic Christians practice restriction of some foods. Muslims are forbidden pork and other flesh not properly killed. Muslims also do not eat from vessels in which pork may have been served or cooked. Coptic Christians do not consume meat or dairy products for more than half of each year. The latter is probably more closely followed in the homeland than in the West.

Social relations

The ideal family structure and living arrangement is the extended family. However, there are few truly extended Ethiopian/Eritrean families living in the West. [Ethnomed](#) notes that the divorce rate is high and that is particularly difficult for single female head-of-household parents to raise children.

In most families, men are dominant, although the roles of some Ethiopian/Eritrean women are changing rapidly in the West. At least in the early days of out-migration, there were many more men than women coming to the U.S. and other countries of refuge. The imbalance of men and women has changed somewhat (now 65% male and 35% female), but single Ethiopian/Eritrean males are more common than among other refugee groups. This is particularly a problem when single men become ill and do not have the social support of family and wife.

Ethiopian/Eritrean women are perceived as needing protection by their husband or male family members. Men make most of the decisions, especially those in relation to the outside world. The emancipation of Ethiopian/Eritrean women in the West is changing family and interpersonal dynamics - including this decision-making. Factors promoting women's emancipation include (1) the power of Western culture and the women's movement and (2) the lack of Ethiopian/Eritrean women living in the West, i.e., with an abundance of men, women do not have to tolerate being dominated.

Traditionally, disputes are settled by community (male) elders. Originally in the West there were few such men, but leaders and elders have emerged in the Ethiopian/Eritrean communities in host countries.

Health Care Problems

Although the drought has eased and the famine far less dramatic than in the 1970s, malnutrition remains a widespread problem in rural and, to a lesser extent, urban Ethiopia/Eritrea.

Few Ethiopians/Eritreans arrive in the West with the dramatic health problems and malnutrition seen in the early days of displacement. Nevertheless, health problems are common, and may include the long-term effects of malnutrition, war trauma (physical and psychological), and a variety of infectious diseases. The prevalence of hepatitis B is high among Ethiopians/Eritreans and other sub-Saharan Africans. In one study, more than half of children >10 years have serological markers for past BBV infection (Bisharat, Elias, Raz, & Flatau, 1998).

Medical problems most commonly seen in newly arriving refugees from Ethiopia/Eritrea and other East African countries (Ackerman, 1997; Gavagan & Brodyaga, 1998) are:

- Malnutrition
- Intestinal parasites (*Enterobius*, *Trichuris*, *Strongyloides*, and *Ascaris*)
- Filariasis
- Leishmaniasis
- Hepatitis B
- Tuberculosis
- Low immunization rate
- Dental caries
- Typhoid fever
- Malaria
- Trachoma
- Syphilis
- Dengue fever
- HIV infection
- Diarrheal illnesses
- Hansen's disease

Recommended laboratory and other tests include:

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD
- Peripheral smear for malaria should be considered

Other problems that practitioners should be especially alert to are cervical cancer, ectoparasites, and post-traumatic stress disorder.

Health Care Beliefs and Practices

Traditional Ethiopian/Eritrean belief is that health results from equilibrium between the body and the outside world; and illness from disequilibrium. The external world may be either the physical (sun, temperature, foods, etc.) or the spiritual world. The relationship between the person and the supernatural world is very important in maintaining health and happiness. Those who live in the Western world are more likely to understand biomedical principles of causation.

Traditional herbal medicine is highly developed and widely used in Ethiopia/Eritrea. Analyses of extracts/fractions taken from traditional herbal medicines show that many such substances have significant activity against disorders for which they are used, e.g., parasites, infections, and other medical problems. There are at least 21 specialized traditional healers operating in Ethiopia/Eritrea. These include tooth extractors, cuppers (i.e., suctioning or cupping - sometimes large amounts of blood), amulet writers, seers, herbalists, and uvula cutters.

As with many others from the Third World, Ethiopians/Eritreans put great stock in medications, with injections more valued than oral medications. Many patients are dissatisfied if medications

are not given while diagnostic tests are pending or the illness does not necessarily call for medication.

Several resources note that Ethiopians/Eritreans tend to take less fluids than is healthy. Fluids are preferred at room temperature. Fluids are particularly a problem when a patient is in the hospital where hydration is most important and drinks are often offered with ice.

Magico-religious practices are common in Ethiopia/Eritrea, and some continue among refugees in the west. Amulets (*kitab*) are worn by some, usually under clothing.

A person's mental condition is thought to play an important role in her or his physical health, hence shocking or potentially traumatic news should be given with care and with family or friend support at hand. Many will prefer that a poor prognosis or other such news be given first to a (male) family member. Open discussion of terminal illness is not desired by most; and acceptance of a poor prognosis is unusual.

Mental illness is attributed to evil spirits by both Muslims and Christians. Mental illness is sometimes attributed to possession by the *Zar* spirit, especially among newer refugees or immigrants. *Zar* possession is more common among women in Ethiopia/Eritrea and among men in refugees and immigrants living in the Western world. Harm can be inflicted on others by persons with *buda* or the power of evil eye. Spirit possession is treated with prayer and herbal preparations or holy water depending on whether the patient is Muslim or Christian. Some people may utilize different sources of religious and medical help for mental disorders, with the reputation of the healer of greater importance than his religious orientation.

Somatic complaints as a manifestation of emotional distress are common. These complaints are often vague and/or difficult to treat. Therapy in mental illness or distress should be more active and include the family. Hodes (1997) suggests low doses of antidepressants as especially helpful. Hospitalized or sick patients take on a passive and dependent role. Physicians are expected to know and convey to the patient what is best for the patient. As with many others from third world countries (especially those with less education), large amounts of information and frequent decision-making by the patient or family may induce anxiety. Health care providers are expected to be warm and friendly (but not act as partners in the health relationship). In Ethiopia/Eritrea the extended family plays a significant role in the care of hospitalized patients, but in the West, few Ethiopian/Eritrean families are of sufficient size to take on such a role and the health care system does not accommodate extensive involvement in care. As among other refugees and immigrants, being in a sick role intensifies whatever difficulties an Ethiopian patient may have in adjustment to a different culture.

Most Ethiopians/Eritreans are stoic with respect to physical (and emotional) pain. Pain medications may be refused and pain control in advanced disease such as cancer is difficult to achieve.

Specific Ethiopian/Eritrean Beliefs About Health and Illness (Hodes, 1997)

- Excess sun (especially if sun strikes a part of the body that is sweating or unclean) causes *mitch* which is translated as sunstroke, but causes rash, itching, or herpes.
- The heart is thought to regulate other organs by producing heat and not involved with blood. Complaints of a "heart problem" (vs. complaints of cardiac symptoms) may be related to dyspepsia or other GI problem.
- The uvula is believed to put infants at risk for suffocation, hence is excised in many Ethiopians/Eritreans.
- Eye problems may be treated with incisions of the eyelids or eyebrows.

- Amulets to treat or prevent disease are called *kitab*.
- Diarrhea in infants may be treated by extracting the milk teeth.
- The evil eye is called *buda* and infants are especially vulnerable.
- Ritual female genital cutting is practiced by Ethiopians/Eritreans from all three major religions (Coptic, Muslim, Jewish). Cutting usually is done in infancy or childhood and includes: (1) slight ritual scarring, or (2) clitoridectomy, including excision of the clitoris or hood of clitoris, or (3) partial or complete removal of labia minora, or (4) infibulation, including excision of the labia minora and inner walls of the majora + sewing together the majora with enough of an opening left for the woman to urinate and for menstrual blood.
- Menopause that leads to increase in abdominal girth may be attributed to pregnancy which "stays bone."
- *Moygnbaggen* or "get a fool" is a traditional disease with symptoms of syncope, fever, headache, abdominal cramps, or stiff neck. The disease is treated by bloodletting (brachial vein).
- Wind (cold) may cause pleuritic chest pain or *wugat*. Treatment is with cupping.
- The stomach is believed to be an inert organ in which ascaris worms live and process food.
- Sexually transmitted diseases may be attributed to urinating under a full moon, urinating on a hot stone, contact with an infected dog, or other means. HIV infection is increasing in Ethiopia.
- Having sex weakens tuberculosis medicines. Responses to this belief may include divorce, ceasing sex, or discontinuing the medications (R. Hodes, personal communication 1/2000).

Pregnancy and Childbirth

Among rural people, pregnancy is thought to be a time of increased vulnerability for the mother. The fetus is also at risk for harm from evil spirits and sorcery. In Ethiopia/Eritrea, most deliveries are performed by a midwife or female family members. In the West, Ethiopians/Eritrean women prefer female physicians. Some feel that Western physicians are too quick to perform Cesarean sections and attempt to prevent such intervention by waiting as long as possible to go to the hospital for delivery.

Some women practice a brief symbolic rejection of the infant for the discomfort and pain caused by pregnancy and delivery. After delivery, the mother may stay in the home for two-six weeks. Breast-feeding (for up to three years) is the norm in Ethiopia and also is practiced in the U.S., but for a shorter time. Many mothers introduce other foods at about four months.

Family planning was not widely available in Ethiopia/Eritrea, but is well-accepted by many Ethiopians/Eritreans in the West.

Section five:

Gypsy Roma

Gypsy (Roma): Health Care Beliefs and Practices

Notes: The authors are aware that the term "Gypsy" is not favored by the Romani people to whom the term is applied by non-Roma. The term Gypsy is used in the title of this document only to aid in internet searching. For the most part we will use the correct terms: Romani, Roma, or Rom as explained below. We urge informed readers to critique this document. What mistakes have we made? What have we left out? Let us know.

This document is a result of involvement in sponsoring and providing health care for a Romani family from Eastern Europe. We knew little about one another's health or socio-cultural beliefs and practices, and the experience was less than satisfying for all concerned. I hope this document and accompanying links (especially the Patrin Journal) will help others in interacting with the Romani people. Charles Kemp

Introduction

A few Romani terms are helpful to understanding this culture. Romani, the adjective; Roma, plural noun; or Rom, singular noun, are the preferred terms when referring to people commonly and incorrectly known as Gypsies. Not all Romani people refer to themselves as Roma. Gadje (or gazho) is the plural term referring to non-Roma. An individual Romani household is a familia consisting usually of three generations of six to fifteen relatives. Unrelated familia living cooperatively in a given geographical region is called a kumpania and the vista is comprised of numerous kumpania and can span across a country. Familia who live apart will unite during transitions such as marriage, serious illness and death. There are numerous variations on these basic structures.

Most Roma maintain their social isolation through their own conscious and asserted effort, and through prejudice from non-Roma. In the United States, there are two primary reasons why the Roma are so successful at remaining largely invisible. First, the large number and variety of minority groups in the U.S. afford the opportunity to blend into other cultures, with Roma sometimes presenting themselves as American Indians, Hispanic or southern Europeans rather than Roma. Second, misconceptions arise from folklore and media with the image of the "gypsy" based on either romanticized or pejorative fiction. As a result, little of substance or accuracy is known about the Roma. Elsewhere in the world (e.g., Eastern Europe), there are recognized Romani communities that are the subject of significant discrimination and in some cases (e.g., post-war Kosovo), significant repression.

There is a strong unwavering social and culture bond forged among the Roma to sustain their way of life. Traditionally they turn inward and reject the outside world to become a self-perpetuating system that renews itself with each new generation (Bodner, 1992). Loyalty to the family is maintained at all cost. Education and technology are not significant factors within the culture and are not traditionally considered important; though there are indications that this is changing. Many older Roma are not literate. In recent years, some younger members of the familia have been allowed to attend Gadje schools until about the age of ten and are thus able to read important Gadje documents. There now are increasing numbers of college-educated Roma - at least in countries like Canada and the U.S.

History of Immigration

The Roma originated in India and migrated to Europe around 1000 A.D. It is unclear why they left India, and there are no explanatory written documents. They reached the Balkans by the 14th Century and spread throughout Western Europe by the 15th Century. The Roma were the first people of color to immigrate in large numbers to Europe, and Europeans tended to treat them as outsiders. In the 18th century, groups of Roma were deported to the American colonies.

Because of their alternative lifestyle and refusal to conform the Roma were also persecuted in the American colonies and were exiled from several places. Their occupations included "magic," fortune-telling, copper-smithing, tinkering, mechanics, horse dealing, and music.

Another large group of Romani people migrated to the United States in the late 19th and early 20th Centuries. They came from Argentina around 1920, after previously residing in Russia. Current Romani population estimates in the United States are difficult to determine as the census does not record their cultural identity, and the Romani population does not record births or deaths. The national population of Romani Americans is estimated to be one million with the largest concentrations of Romani people in urban areas such as Los Angeles, New York, Chicago, Boston, Atlanta, Houston, Seattle, Portland, San Francisco and Fort Worth. In Europe, large Romani ghettos exist at the outskirts of many urban areas, especially in Eastern Europe. The largest numbers are in Romania, followed by Hungary, Bulgaria, Slovakia, and Yugoslavia/Serbia (Patrin Journal, 1999). There are an estimated 12,000,000 Romani worldwide (Smith, 2000).

Throughout their history in the West, the Roma have experienced discrimination because of gypsy folklore, Romani practices, and the prejudice inherent in all societies. Even the Bible has been used to justify discrimination against the Roma:

"Cursed be Canaan;

A servant of servants

He shall be to his brethren" Genesis 9:25

There is also the legend (still alive in rural Balkan countries) that the Roma made the nails that were used to crucify Christ and/or that they stole the fourth nail, thus making the crucifixion more painful. Gypsy hunting and other such persecutions have occurred almost from the beginning of the Roma presence in Europe, and continue to this day. Nazi Germany institutionalized the hatred and killing, with Gypsies treated the same as Jews in all respects. Approximately 500,000 - 1,500,000 Roma were murdered in the Holocaust ("the devouring" to Roma). Persecution and discrimination is now carried out by governments, communities, and individuals - especially in Eastern Europe and increasingly so since the fall of communism (Berlanger, 2000). The growth of xenophobic nationalism and the skinhead movement are current and significant forces in repression of the Roma.

Recent Romani refugees and immigrants to the U.S. have come primarily from Eastern Europe, e.g., Romania, Bosnia, Bulgaria, and Kosovo. They tend to have less education, more health problems, and greater difficulty with resettlement than other Eastern European refugees and immigrants. It is not known to what extent recent Romani arrivals have assimilated into indigenous Romani culture in the U.S. or other countries of second asylum.

Communications

The language of the Roma is called Romani and is derived primarily from Sanskrit; with strong influences from Persian, Greek, and Slavic languages (note that these track the Roma diaspora). Until recent years, Romani was solely a spoken language, but there is increasing use of written forms of Romani. There are different forms of Romani depending on which clan the Rom belongs to. Interaction between different clans is limited, and the form of Romani spoken is an important means of distinguishing between clans.

There also are customs in communicating with Gadje. In the healthcare setting, only the elder males are likely to communicate with healthcare personnel. Women are not permitted to interrupt men nor to be alone with a man who is not her husband or relative.

Social Structure and Kinship

There is an extensive and complicated social structure among the Romani people. Generally, there are four loyalties and/or identities (nation, clan, family, and vista). First, Roma are divided into Natsias or nations, which is their main identity group. The four common Romani nations are the Machwaya, Kalderasha, Churara and Lowara. The nations are then divided into Kumpania or clans. A clan is "an alliance of families united by ancestral, professional, or historical ties" (Thernstrom, 1980, p 442). This loyalty or group consists of extended family that travel and reside together and maintains economic control over a particular territory. The clans that are most numerous in the United States are the Romnichals, Bayash and Rom. Each clan has a leader and the social structure of the clans may differ. There are, incidentally, no "Gypsy Kings." Some clans are further subdivided into tribes, but many clans are simply composed of familia. The one common thread in all clans is the importance of the familia, the most important social group to the Roma. A vista is an extended familia, which includes anywhere from 20 to 200 members who are all related by blood or marriage. The familia has a social structure of its own that is very similar within all clans. Families are male dominated, with a group of male elders within the familia being the major decision makers. Romani women are often not included in the decision making process and generally have a much more subordinate role within the familia.

Culture

The Roma are ethnocentric, tending to demonstrate a sense of moral superiority and contempt toward the Gadje. The Roma have a strict taboo code that classifies all outsiders as soiled or unclean. This code prevents interaction with the Gadje and further limits acculturation. Some refuse to use the Gadje language to record births, participate in census or other surveys, or to record deaths. They maintain enough of a link with the outside world to meet their primary economic and cultural needs. Very few are employed by Gadje except as contractors and then nearly always on a temporary basis.

Important Romani concepts related to health care are "wuzho" and "marimé". Wuzho is the Roma word for pure while marime is a broad term referring both to a state of pollution or impurity or a sentence of expulsion imposed for violation of a ritual or moral nature. Other terms for marimé are moxadó, melali, mageradó, mokadi, kulaló, limaló, prastló, palecidó, pekelimé, gonimé or bolimé.

The Romani culture has strict rules about anything considered polluted. A person can be found to be marime for violations of sexual conduct, not following Romani rules for food preparation, clothes, washing or cleaning, or other activities involving pollution. Women are particularly associated with marimé, with any part of a woman's body above the waist being wuzho or pure

and below the woman's waist being marimé or polluted - especially the genitoanal area and its secretions. Secretions from the upper half of the body are not polluting or shameful. Washing hands after touching the lower body before touching the upper body is required. Separate soap and towels are used on the upper and lower parts of the body and they must not be allowed to mix. To the Roma, failure to keep the two sections separate in everyday living may result in serious illness. For this reason, most Romani women will not agree to a gynecologic examination unless the procedure is clearly explained as being essential to her well being. Certain food or animals (birds and cats) may also be considered marimé.

When a young woman reaches menarche, she is introduced to shame and must begin observing the washing, dressing, cooking, eating and behavioral rules of adult women for her own protection as well as the protection of others. Her clothes must be washed separately from those of men and children because of the impurities of her body. She cannot cook food for others during menstruation. She must show respect to men by not passing in front of them, stepping over their clothes, or allowing her skirts to touch them. Pre-pubescent girls and older women are placed in a different category because they do not menstruate. This allows them freedom, and they are allowed to socially interact with fewer restrictions.

The Roma are supposed to wash only with running water, with a shower acceptable but a bath looked upon as sitting or lying in dirty, stagnant water. Dishes cannot be rinsed in the same sink or basin that is used for washing clothing. The kitchen sink is used only for washing dishes and cannot be used to wash one's hands.

Because they do not observe body separation, Gadje are seen as a source of impurity and disease. The impure public places where Gadje are congregate are also considered potential sources of disease. These places are considered less clean than the Romani home or open outdoors. The Roma generally avoid touching as many impure surfaces as possible. They will attempt to lessen the pollution by using disposable paper cups, plates and towels.

Marriage

Gypsies tend to marry young. Some tribes practice arranged marriages while others allow courtship. If the marriage is arranged, the groom's father selects and pays for a bori or daughter-in-law through the help of a marriage arranger. Marriage is not always for love but may be arranged or undertaken according to practical, economic, and/or social considerations of the family or clan. Marriage in the Romani culture has occurred as early as age nine but usually does not take place before the age fourteen. Outside marriage is considered a serious transgression in some clans and may be grounds for expulsion. In other clans, if a Romani male marries a female Gadje his community may eventually accept her provided she adopts the Romani way of life. Marriage festivities last three days after which time the bride and groom are allowed to consummate the marriage. The newlyweds traditionally live with the groom's parents until they have several children of their own, and the family is satisfied with their adult behavior and skills, at which time they are allowed to establish a semi-independent nuclear household. The daughter-in-law must prove herself to her new family and is expected to perform services with little in return. She is expected to care for her in-laws and produce grandchildren. With the birth of her first child the daughter-in-law moves from the child or bori status to mother-of-the-child status.

Religion

There is not a separate Romani religion. Since they are generally a nomadic people, they have traditionally adopted the dominant religion of the country in which they live. For example, the Roma and Boyash clans are largely Roman Catholic while the Romnichals are largely Protestant. There are also Eastern Orthodox, Hindu and Muslim believers among the Roma. Many of the cultural practices of the Roma can be traced to other religious beliefs. For example, Roma practices of ritualistic cleansing can be traced back to ancient Hindu customs. If Roman Catholic, they will also celebrate the days of the Saints believed to have helped the familia. Evangelical activities among the Roma have increased in recent years.

Although the Roma adopt the religious practices of those around them, they also maintain several strong faith practices and beliefs in the supernatural, omens and curses. They believe in charms, amulets and talismans which they will carry in their pockets for safety, good luck and to prevent illness. They also have female healers, called drabarni or drabenhgi, who prescribe traditional healing rituals and cures. One traditional means of healing is to carry a mole's foot as a cure for rheumatism or a hedgehog's foot to prevent toothaches. Interestingly, the Roma do not believe in fortune telling. This practice is used only to earn money from the Gadje.

Health Care

Roma who enjoy good health are believed to be blessed with good fortune, and those who are ill are said to have lost their good luck. Roma believe that actions (e.g., clean or polluting) can promote health or result in illness. To return to a state of purity, cure, and good health one must conform or correct the marimé social behavior.

The Romani people tend to use the Gadje health care system only in crisis situations when there is an acute and/or unresolved condition for which folk medicine has failed (except as noted under "Pregnancy . . ." below). Generally, they see the mainstream healthcare system as causing more harm than good. Romani may request specific "famous name" physicians and demand specific treatment even if the treatment or physician is inappropriate. There also is preference for older physicians over younger ones. Sharing medications is common and Roma have also been known to request a specific color of medication for a specific illness.

For the Roma, illness is not just the concern of the individual but a problem shared by the entire clan. When a clan member must enter a hospital, family members are expected to remain with that person day and night to watch over, protect, and perform caring and curing rituals. This cultural coming together is one of the strongest values of the Romani culture. Cultural care and accommodation of this group kin presence is a major factor to be considered in planning and providing care for a Rom. Roma are especially fearful of any surgical procedure that requires general anesthesia because of a belief that a person under general anesthesia undergoes a "little death". For the family to gather around the person coming out of the anesthesia is especially important.

Health Risks Among the Roma

In parts of Europe, most Roma have a life expectancy of under 50 (Reyniers, 2000). Poverty, isolation, prejudice, and other factors discussed above and below contribute to this appallingly short life span.

The Romani culture in itself can sometimes increase risk for certain illnesses. For example, the belief in purification rituals and ritualistic cleansing to prevent illness translates to resistance to childhood and adult immunizations. Social isolation can be carried to such extremes (refusal to

register births and deaths) that significant trends in morbidity and mortality may be hidden. Isolation also results in lower participation in health screening, and beliefs about marimé mean that cervical and colon cancer screening are especially difficult to promote.

Dietary habits include high fat and salt content in foods. A large percentage of Roma smoke and are obese. These practices put the Roma at increased risk for hypertension, diabetes, occlusive vascular disease, strokes and myocardial infarctions (occurring in Rom as young as 20 years). Again, social isolation and resistance to screening result increased health risk such as end-organ damage from undiagnosed hypertension or diabetes, especially among women who are even less likely than men to be screened.

Social (or societal) isolation also leads to an increase in consanguineous marriages, and thus an increased risk for birth defects. Crowded living conditions lead to an increase incidence of gastrointestinal infections, respiratory infections and hepatitis. Romani infants are more likely to be born prematurely and low birth weight due to a lack of prenatal care. In some clans, the infant mortality rate and abortion rates are high. Romani babies also have an increased risk for the development of phenylketonuria. Please see section on screening and risks at the end of the document.

Pregnancy, Childbirth and Child-rearing

A woman is considered to be marimé (polluted or unclean) during her menses, pregnancy and for six week after the birth of the child. Childbirth should not occur at the familia's usual home lest the home lose its purity. For this reason, there is increased acceptance of hospital births.

A new baby is immediately swaddled tightly and should only be handled by his/her mother to maintain a state of wuzho. When a baby is delivered in a hospital, the mother should be allowed to practice ritualistic cleansing and the father not pushed to visit during this marimé time. There are rituals (that vary with tribe) involving the formal recognition of the infant by its father. In some cases, the child is wrapped in swaddling on which a few drops of paternal blood are placed. Other rituals involve the child being covered by a piece of clothing that belongs to the father. In some tribes, the mother puts the infant on the ground and the father picks up the infant and places a red string around its neck, thereby acknowledging that the child is his (Patrin Journal, 1999). The Patrin Journal has more extensive information on this and other aspects of birthing. In the first weeks postpartum at night, no member of the family is allowed to go in and out of the mothers room, and all the windows and doors are kept shut lest the spirit of death called "the night" enter and harm the baby. If a baby dies, it is bad fortune and the parents must avoid the baby's body. Traditionally, the body is buried in a secret place by the grandparents. Another way to avoid bad luck after the death of a baby is to leave the funeral and burial to hospital authorities. Note that bad luck here is far more than bad luck finding a parking space or in game of chance! Bad luck in the life of the Roma is life-altering for individuals, families, and clans. Children are a major focus of Romani culture and are believed to bring good luck. Child rearing is the responsibility of everyone in the family. Due to the large and complex social structure, most of the children are raised and cared for by many different people including extended family members and clan members living in the same residential area. Infant care tends to be both permissive and protective. Infants and young children enjoy freedom from most social restraints and are not expected to understand or demonstrate shame. It is not until puberty that they are introduced to the concept of shame and expected to observe marime. Children are not expected to take many of the precautions that adults do to ensure cleanliness in their daily lives,

and in contradistinction to adults, may eat food prepared by Gadge. They are weaned and toilet trained in a very gradual fashion as these are not considered important events in the Romani culture.

In Romani culture older children act as miniature adults. Teenagers do not experience a carefree adolescent period as with many Western cultures. They are expected to begin adult socialization and to start a profession by ten years of age. Separation is by gender to learn the skills of the adult. Children are expected to respond with respect to multiple parent figures.

Dying and Death

Romani belief in the supernatural and fears about death play a significant role in their rites and customs related to dying and death. When a Rom is about to die, there is an extensive ritualistic process that must be initiated. Through an elaborate communications system, relatives from other geographic areas come to be with the dying or dead. If the person is dying, it is essential that relatives be allowed to be present at the moment of death. When the person is near death, a special candle is brought into the room. At the time of death this candle is lit and a window opened. It is believed that the candle will light the way to heaven for the deceased person's soul. The body is rubbed with holy oil, and family displays intense grief. For three days, all Roma must grieve by remaining in the presence of the dead. During this time they do not bathe, shave, wear jewelry, change clothes or prepare food. They are allowed to drink coffee, brandy or other liquors. Mirrors may be covered and vessels containing water may be emptied.

It is culturally acceptable for relatives to be deeply absorbed in their grief. Displays of grief may include moaning and shouting out to the deceased, scratching their faces, pulling their hair out and throwing themselves to the floor or into a wall. There is great fear among the survivors that the dead might return in a supernatural form to haunt the living. For this reason the name of the deceased should not be mentioned, the body is not touched and all objects belonging to them destroyed. After a three day wake, the funeral is held, which is followed by a death feast in honor of the deceased. For this feast, food is always prepared in units of three (three chickens, three pots of potatoes, etc.). Additional feasts are held to mark the three days, nine days, six weeks and one year intervals after the death. Close relatives of the deceased wear mourning clothes for a full year. It is believed that after one year the deceased soul enters heaven.

Health Risks in Roma and Other Refugees from Eastern Europe or Russia (Ackerman, 1997)

Nutritional deficit

Hepatitis B

Tuberculosis

PTSD

Recommended Laboratory and Other Tests for Refugees from Eastern Europe or Russia

Hepatitis B surface antigen

PPD

Nutritional assessment, hemoglobin and hematocrit

Stool for ova and parasites should be considered.

Other Recommended Tests for the Roma

Blood and urine tests for phenylalanine

Lipid profile

Fasting blood glucose and/or Glucose tolerance test

Blood pressure

Authors: K. Ryczak, L. Zebreski, M. May, S. Traver, and C. Kemp

References and Resources

Internet

The Patrin Web Journal: Romani Culture and History. This is a "The Resource" on the Romani. Extensive information and excellent quality. I don't think you will need more than this:

<http://www.geocities.com/Paris/5121/index.html>

O Vurdon: This site is a labor of love and a demand for justice. Several lovely photographs, poems, and extensive information on culture: <http://www.dag.it/franzese/english.htm>

Roma National Congress (news, other information): <http://www.romnews.com/>

Christian-oriented Association of Gypsies/Romani International:

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Section six:

Haitian

Haitian Refugees and Immigrants

Background on Country of Origin

Haiti or The Republic of Haiti lies on the western third of the Island of Hispaniola in the West Indies. The Eastern portion of Hispaniola is the Dominican Republic. Haiti is mountainous, densely populated (>7,000,000 people), and has the lowest per capita income in the Western Hemisphere. Most of the population is black descendants of African slaves brought to the West Indies by French colonists.

Poverty in Haiti is a result of a matrix of overpopulation, high unemployment rate (60%), high and accelerating inflation rate, high illiteracy rate (55%), destruction of natural resources, no industry or exports, and little viable industrial or government infrastructure. Results of this poverty include extraordinarily high infant mortality rates (102/1000 live births), high child death rates (133/1000 < 5 years), short adult life spans (approximately 50 years), and high rates of acute and chronic illnesses (Pan American Health Organization [PAHO], 1996).

From 1957-1971, Haiti was ruled by "President for Life" Francois "Papa Doc" Duvalier. Duvalier's secret police, the *tontons macoutes* used terror and repression to control the country. "Papa Doc" Duvalier was succeeded by his son, Jean-Claude "Baby Doc" Duvalier in 1971. In 1990, Jean-Bertrand Aristide was elected president and there was tremendous optimism in Haiti that the Duvalier's reign of terror was finished. In 1991, Aristide was overthrown by elements of the former regime, but with assistance from the U.S. was returned to power in 1994. The Aristide administration (now the Preval administration) was more democratic and less corrupt than previous administrations, but the country remains impoverished and the military remains powerful.

History of Immigration

Haitians come to the U.S. as legal immigrants, illegal immigrants, and as refugees. Legal immigration tends to be difficult for Haitians, but because of desperate economic conditions in Haiti, the rate of illegal immigration remains high. Most illegal immigrants leave Haiti via small boat, despite significant risk of drowning or interdiction in the sea journey to the U.S. The number of refugees, never very great, has declined since the early 1990s to several thousand/year. Most new Haitian immigrants and refugees are adults or teens (with few infants or old people), and most are poorly educated. The largest number of Haitians in the U.S. live in Miami, Boston, New York, and Chicago. Other concentrations are found in New Orleans, Houston, Los Angeles, and Washington, D.C.

Culture

Many Haitian refugees and immigrants come from the city of Port-au-Prince, but may actually be from rural backgrounds. Many are poorly educated, speak only Creole, and have marginal or no ability to read or write. Influences on Haitian culture include their West African origins, experiences as slaves, and the crushing poverty of Haiti. The better-educated Haitians tend to be more future-oriented, while those with less education tend to be oriented to the present, and, like many refugees, also oriented to a past that may become increasingly romanticized as time passes in the new land. As is true among most people, socioeconomic status is a huge factor in how Haitians categorize themselves. In both Haiti and the U. S., the vast majority of Haitians are poor

and undereducated. There is a small middle class and a miniscule wealthy class. It should be noted that despite physical similarities, there is little interaction or perceived commonality between native American Blacks and Haitians.

Communication

Most Haitians speak Creole, a French/pidgin dialect that is seldom written; and the educated speak French. Communication tends to be relatively direct (except, perhaps, regarding certain religious and personal matters). Some Haitians will indicate agreement with a person of higher socioeconomic status rather than risk conflict in disagreement. In communicating with friends, direct eye contact, expressive or animated tone of voice, and expressive hand gestures are common, as is touching the other person. Personal space is often not as pronounced as among some other cultures, and interaction may be very close. Touch by caregivers is often appreciated. Interpreters outside the family may be mistrusted, but use of children to interpret (the most likely English speakers) carries the potential of creating conflict within the family or within the interpreter who may be called on to deal with difficult matters. An interpreter unknown to the patient may be better than a friend. Written materials are often of little use.

Religion

Most Haitians (80%) are Catholic, and many of these also believe to at least some extent in Voodoo (also spelled Voudou, Vodoun, or Vodun). There are increasing numbers of Haitians who have become Protestant, e.g., Baptist, because of missionary contact in Haiti or in "Little Haiti" areas in the U.S. In either case, religion may play a central role in the life of an individual, especially during illness or other crisis. From a cosmopolitan perspective, religion may be seen as akin to magic.

Voodoo beliefs include the presence of a powerful spirit world from which neglected ancestors, malicious spirits, or even the raised or living dead (zombies) may come to the living to bring misfortune or death. (Zombification is a result of poisoning with neurotoxins from one or more species of puffer fish.) Spirits are known as *loas*, *mysteres*, or *saints*. Some Haitians work to maintain a strong relationship with this spirit world and significant effort made to ensure that the relationship is protective or at least not damaging. Spirits may be controlled or brought into activity through ritual and/or the efforts of sorcerers or practitioners. Types of Voodoo or related practitioners (Cosgray, 1995) include:

- Readers or diviners
- Shaman or Voodoo practitioner - *houngan*, *mambo*, or *bokor*
- Herbalist or leaf doctor - *docte fey*
- Midwife - *matronn* or *fam saj*
- Bonesetter - *docte zo*
- Injectionist - *pikirist*

Male priests are known as *hungan* and female priests as *mambo*. Practitioners of black magic are called *bokors*. Catholic saints are incorporated into Voodoo, except that they may have different functions and names in Voodoo. What appear to be Catholic amulets may actually be Voodoo or in some cases (from a Voodoo perspective), both Catholic and Voodoo.

Social Relations

The extended family is the ideal social unit, but because of previously noted difficulties in immigration, is relatively rare in the U. S. In many respects, Haitian society is matriarchal, especially where child-rearing and family life is concerned. The man, however is likely to hold ultimate control and authority in most matters, especially those related to the world outside the family. Parents are authoritarian and the use of force as a means of discipline is common. Like so many other refugee and immigrant groups, many Haitians are deeply concerned about the negative effects of American culture on child-rearing and family life. Respect for adults, support to the family, and achieving in school are strongly held values that often do not survive in American urban settings.

As noted in the section on communication, relationships and communications may be very affectionate and even unrestrained. Many Haitians live in ethnic enclaves that serve as cultural/emotional support systems to people who have lost their primary support system (the extended family). On the other hand, ethnic enclaves also allow Haitians and others to not learn how to live at a higher level in their new country.

Health Beliefs and Practices

Educated Haitians or those with experience in modern health care are likely to have a greater understanding from a lay perspective of the scientific basis of illness. Illness may also be attributed to natural causes outside the body, such as cold, heat, winds, or humoral imbalance. Changes in eating, living, or other habits may also influence health and illness. Illness may be seen as punishment (*malediction*) from God, especially when a person's relationship with God is weakened and thus one's body also is weakened. A state of *depression* means generalized weakness, dejection, and worry that makes one vulnerable to illness (Martin, et al, 1995). As noted earlier, some sickness is thought by some Haitians to be a result of *expedition* or illness sent by another through spirits.

Haitian beliefs about health and illness may also be strongly influenced by life in Haiti where few people had any access at all to the most basic health care (clean water, immunizations, prenatal/obstetric care, antibiotics, and so on). Thus, a reliance on folk and/or spiritual explanations and treatments for illness may simply be the only option a person has ever had. Health care providers should also be open to (and respectful of) the likelihood of patients simultaneously using multiple sources of care for an illness: herbalist or *docte fey*, primary care clinic, and sorcerer.

In seeking health care, the primary focus among most Haitians is on solving a specific problem. In most cases, a Haitian who presents at a primary care or other source of cosmopolitan health care will already have tried home or traditional remedies. Use of modern health resources for prevention of illness and health promotion is uncommon. However, use of traditional or magic-religious measures to prevent illness or harm is almost universal among Haitians (DeSantis & Thomas, 1990). Traditional means of health promotion and disease prevention (Colin & Paperwalla, 1996) include:

- Eating well (being plump), sleeping well, keeping warm, exercising, and keeping clean are important to maintaining strength and avoiding weakness (*febles*).
- Maintaining equilibrium between "hot" and "cold" factors, including "hot" and "cold" or "light" and "heavy" foods helps prevent illness.
- Enemas (*lavman*) are given to children and purgatives to pregnant women and infants. Both are for the purpose of cleansing the inner body of impurities.

- Herbal teas, massage, are used to treat illness in early stages.
- Spiritual practice, especially Catholic ritual, prayer, and Voodoo practices are used to prevent harm or sickness.

The treatment of chronic illnesses such as diabetes and hypertension is very difficult because of high rates of noncompliance (Preston, et al, 1996). Noncompliance may be due to difficulty understanding the nature of chronic illnesses, difficulty accessing and maintaining a relationship with health care providers, and reliance on traditional or magical means of treatment.

Socioeconomic status plays a well known role in increased morbidity and mortality in all populations and in all diseases - and such is the case with Haitians. Self-medication, including with black market antibiotics or antibiotics loaned by friends is common.

Breast feeding is the norm for Haitians, but bottle feeding allows the mother to work outside the home, hence the bottle may be an economic necessity in the U. S. It is common for Haitian mothers to mix starchy additives to formula to promote weight gain and docility in the infant. Women make regular use of purgatives during pregnancy. Newborns are also given purgatives and their use may be continued through childhood (Thomas & DeSantis, 1995).

Privacy is important to Haitians, and especially around people outside the culture, modesty is important. Thus, some parts of the physical examination may result in discomfort, especially if the practitioner does not endeavor to keep the patient's body covered. Breast self exams are difficult to teach because of the modesty factor. Modesty and privacy also play a role in health histories often being incomplete.

Health Problems and Health Screening

More than 50% of all Haitian preschoolers are malnourished, hence new Haitians refugees or immigrants may present with problems of malnutrition and those who have been in the U. S. for longer periods may suffer from long term effects of malnutrition, e.g., developmental delays. Obesity is common among Haitians living in the U.S., and thus related chronic health problems (hypertension, diabetes) may exist. More than 35% of all Haitian women are anemic and many have experienced complications of pregnancy and/or delivery (PAHO, 1996).

Access to services and compliance with care are, of course, significant problems. Outreach is important in reaching Haitians. The tendency among health workers to rely on brochures must be resisted. Personal relationships are necessary to effective outreach among most Haitians.

Teaching self-care for chronic illness also requires ongoing effort and a relationship between the individual/community and the health care worker/system.

Common health problems of new Haitian immigrants are fever (in some cases dengue fever), malaria, otitis media, upper respiratory tract infection, tuberculosis, measles, pneumonia, varicella (chicken pox), cellulitis or abscess, filariasis, and sexually transmitted diseases, including HIV and syphilis (gonorrhea and chlamydia not screened) (Ackerman, 1997). AIDS is the leading cause of death among sexually active Haitian adults (Pape). There is a high incidence of cervical cancer and gastrointestinal cancers among Haitians (Holcomb, et al, 1996). Specifically recommended (Ackerman, 1997) laboratory tests for Haitian refugees and immigrants:

- Nutritional assessment, VDRL, HIV, and PPD are strongly suggested.
- Stool for ova and parasites, hepatitis B for surface antigen, and hemoglobin or hematocrit should be considered.
- Peripheral smear for malaria is not routinely suggested.

Although not commonly a part of refugee or immigrant screening, Papanicolaou (Pap) smear should also be considered, especially if cervical cancer risk factors exist (early age of sexual intercourse [< 16 years], early first pregnancy, multiple partners, and/or STDs).

Other screening measures for Haitians are the same as for other refugees

Author: Charles Kemp, R.N., CRNH

Links

http://www.haitibook.com/html/haiti_sites.html - Excellent listing of links.

<http://www.egallery.com/haiti.html> - Haitian art, including Voodoo flags. Definitely interesting.

<http://www.odci.gov/cia/publications/factbook/ha.html> - CIA Factbook.

<http://www.arcana.com/voodoo/voodoo.html> - Excellent site for Voodoo information.

<http://www.j51.com/~spwoody/haitilinks.htm> - Haitian links. Not all current, but still, worth a look.

<http://mh101.infi.net/~loa/> - the homepage of LePeristyle Haitian Sanctuary. Much information on African religions from an Afrocentric perspective. Want to get a better feel for Voodoo?

<http://www.fmch.ucla.edu/exhibit/tour2.htm> - Limited collection of Voodoo art.

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Section seven:

Hispanic Mexican – Mexican American

Hispanic Cultures: Mexican and Mexican-Americans (Clinical Notes)

Charles Kemp, RN, CRNH

Introduction

This site is intended to help health care professionals and students to better understand Hispanic patients, families, and communities. While it is impossible to make global characterizations of a culture and people with any degree of accuracy, there are commonalities and unique characteristics in every culture. For the purposes of this discussion, we will use the following definition of culture:

"Culture . . . is a system of symbols that is shared, learned and passed on through generations of a social group. Culture mediates between human beings and chaos; it influences what people perceive and guides people's interactions with each other. It is a process rather than a static entity and it changes over time" (Lipson, 1996).

Not everything written here applies to Hispanics; but much of this information does apply to some degree to this population. As Lipson notes above, this information and the way it is lived out is best perceived as dynamic and changing.

There are, of course, differences among individuals in any population and differences among populations within cultures. Differences may be due to personal differences and differences in socio-economic status, migration status/pattern, subculture, age, gender, life experiences, and myriad other factors.

The racial breakdown of people living in Mexico, and presumably Mexican-Americans, is 60% Mestizo (Amerindian and Spanish), 30% primarily Amerindian, 9% Anglo, and 1% other (Central Intelligence Agency [CIA], 1998).

Readers should keep in mind that while such differences exist, there also are many similarities within populations. For the most part and unless otherwise noted, this paper focuses on Mexicans and Mexican Americans (hereafter termed "Hispanics" or "Latinas") who hold traditional beliefs, such as first generation, new immigrants, and older persons. Much of the information applies also to persons of lower socio-economic status, even though they may be second or third generation.

History of Immigration

People migrate from Mexico (and other Latin American countries) to the United States for a number of reasons, including:

- Many Mexicans are poor and there is little likelihood of improving their economic status in Mexico. There are an estimated 98,000,000 people living in Mexico and of these, about 66% live in poverty. While the Mexican economy has grown in recent years, buying power has shrunk 80% since 1976 and inflation continues to increase at a faster rate than wages (CIA, 1998; Rangel, 1999).
- Economic and educational opportunity in the U.S. is far greater than in Mexico. The "American dream" is a reality for people the world over; and in some cases, the dream comes true.

To more fully understand the Hispanic population in a given area in the U.S., it is helpful to determine if there is a specific area of Mexico or other countries from which the people originate, as there may be health beliefs, practices, or problems specific to that area. In certain industrial areas of Mexico, for example, up to 92% of children have unsafe serum lead levels (Preston, 1999).

There are several basic patterns of legal and illegal migration to and settlement in the U.S.

- Migrant workers may travel to the U.S. each year and follow agricultural patterns of sowing and reaping from one crop to another before returning home to Mexico. Migrant health is a highly specialized field and is not addressed here.
- Others, especially men, come to the U.S. to work as day laborers for individuals and businesses while seeking steady employment. Most share apartments with several other men in similar circumstances and send money home to their families on a regular basis. Except to persons who use such labor, these individuals are virtually invisible to the Anglo community and are seldom, if ever, included in community assessments.
- Other Mexican migrants, especially families, come to the U.S. and seek employment and housing in one locale, and thus establish themselves as part of a community. Those who came before the mid 1990s are eligible for permanent resident status and eventually U.S. citizenship.
- Readers should remember that many Mexicans are college graduates who come to the U.S. for professional employment; and many have sophisticated world views and understanding of health.

In all the above patterns and variations on these patterns, it is common to travel back and forth from the U.S. to Mexico at least yearly, and sometimes monthly. It is not uncommon for people to obtain much of their primary health care in Mexico where the cost of care and medicine is significantly less than in the U.S. In other cases, especially among the very poor or those treated without success in Mexico, the U.S. is a primary source of health care. There are others who obtain care from both sources.

Implications: Hispanics encountered in health care settings and elsewhere range from physicians with post-graduate degrees and born in the U.S. to uneducated, non-English speaking peasants who arrived in the U.S. last week. In many cases, those who live in barrios will have significant intrinsic and extrinsic barriers to health care.

Communication

Spanish is the primary language of many Hispanics. There are numerous dialects and variations, but little difficulty with understanding among those who have differences. Among the young, it is common to use a mix of Spanish and English. Newer immigrants, especially women who do not work outside the home, tend to speak less English.

About 90% of Mexicans are literate (CIA, 1998) and a higher percentage of Hispanics in the U.S. are literate. This does not mean, however, that reading and writing are common means of communication among those from lower socio-economic backgrounds. The most commonly encountered books in many Hispanic homes in the barrio are required schoolbooks, pictorial novelettes, and the Bible.

Verbal and nonverbal communications from Hispanics usually are characterized by *respeto* (respect) and communications to Hispanics should also be respectful. There is an element of formality in Hispanic interactions, especially when older persons are involved. Over-familiarity,

physical (touch by strangers) or verbal (casual use of first names), is not appreciated early in relationships (de Paula, Lagana, & Gonzalez-Ramirez, 1996). It is uncommon for Hispanics to be aggressive or assertive in health care interactions. Direct eye contact is less among Hispanics than among Anglos. Direct disagreement with a provider is uncommon; the usual response to a decision with which the patient or family disagrees is silence and noncompliance. A brusque health care provider may (1) not learn of significant complaints or problems and (2) find the patient unlikely to return. Despite a lack of public complaint, Hispanics tend to have an acute sense of justice and often perceive failures in communication to be due to prejudice.

Communications and the relationship between patient and health care provider are key to providing quality care. Trust and interpersonal comfort is a critical component of the relationship between the person who is ill and the healer. In large part, it is this relational aspect of care that places folk healers in a place of importance among Hispanics living in the U.S. (Zapata & Shippee-Rice, 1999). Note that quality care as seen here is not just correct diagnosis and treatment, but also the way in which the treatment is provided.

The use of interpreters is often necessary, and ideally these should be of the same gender. Family members or friends are sometimes pressed into service as translators, but this may result in problems (personal, sexual, etc.) not brought up. The use of family or friends to interpret also presents difficulty in communicating and assessing the accuracy of vital communications such as medication regimes, side effects the patient must understand, and informed consents. Using children to translate puts the parent and child in a difficult reversed power and authority position, hence using a child to translate for a parent should be a last resort. In general, it is best to have Spanish-speaking staff or volunteers to translate. When there are staff whose primary function is translating, care should be taken that the position does not become an opportunity to wield power or make an additional profit from non-English speaking persons.

Communications about family planning are especially sensitive. Most Hispanics are Catholic, but increasing numbers of Latinas are using contraception without informing their husbands. Depo-provera seems to be the contraceptive of choice.

Implications: It is vital to have Spanish-speaking staff. In most cases it is best to use staff to interpret; and in nearly all cases it is best to avoid using children to interpret. Interactions with patients and families should be formal and concurrently warm, at least early in the relationship. Formality may decrease over time, and warmth increase. Use formal terms of address; a firm, slightly longer handshake than is customary among Anglos; and avoid prolonged eye contact. While written instructions (on medications, treatments, etc.) are important, personal instruction that is directive, active, and visual is most effective. Do not rely on brochures! Close personal space and brief, non-intimate touch makes compliance a personal favor. Emphasize present time orientation with short-term goals. Most patients ask few questions. To assess learning, ask questions; use directive active, visual instructions; self-disclosure is appropriate. Emphasize present time orientation with short-term goals. Family planning discussions should be completely private (Lieberman, Stoller, & Burg, 1997).

Social Relations

Familism, the valuing of family considerations over individual or community needs, is a strong, almost universal value in the Hispanic community (Juarez, Ferrell, & Borneman, 1998; Lieberman et al, 1997). The nuclear family is the most basic and common social unit, but many

extended families also present. It is common for several family units to live in close proximity to one another and there is usually a strong reliance on family in day to day functions and crises. The father or oldest male (direct relative) holds the greatest power in most families and may make health decisions for others in the family. Men are expected to provide for and be in charge of their families. Though increasing numbers of women work outside the home, homemaking is the expected role. At least publicly, women are expected to manifest respect and even submission to their husbands. Privately, some women will hold a greater degree of power. However, in too many marriages, the threat of physical violence is real and under-reported (de Paula et al, 1996). Two specific gender roles should be noted here:

- Machismo or macho is stereotypically viewed as a kind of foolish male pride in which men are depicted almost as buffoons driven to folly by male hormones. To the contrary, machismo is a defined sense of honor that is vital to the Hispanic sense of self, self-esteem, and manhood.
- Women are idealized in some respects and oppressed in others. Family violence is not uncommon. The woman is expected to be the primary force holding the family and home together through work and cultural wisdom, the primary caregiver, and responsible for most parenting. The Virgin of Guadalupe is a powerful symbol (dark-skinned Mother of Christ) and model for Mexicans and Mexican Americans.

Upward mobility, education, and other societal forces are changing the above; yet in isolated communities and among new immigrants, little has changed. Gender roles are important to the sense of culture and at least in public, are likely to be followed. Also see childbirth and related below.

Implications: Many patients seeking medical care will have already sought help from family resources (also see Lay Healers below). Family involvement in health care is common and health care providers are strongly advised to encourage such involvement and to include the family as a resource and focus of care in health planning, whether for individuals or a community. Showing *respeto* to all adults is important. Health providers should understand and comply with patient and family gender roles.

Religion

Most Hispanics are Roman Catholics and the faith and church often are involved in day to day family and community life, with activities throughout the week and all day Sunday. Spiritual and religious influences play a major role in health, illness, and daily life (Juarez et al, 1998; Zapata & Shippee-Rice, 1999). Also see Health Beliefs below. Along with Catholicism, is a concurrent belief in and use of magico-religious means of dealing with life. Candles with pictures of saints are found in many homes and are often part of alters in the living room or bedrooms. Each saint has a specialized as well as general religious function. The saint associated with cancer is St. Peregrine; with dying is St. Joseph; and with bodily ills is Our Lady of Lourdes. Candles representing the Virgin of Guadalupe or Our Lady of San Juan are very common. One prayer (oracion) to St. Joseph is as follows:

God, who in Thine ineffable providence didst vouchsafe to choose Blessed Joseph to be the husband of Thy Most Holy Mother, grant, we beseech Thee that we may be made worthy to have Him for our intercessor in heaven, Whom on earth we venerate as our Holy Protector. To You who livest and reignest forever and ever. Amen.

Important rites include mandatory baptism of infants, which is especially important in life-threatening situations. The Rite for Anointing the Sick (sometimes termed last rites) is required in life-threatening situations.

As in other aspects of life, the church and the people's relationship with the church is changing. One dramatic area of change is the increasing number of Catholic women who, despite clear proscriptions from the church, utilize birth control.

Protestant evangelical churches are playing an increasing role in the life of Hispanic communities. In particular, Victory Temples and other such Pentecostal churches offer answers to families that are threatened by social change, crime, gang involvement, and other such modern plagues.

Implications: Churches are central to the life of the family and community, hence can be important resources in planning and delivering services. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

Health Beliefs and Practices

Physical or mental illness may be attributed to an imbalance between the person and environment. Influences include emotional, spiritual, and social state, as well as physical factors such as humoral imbalance expressed as too much "hot" or "cold" (de Paula et al, 1996; Spector, 1996). It is important to understand that belief in the concept of balance does not in any way obviate a concurrent belief in biomedical theories or practices (Zapata & Shippee-Rice, 1999).

Hispanics who follow these beliefs may not express them to health professionals.

"Hot" and "cold" are intrinsic properties of various substances and conditions, and there are sometimes differences of opinion about what is "hot," what is "cold." In general, cold diseases/conditions are characterized by vasoconstriction and low metabolic rate. "Cold" diseases/conditions include menstrual cramps, *frio de la matriz*, coryza (rhinitis), pneumonia, *empacho*, and colic. "Hot" diseases/conditions are characterized by vasodilation and high metabolic rate. Pregnancy, hypertension, diabetes, acid indigestion, *susto*, *ojo*, and *bilis* are examples of hot conditions (Neff, 1998).

Folk illnesses are health problems associated with members of a particular group and for which their culture provides etiology, diagnosis, prevention, and regimen of healing; and which also have psychological and/or religious overtones (Neff, 1998). Folk or ethnomedical illnesses or conditions one might encounter in a Hispanic patient (de Paula et al, 1996; Lieberman et al, 1997; Neff, 1998; Spector, 1996) include:

- *Antojos* are cravings in a pregnant woman. Failure to satisfy the cravings may lead to injury to the baby, including genetic defects.
- *Barrevillos* are obsessions.
- *Bilis* is thought to be bile flowing into the blood stream after a traumatic event, with the end result of nervousness.
- *Caida de la mollera* is the presence of a sunken fontanelle in an infant.
- *Decaiminientos* is fatigue and listlessness from a spiritual cause.
- *Dercernsos* are fainting spells.
- *Empacho* is intestinal obstruction and is characterized by abdominal pain, vomiting, constipation, anorexia, or gas and bloating. Post-partum women and infants and children are most susceptible.

- *Mal de Ojo* is the "Evil Eye" may affect infants or women. It is caused by a person with a strong eye (especially green or blue) looking with admiration or jealousy at another person. *Mal de Ojo* is avoided by touching an infant when admiring or complimenting it.
- *Nerviosimo* is "sickness of the nerves" and is common and may be treated spiritually and/or medicinally.
- *Pasmo* is paralysis or paresis of extremities or face and is treated with massage.
- *Susto* is fright resulting in "soul loss." *Susto* may be acute or chronic and includes a variety of vague complaints. Women are are affected more than men.

"Cold" conditions are treated with "hot" medications and "hot" with "cold" medications, thus bringing the individual back into balance. Problems that are primarily spiritual in nature are treated with prayer and ritual. However, few Hispanics who use folk means of treating illness are troubled by simultaneously using cosmopolitan treatments such as antibiotics, antihypertensives, and so on.

Our impression is that most Hispanics, including those from traditional backgrounds, use cosmopolitan sources of health care (e.g., primary care physicians) as primary sources of health care to a far greater extent than traditional or folk sources as described below. A common hierarchy of seeking relief from lay healers begins with home remedies or seeking assistance from relatives or neighbors (especially female). A common home remedy is a tea made from various herbs, spices, or fruits; and prepared in a specific and prescribed manner (Zapata & Shippee-Rice, 1999). If the home remedy or consultation with a *senora/abuela* does not bring relief, and depending on the problem, help may be sought from a *yerberero* (herbalist), *sobador* (massage therapist), or *partera* (midwife who may also treat young children). In most cases, it is only after these are not helpful that help is sought from a *cuarandero total* (lay healer who intervenes in multiple dimensions, e.g., physical and spiritual) (Neff, 1998). *Cuaranderos* are not used or are not reported as used as much in the U.S. as in countries of origin (Neff, 1998; Zapata & Shippee-Rice, 1999). *Cuarandero* use may be diminished because of increased access to care or the more cosmopolitan nature of those living in the U.S.; or under-reported because of fear of misunderstanding or prosecution (of the *cuarandero*).

At any point in this process, help may also be sought from cosmopolitan sources such as a clinic or physician. A naturalist doctor or *doctor naturalista* may also be utilized. The *doctor naturalista* prescribes "natural" remedies, but does not usually provide the spiritual component of care the patient would expect from a *cuarandero*.

Note also that medications, including prescription, are shared within social networks. There are instances in which a sick person may simultaneously be using prayer, folk and/or herbal medicine, prescription medications obtained from a friend, and prescription medications prescribed by a nurse practitioner or physician. Regardless of the source of care, the patient (and family) are likely to include faith in God as a vital component of understanding of the problem and the cure (Zapata & Shippee-Rice, 1999).

In the excellent article, Folk Medicine in Hispanics in the Southwestern United States, Neff (1998) presents the below information:

Folk Remedies Everyone Should Know (+ indicates yes, with + being least and +++ being most; - indicates no, with - being least and - - - most, i.e., - - - in the safety column indicates the treatment is dangerous)

Spanish	English	Uses	Efficacy	Safety
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Name	Name			
<i>Ajo</i>	Garlic	Hypertension, antibiotic, cough syrup, <i>tripaida</i>	+	+++
<i>Azarcón/Greta</i>	Lead/mercury oxides	<i>Empacho</i> , teething	--	---
<i>Damiana</i>	Damiana	Aphrodisiac, frio en la matriz, chickenpox	0	+
<i>Estafiate</i>	Wormwood	Worms, colic, diarrhea, cramps, <i>bilis</i> , <i>empacho</i>	+ purgative	--
<i>Eucalipto</i>	Eucalyptus (Vicks VapoRub)	Coryza, asthma, bronchitis, tuberculosis	+ respiratory Sx; ?? tuberculosis	+
<i>Gobernadora</i>	Chaparral	Arthritis (poultice); tea for cancer, venereal disease, tuberculosis, cramps, <i>pasmo</i> , analgesic	+ as a poultice 0 as a tea	--- (internal)
<i>Gordolobo</i>	Mullein	Cough suppressant, asthma, coryza, tuberculosis	++	++ (if right species)
<i>Manzanilla</i>	Chamomile	Nausea, flatus, colic, anxiety; eyewash	++	++ (if no allergy)
<i>Orégano</i>	Oregano	Coryza, expectorant, menstrual difficulties, worms	?+	+
<i>Pasionara</i>	Passion Flower	Anxiety, hypertension	+++ sedative	++ (if right species)
<i>Rodigiosa</i>	Bricklebush	Adult onset diabetes, gallbladder disease	???	???
<i>Ruda</i>	Rue	Antispasmodic, abortifacient, <i>empacho</i> , insect repellent	??	--- (internal, external)
<i>Saliva</i>	Sage	Prevent hair loss, coryza, diabetes	+	-- (chronic use)
<i>Tilia</i>	Linden Flowers	Sedative, hypertension, diaphoretic	+ sedative	-- (chronic use)
<i>Tronadora</i>	Trumpet Flowers	Adult onset diabetes, gastric symptoms, chickenpox	???	???
<i>Yerba buena</i>	Peppermint	Dyspepsia, flatus, colic, <i>susto</i>	+++	+
<i>Zábila</i>	Aloe Vera	External - cuts, burns Internal - purgative, immune stimulant	External + ++ Internal +	External + + Internal --

				-
<i>Zapote blanco</i>	Sapodilla	Insomnia, hypertension, malaria	???	???

Diet: The diet of Hispanics in the U. S. is variable, but certain traditional Mexican foods are common. These include rice and beans, usually prepared with lard. In many homes, tortillas are eaten at most meals, and these too usually include lard as an ingredient. Although some references (e.g., de Paula et al, p. 208) report that Mexican-Americans consume "traditionally, fresh natural ingredients," our observation in inner-city barrios in Texas is occasional fresh foods are consumed, but processed foods are more common. Meals tend to be large and "heavy." Fast foods, both American-style such as hamburgers and Mexican such as *as tacos de fajita* are enjoyed by many. Chicken soup (caldo de pollo) is frequently given to persons who are ill or recuperating from illness. Obesity is a significant problem in Hispanic communities (U.S. Department of Health and Human Services [DHHS], 1998).

Pregnancy, childbirth, and child-rearing: As noted earlier, increasing numbers of Latinas are practicing family planning. Pregnancy is viewed as natural, and despite a tendency to seek prenatal care late in pregnancy or in some cases, not seeking care until delivery, birth outcome statistics for this population are good (de Paula et al, 1996). The extended family and community exert a strong influence on health practices related to pregnancy and childbirth. Women who work outside the home usually continue to do so only if absolutely necessary. When going to clinic for prenatal care it is relatively common for women to be accompanied by their husbands; and more common for them to be accompanied by a sister, mother, or other female relative. Female relatives tend to play a significantly supportive role throughout pregnancy and into the post natal period or *la cuarentena*.

Some Latinas moan during delivery and there is no effort to be silent. Breastfeeding is more common among new immigrants, but our observation is that breastfeeding is increasingly popular among those who have lived in the U.S. for extended periods of time or second or third generation Latinas.

Child-rearing is primarily the woman's responsibility in most families. Both female and male children are encouraged to be stoic from an early age. (There is little crying or fear shown in immunization clinics in Hispanic communities.) Paradoxically, many Hispanic homes are warm and protective toward the children. Familism is a thread throughout Hispanic life, including in child-rearing. Older children often have significant responsibility for younger siblings or relatives, and from all outward appearances, do not find this burdensome. Among Hispanics, children seem generally to be enjoyed and even treasured across generations.

Dying and Death Practices: The family (except for pregnant women) is often significantly involved in caring for a family member who is dying. Women tend to do most of the actual care, while men seem to stay in another room or outside, but still, are always there. In addition, many parishes have an active auxiliary, and members may be involved in caring for the person who is dying or supporting the family in the care. Autopsies and organ donations are usually resisted, especially by Catholics, but also by others. Public expression of grief is expected under some circumstances, especially among women (de Paula et al, 1996), but stoicism is also valued.

Disease prevention and health promotion: Traditionally, neither prevention nor promotion are valued; and this contributes to higher prevalence of chronic illnesses such as diabetes and hypertension, as well as waiting to seek care until illness has progressed (Neff, 1998). However, in recent years there seems to be increasing acceptance of these concepts. For example, it is increasingly common for new immigrants or visitors from Mexico to come to a community clinic reporting diagnosis and treatment for these disorders in Mexico. Still, the presence of chronic illness and risk factors such as obesity coupled with the overarching problem of difficulty accessing services, result in preventable morbidity and mortality (DHHS, 1998; Neff, 1998).

Implications: Some Hispanics have unique traditional health beliefs and practices and these are practiced to varying degrees. Having an understanding of these is helpful in assessing and understanding Hispanic patients and communities. Some traditional practices are helpful and some are harmful. Many persons who follow these practices are reluctant to share their beliefs with nurses or physicians, hence building trust and resisting judgment is essential to practice in these communities. Disease prevention (and detection) and health promotion need to be encouraged and promoted in Hispanic communities. Assessment of health beliefs and practices is facilitated by use of a brief tool such as that developed by Tripp-Reimer, Brink, & Saunders (1984):

Brief Assessment of Patient/Family Perceptions of Health Problems

- What do you think caused your problem?
- Do you have an explanation for why it started when it did?
- What does your sickness do to you; how does it work?
- How severe is your sickness? How long do you expect it to last?
- What problems has your sickness caused you?
- What do you fear about your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?

Health Problems

This discussion of common health problems of Hispanics living in the United States focuses on those who hold traditional beliefs, such as first generation, new immigrants, and older persons; and also on Hispanics of lower socio-economic status, even though they may be second or third generation. Health problems most consistently documented in the literature (DHHS, 1998; Lieberman et al, 1997; Neff, 1998; Spector, 1996) are:

- Difficulty in accessing and utilizing the healthcare system may be viewed as both a singular health problem and a highly significant etiology in or contributor to other health problems. Factors contributing to difficulty accessing services include language barriers, low rate of medical insurance coverage, low incomes, and limited knowledge of health services (Chavez, Hubbell, & Mishra, 1999).
- Diabetes is about twice as common among Hispanics as among Anglos.
- Obesity is more common among Hispanics (especially women) than in the general population.
- Latinas with breast cancer tend to have larger tumors and/or metastatic disease than do Anglo women.

- Causes of death nationally among Hispanics are (in decreasing order) heart disease, cancer, injuries, stroke, homicide, liver disease, pneumonia/influenza, diabetes, HIV infection, and perinatal conditions (Spector, 1996).

Implications: Any health planning for Hispanics should consider the issue of access to care in all phases of planning. Causes of morbidity and mortality should also be considered.

Teaching Tip: Patient information and other materials in Spanish are available online at <http://www.noah.cuny.edu/>. Non-Spanish speakers can simply go to the English section, identify topics/materials to print out, and then go to the mirror section en Espanol. What a fabulous resource! Readers are encouraged to notify us of other such resources.

Health Risks and Screening Recommendations for Immigrants from Latin America (Ackerman, 1997; Gavagan & Brodyaga, 1998; Uphold & Graham, 1998).

Not all the below apply to Mexicans, among whom the primary risks are malnutrition, especially obesity, and chronic disease such as diabetes and heart disease. However, readers should keep in mind that circumstances and climate vary in Mexico, hence malaria, etc. is a risk for some, but not others. Moreover, there is a significant influx of people from other Central American countries (especially Honduras) and both immigrants and others in immigrant communities may be at risk for problems that are not yet documented.

- Malaria
- Intestinal parasites (helminthic, amebiasis, giardiasis)
- Hepatitis B
- Low immunization rate (risk for measles, mumps, rubella, diphtheria, pertussis, tetanus)
- Chagas disease (trypanosomiasis)
- Filariasis, leishmaniasis, onchocerciasis, lymphaticfilariasis, cysticercosis, schistosomiasis, echinococcosis
- Typhoid fever
- STDs, including HIV

Recommended Laboratory and Other Tests for Immigrants from Mexico

- Nutritional assessment
- PPD (Note that having had a BCG vaccination [1] may confound the Mantoux/PPD by causing variable results and [2] does not contraindicate PPD as is sometimes thought [Uphold & Graham, 1998].)
- Consider hemoglobin or hematocrit

Summary

Understanding some broad parameters of a culture is important to providing quality care to individuals, families, and communities. While there are variations within Hispanic cultures, there also are constants. Among the most significant are:

- Familism
- Spanish language
- Faith in God

- Difficulty accessing care

While there are other similarities or constants that should be considered in providing care to this population, these four listed above emerge as generally most significant in planning and implementing care. All should be included in all phases of care.

Helpful Links: Sites described as "organization sites" function primarily to describe the organization behind the site and thus may be of limited interest in clinical practice.

<http://www.paho.org/> Pan American Health Organization. Information on countries, health statistics, and related.

<http://www.calacafeast.com/> Check it out: Great site on the Days of the Dead.

<http://192.147.157.49/galaxy/Community/Health/Family-Health/Hispanic-Health.html> An *excellent site* focused on clinical issues and folk medicine.

<http://www.noah.cuny.edu/> Noah: New York Online Access to Health. Health information in Spanish and English for patients and professionals

<http://atlas.uchsc.edu/predoc/clerkshp/hispanic/his-lnks.htm> ñ University of California Health Sciences Center site with information Hispanic and health care curriculum.

<http://www.4women.gov/faq/latina.htm> ñ a U.S. government "frequently asked questions" site with some information (and links) related to Latinas.

<http://www.dhhs.gov/about/ heo/hispanic.html> ñ U.S. Department of Health and Human Services site on Improving Health for Hispanics.

<http://www.cossmho.org/> - the National Coalition of Hispanic Health and Human Services Organizations. An organization/clearinghouse type site.

<http://www.incacorp.com/nahn> ñ National Organization of Hispanic Nurses: An organization site.

<http://www.hispanicnurses.org/> - Hispanic Nurses Association: An organization site.

<http://www.nal.usda.gov/ric/richs/hispanic.htm> ñ A good, focused listing of links.

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Section eight:

Iraqi

Iraqi Refugees

Iraqi Refugees in New Hampshire

The New Hampshire Refugee Program began to resettle Iraqis in 1992. The program had a brief rise in 1999 (27 refugees) and 2000 (31 refugees) but has since tapered off. The vast majority of Iraqi refugees (75%) were resettled in Manchester with the rest now residing in Concord (22%) and Laconia (5%).

Background

This section details historical and cultural factors for Iraqi refugees. From the outset a distinction is made between Iraqi refugees and Kurdish refugees fleeing from Iraqi Kurdistan. For this discussion, then, Iraqi refugees consist of two main groups, Iraqi dissidents and deserters from Saddam Hussein's national army, and Shiite Moslems, the so-called "Marsh Arabs," from southern Iraq. A portion of this minority group are of Iranian descent. (There is also a third, smaller group of Iraqi "Turkomens" or Iraqis of Turkish descent.)

The Iraqi soldiers deserted Saddam's army throughout the course of the Gulf War, with mass surrenders common by the end. They were held in Saudi Arabia and were treated essentially as prisoners of war, facing certain execution upon return to Saddam's Iraq. Furthermore, many were persuaded to surrender with the promise of U.S. support.

With the collapse of the rebellion against Saddam Hussein's regime in southern Iraq in March of 1991, at least 100,000 Iraqi Shiites fled into neighboring Iran, Saudi Arabia, and the U.S.-occupied zone along the Iraq-Kuwait border. Fearful of retribution against these refugees with the advent of U.S. troop withdrawals from the region, the U.S. brokered a deal with the Saudi government for the establishment of a Saudi-maintained refugee camp near Rafha, and another camp called AlArtawea. Many refugees report that conditions in the AlArtawea camp were poor, especially for Arabs (as opposed to Kurds who also were housed there). Eventually, AlArtawea was closed, and all the refugees were sent to Rafha.

Rafha camp was divided between the military deserters, overwhelmingly comprised of single men, and the Iraqi families, most of whom were Shiites. After several years, it became clear that Saddam Hussein's regime had not weakened, and repatriation for these refugees meant certain retribution. With pressure from the Saudi government, the U.S. agreed to resettle this group en masse, beginning in 1994. The government's decision to resettle met with considerable opposition, especially from veteran's groups, who argued that the resettled Iraqi deserters had been potential adversaries to our troops during the war. Furthermore, the resettled Kurdish populations also demonstrated an element of distrust to these "agents of Saddam."

Many Iraqis here fear retribution against their families still in Iraq; contact with kin in Iraq is guarded and limited, and return visits virtually impossible at this time. Some have met with family in Syria and Jordan.

Religion

Most Iraqis are Shiite Moslems, but Saddam's family and the capital area of Baghdad in general are Sunni. There are a few differences between the Shiite and Sunni sects. In general, Shiites are more strict and restricted, in religious practices, food proscriptions, and especially, treatment of women. Shiite Moslem women dress typically in black, especially older women and widows, in

full "purdah," covering their bodies and faces. At all public events, and even within the household, women are segregated from men. It is never acceptable to shake the hand of a Shiite woman. Sunni women, on the other hand, are less restricted. In Iraq, Sunni women doctors examine Shiite females. Female patients here in the U.S. are very conservative; a male caseworker once told of a Shiite female patient pulled her scarf over her head to hide her ear from him during an exam.

Dietary laws are another area where the Moslem religion is very restrictive. Both Sunnis and Shiites also adhere to *halal* laws regarding food. Briefly, any meat consumed by a Moslem must come from an animal slaughtered by another Moslem in a prescribed way, or it is considered impure, *haram*. This ritual involves asking God for forgiveness for taking the life of the animal. Furthermore, pork and alcohol are especially *haram* and should never be consumed. Even in the U.S., most Iraqis do not buy meat or chicken in a grocery store but prefer to go to farms to buy the meat fresh, or from a few trusted *halal* markets.

Marriage

It is not uncommon for girls to be involved in arranged marriages at a young age, as young as twelve or thirteen years. There is preferential first-cousin marriage. To Iraqis, especially Shiites, the Islamic marriage is very sacred and greatly valued for its bond between families and its protection and treatment of women. Of course, the purity of the girl is closely guarded. However, this tradition of early marriage has flown in the face of U.S. law; there have been several widely-publicized cases of arrests of men involved in unions with girls younger than sixteen. According to Islam, men may have up to four wives, but this not common among Shiites.

At marriage, women come to live with the husband's family. Married sons usually stay within the household, all eat and work together. Children are to be the caretakers of their parents when they are elderly.

Traditional Medicine

Herbs and Practices

Cumin powder dissolved in water is given for stomach ache, as is green tea. Karawya herb, boiled in water, is also given for stomach ache, diarrhea and constipation, because it is believed to ease abdominal pain, especially for children. Lemon juice and plain rice are also given for diarrhea. A heated brick is also used for diarrhea, where it is covered with a cloth and sat upon. For cough, honey and lemon juice together, and also lemon and orange juice together, are consumed. A sort of steam tent is done for colds, and the patient can be kept covered for up to twenty-four hours. Anise seed is used for sore throat or laryngitis, boiled in water. Ground cumin, ninia seed, shabak seed, are all ground and mixed together as a powder and put on the gum for toothaches. For a dislocated shoulder, ninia and churn butter mixed together as a salve and put on the shoulder. For burns, barley is burned, mixed with butter, and applied as a poultice on the burn for 48 hours. For a splinter, a dough of flour and sugar is put over the splinter, or an infected pimple or cyst. For an infected eye with pus drainage, a cloth boiled in tea is put over the eye. For fever, cumin and egg yolk heated in water, is dipped onto a rag and put over the forehead. Handel, a type of bitter fruit, is cut, boiled, and drank for pain in the sides. For swollen tonsils, certain elderly women know how to stick their finger in mouth of the child and manipulate the tonsils by pushing from side to side.

Henna dye is considered to have magical healing properties, and is quite commonly seen, especially on Iraqi women. For example, it can be used for treatment of migraine headaches, where the hair is dyed. Henna can also be painted on the hands and feet, not just for decoration

but for pain relief and also for protection from evil spirits. Tattoos can also serve the same purpose. For example, Islamic holy words can be written on the hand, such as "Allah" on the front, and Ali on the back. Circular tattoos over the temples are common for treatment of migraine headaches.

In Iraq, midwives deliver at home. The placenta, thrown in water, is a folk belief to encourage milk production. Also, for infertility, a placenta can be placed on the threshold of the infertile couple's house. Circumcision of boys usually occurs within the first few days, accompanied by a ceremony and feast. Commonly, a barber performs the circumcision; crushed onions, sumac seed, and other acidic foods are placed over the circumcision and the umbilicus, for a few days, to promote healing. During the circumcision, the person who holds the child is known to establish a very significant bond with the child. Females get their ears pierced at one week.

Breastfeeding is the norm, a least one year, for both sexes. Rice soup, potatoes, and bread are common weaning foods, as is leban, a yogurt-based drink.

Birth control is virtually non-existent in Iraq, as limiting births or interfering with conception in any way is against the laws of Islam. Life is considered a gift from God. Likewise, abortion in any form would be out of the question. Here, the pill, depo-provera, IUD's, and even tubal ligation are beginning to be used. Even among husbands support for birth control is growing. There is an acceptance, or at least a rationalization, that limiting births is a means for adaptation and economic sufficiency here.

Funerals

At death, the body is taken to the mosque, where family, friends, and the Imam take turns reading from the Koran. White sheets are wrapped around the body, after ritualistic washing, and burial takes place as soon as possible, usually the same day. The body is carried to the graveyard on a litter during a funeral procession. The ritualized recitation from the Koran (sometimes a tape recording may be substituted) continues from three to seven days, asking God to forgive the deceased for past sins. Black clothes are worn during mourning. A widowed wife may remarry three to six months after the husband's death, sometimes to the husband's brother.

There is a spiritual-healing ceremony centered around the gravesite of a sheikh or a very holy person. Here one takes patients with mental problems or patients having infertility (almost always assumed to be the woman), to the grave marker. An animal is sacrificed, and food is given to the poor. Through prayer, as the participants hold hands around the gravesite, the sheikh's spirit is called upon to ask God to intervene on the sick person's behalf. Similarly, some patients can have a bad spirit, *jinn*, which can be exorcised through this ceremony. Commonly, a certain green material is hung around the gravesite, like a curtain. People, especially Shiites, cut scraps of the material and pin it to themselves as a sort of charm for protection against evil spirits.

Health Risks in Refugees from the Middle East

- Thalassemia
- Schistosomiasis
- Parasites (hookworm, amoebae, echinococcosis)
- Leprosy
- Tuberculosis
- PTSD

Recommended Laboratory and Other Tests for Refugees from the Middle East

- Nutritional assessment

- Stool for ova and parasites
- PPD

Hepatitis B surface antigen and hemoglobin or hematocrit should be considered.

Section nine:

Kosovo

Kosovo Refugees

Kosovar refugees in New Hampshire

In response to the 1998 Serbian campaign against the Kosovar Albanians, the United States sponsored a large-scale evacuation. In 1999, New Hampshire resettled 59 Kosovar Albanians, 53 of whom were resettled in Manchester and the rest in Laconia.

Introduction/Background

Kosovo was an autonomous federal unit of Yugoslavia until 1989. In 1989, the Serbian government stripped away the basic rights of the Albanians (hereafter Kosovars) and suspended the Kosovo parliament. Initially, the Kosovars responded with peaceful and passive resistance. In 1992, the Kosovars continued to hold elections, chose their leaders, and utilize the Albanian language, education, and health-care. Later a guerrilla movement called the Kosovo Liberation Army (KLA) was formed after peaceful attempts were ineffective. In 1998, the Serbian (former Yugoslavian) government began a campaign of violence ("ethnic cleansing") against civilians, including women and children, causing over a quarter of a million Kosovars to flee the country. Kosovo covers a total of 10,887 square kilometers with a population 2 million. Ninety percent of the population is ethnic Albanian. The country is about the size of Kentucky. Kosovo is bordered in the north by Serbia, the east by Bulgaria, the southeast by Macedonia, the west by Albania, and the northwest by Montenegro.

History of Immigration

Serbs have lived in Kosovo since the 6th century. Kosovo holds many Serbian cultural monuments and is considered by Serbs to be a national treasury and the center of Serbian statehood. Kosovo was the least developed region of the Serbian areas until the Second World War. Over the past several decades, Albanians from Yugoslavia, Greece, and Macedonia have migrated into Kosovo.

In 1998, Serbian aggression or ethnic cleansing against the Kosovar Albanians caused hundreds of thousands men, women, and children to leave their homes. It is estimated that approximately three-quarters of a million Kosovo refugees fled to Macedonia, Albania, Montenegro, Bosnia, and other countries abroad. After several months of being bombed, the Serbian government accepted a resolution to the Kosovo crisis and by June 20, Serb forces had left Kosovo. Over 715,000 refugees returned to Kosovo from neighboring countries and 30,000 from abroad.

Culture/Social Structure

Extended family is very important to Kosovars. They do not have nursing homes and tend to take care of their own. If the family can not take care of the elderly or children, neighbors help. Women are considered by men as equals and often function as decision makers. Teuta, a former ruler of Kosovo, was not only Roman Catholic, but also a woman. Many of the people live in villages among the mountains. Each village has a unique style and color concerning dress. The men of the villages wear beige hats. These hats are tradition for Albanians and this distinguishes them from other ethnic groups. Many urban Kosovars are educated at the University of Pristina located in the capital of Kosovo.

Language

The Albanian language is one of the original nine Indo-European languages and is not derived from any other language. About 90% of the inhabitants of the Adriatic Coast, primarily in Kosovo and Macedonia speak Albanian. The official Albanian language, adopted in 1909 was written in a standard Roman orthography and based on the Gheg dialect. Since 1974, citizens of Kosovo and Macedonia speak varieties of eastern Gheg.

Religion

There is a mixture of religions in Kosovo, especially Islam, Orthodox, and Roman Catholicism. Roman Catholicism was the first religion of Kosovo, but many Kosovar refugees are Sunni Muslims. There is not a strong conservative or radical Muslim movement in Kosovo as there is in the Middle East. Please see the Refugee Health site section on religions for a discussion of Islam and Orthodox Christianity.

Health Care Practices/Beliefs

Male circumcision is strongly encouraged, but not forced. It is believed to be only a procedure for cleanliness. Female genital cutting or "circumcision" is not a practice and is condemned on an Islamic basis.

The younger generation participates in the use of narcotics at an alarmingly increasing rate. The use of alcohol and smoking are endemic and are increasing among the people as a whole.

Immunizations are considered very important. The medical profession goes into the villages and cities to provide immunizations.

Midwives are often used in the villages for labor and delivery. Midwives are often elderly women who have had babies and possess some of the knowledge needed in helping with labor and delivery. A few are medically trained. Hospitals are used by most urban women, but many of the resources taken for granted in Western countries are not widely available.

Birth control is hard to obtain and not highly utilized. The younger generations use it more often, but the older generation population desires to have more children to help with the land and the elderly. Many women use the saying "my son for me, my son for land."

As life expectancy has increased among Kosovars, chronic illness has increased as well.

Hypertension and other cardiac-related illnesses take on increased importance inside Kosovo as well as among refugees. Kosovar refugees have not presented at countries of second asylum with any significant pattern of health problems.

Healthcare Concerns

The refugees of Kosovo are returning to their homes where over 50% are destroyed, and few, if any, health-care facilities are operable. Many organizations such as, International Medical Corps, Doctors Without Borders, and others (see links in Refugee Health site) are making special efforts to provide basic needs (food rations, blankets, clothes, soap, and mattresses) to people returning and living in remote areas.

On the average, Albanian women give birth to 2.7 children and fewer than 10% use contraceptives. The number of abortions is high and many women lose their life following complications. Maternal mortality in Kosovo, is the highest throughout Europe and infant mortality is increasing.

Due to the summer and winter weather extremes, lack of water, and overcrowding, epidemics are another major concern. Cholera, poliomyelitis, and meningitis are a problem in refugee facilities in and near Kosovo. Lack of housing secondary to ethnic cleansing and bombing also increases the risk of communicable disease.

Health Risks

- Malnutrition
- Cholera, poliomyelitis, meningitis
- HIV infection and STDs
- Pneumonia and respiratory illness
- Hypertension
- Diabetes
- Cardiovascular diseases
- Low birth weight infants and related problems
- Dental caries
- Tuberculosis
- Immunizations
- Measles
- Drug and alcohol abuse
- Post traumatic stress disorder, depression

Mental Health

Refugees from Kosovo are vulnerable to mental health problems. Many will suffer from post traumatic stress disorder (PTSD) and depression as the most common psychiatric diagnosis. Other diagnosis may include somataform pain syndrome, dissociative disorders, and recurrent panic attacks. Women and girls who were raped often have a difficult time dealing with the long-term effects of the trauma. Pregnancy and STD testing may be needed with new refugees and should be done with sensitivity.

Resource Materials and References

Geissler, E. M. (1998). Cultural Assessment. St. Louis, Mosby.

<http://www.albanian.com>

www.dwb.org Doctors Without Borders

<http://www.imc.org>/International Medical Corps

<http://www.un.org/> United Nations

Authors: Kathryn Bongers, Cory Laisure, Tracey Mackling (Baylor University School of Nursing)

Section ten:

Kurdish

Kurdish Refugees From Iraq

Background on Country of Origin

The Kurds are a diverse ethnic group of an estimated 22 million living in the homeland known as Kurdistan, encompassing parts of the countries of Turkey, Iran, Iraq, Syria, as well as provinces of the former Soviet Union. Their struggle for independence has waged for centuries, but political and ethnic divisions within the populations have prevented them from achieving unity. Hence they remain minorities, frequently persecuted, within the countries they live.

History of Immigration

The Kurds of Iraq have a long history of persecution under the Baghdad regimes. In the mid-1970' a failed Kurdish revolution provoked thousands of Kurds of the Kurdish democratic party to flee to Iran, and they were eventually resettled to the United States and abroad.

Similarly, after the defeat of Iraqi forces in the Iran-Iraq War of 1988, Kurds in northern Iraq were particularly scapegoated for annihilation, and biological and chemical weapons ostensibly maintained for use against the Iranians were turned against them. A systematic plan, the Anfal, to destroy villages controlled by Kurdish resistors, known as peshmerga, was launched by Saddam Hussein in 1988. The worst of these attacks came on the Kurdish settlement of Halabja, resulting in thousands of casualties and forcing 60,000 refugees to flee to the Turkish border.

At the Turkish border, these refugees were forcibly routed by the Turkish authorities to four primary refugee camps set up inside Turkey: Diyarbakir, Silopi, Mardin, and Mush. Here they remained for an average of two years or more, some up to five years, under variable but frequently severe conditions until the international community selected some for resettlement. Many others were pushed back to Iraq.

A third, larger wave of Iraqi Kurds fled Iraq to Turkey and Iran immediately after the failed Kurdish uprising during the Gulf War, in early 1991. This group of an estimated 1.5 million refugees in the mountains of the Turkish border evoked a large humanitarian relief effort, culminating in the resettlement of some to the West beginning in the Spring of 1993.

A fourth, most recent wave of Iraqi Kurds were evacuated by United States forces from Arbil following an Iraqi army incursion and internal political strife in northern Iraq in the Fall of 1996. These refugees were airlifted directly to Guam, where they received a few months of orientation prior to their resettlement in the United States.

Culture

The Kurds on the whole come from mountainous regions where they practiced pastoralism of sheep and goats and tended small farms, growing mostly wheat, rice, and fruit. While many of the Kurds had rural origins, the cities like Dohuk, Arbil, Suleimania, and Kirkuk are growing from refugees displaced from their villages due to warfare. There are also sizeable oil reserves in Kurdistan, representing potential wealth which adds to the political infighting in the region. Many of the adult men have been involved in the fighting; these soldiers are known as **peshmerga**, or freedom fighters.

Communication

While there are many cultural similarities which all Kurds share, especially historical factors, there are also many differences among Kurds. For one, there are two dialects of the Kurdish language: Sorani and Kurmanji (Bardini), which are mostly mutually-intelligible. Most Iraqi and Iranian Kurds speak Sorani; Kurmanji is the dialect of Dohuk Province in Iraq (where most United States-resettled Kurds originated) as well as most of Turkey, Syria, and former Soviet

Union. Most Kurds are also bilingual in the lingua franca of the country in which they live, for example, Arabic in Iraq, Turkish in Turkey, and Farsi in Iran. Most Kurds are literate in their own language, but only those with more advanced education, restricted generally to males, can read and write Arabic, Turkish, or Farsi.

It is appropriate to make eye contact when speaking with Kurds. When greeting, handshakes are usually appropriate between and within the sexes, and a two-handed handshake is considered especially warm and polite. The exception here is that it is inappropriate for a man to shake the hand of an elderly women. In Kurdistan, and between very close friends or relatives in the U.S., men may greet each other with a kiss to both cheeks. For the most devout Muslims, especially men, one is not to be touched by anyone, including a spouse, after one has ritually purified oneself prior to the daily prayers.

In addition to linguistic traits, Kurds have also adopted (or were forced to adopt) over the years other cultural traits from the surrounding dominant cultures where they live. For example, Kurds in Turkey primarily wear the style of dress of Turks.

Religion

In terms of religion, most Kurds adhere to the Sunni tradition of Islam, which is widely practiced throughout Iraq and Turkey. A few Kurds in Iran practice Shiite Islam. In general, the status of Kurdish women is higher than in other Islamic cultures; women are not veiled, are more free to associate with men, and they may even occupy political offices. In addition to Islam, there are also converts to Judaism and Christianity throughout Kurdistan.

Social Relations

Kurds tend to be strongly clanish in their social organization, organized around a male descendent. This is especially true of those descended from important political figures; overall there is much reverence paid to ancestors. Villages are often identified along extended family lines. To protect clan resources, intravillage marriage is preferred; in fact, first cousin marriage is common. Polygyny of up to four wives is allowed by Islamic as well as cultural mores, but is not common. Marriages were frequently arranged in the past, although this custom is beginning to wane. However, family agreement is mandatory, and the exchange of goods, including bride-price, and other ceremonial visits are still practiced according to tradition. "Exchange" marriages are also common in poorer families to save the expenses: a son and daughter from one family marry a daughter and son in another family. After marriage, the woman comes to live with the groom's family. Women retain their names at marriage, but children are named after the male line. Specifically, children traditionally receive as a last name the paternal grandfather's given name. It should be noted that some resettled refugees are now adopting American-styled naming at marriage and birth; some are even involved in legal name-changing. There is a strong emphasis on large families, and a preference toward males, at least in Kurdistan; not only is birth control considered amoral according to Islamic law, but having a large number of offspring guarantees the family line and provides workers for the homestead.

There are several important holidays in Kurdish culture. For one, the birth of a child is celebrated by a feast given by the parents and their family. Newborn boys are typically circumcized within the first month or two. Birthdays are not widely observed, except perhaps for U.S.-born children. The most important holiday is Kurdish New Year (newroz), on March 21, celebrating an ancient Kurdish legend marking the independence of Kurds. Kurds also observe the religious period of Ramadan, although the strictness of adherence to the rules on fasting vary considerably according to their orthodoxy.

Politically, Kurds are fractionated into several political parties. In Iraq, the Kurdish Democratic Party, headed by Masoud Barzani, rivals the Patriotic Union of Kurdistan of Jalal Talabani and many other smaller political groups. These political factions have been engaged in bitter civil war in Iraq, and these divisions can carry over even to the country of resettlement. In Turkey, the main political party of Kurds is now known as the Worker's Party, PKK, which is considered a terrorist group by Turkey on account of its fiercely pro-independence stance.

Before the uprising of Kurds in 1990-91, people in cities and some from the countryside could access regional Government hospitals in Northern Iraq or even Baghdad. However, more recently, with political events in Iraq, even the modern hospitals suffer chronic shortages of medicines and supplies. In villages, Western health care continues to be rudimentary at best; for example, children from these areas rarely receive childhood immunizations.

Kurdish Home Remedies

In terms of non-Western or traditional remedies in Kurdistan, there are shops which sell different herbs, with the proprietors knowledgeable of treatments. However, there are only a few herbal treatments, for such conditions as stomach problems and kidney stones. For the latter, there are certain tree leaves which are made into tea and drunk on an empty stomach before breakfast. For fainting, which is believed to be brought on by a spirit, a raw onion is held under the nose, and also black ash may be applied to the forehead and cheeks. There are some leaves which grow wild that people put on wounds, described as a thick leaf with liquid inside. One can also put snow on the wounded area to stop bleeding and pain.

We learned of very few folk treatments for children. For fever, for example, only cold wet towels are used, together with a hand fan. In general, for treatment of diarrhea one gives soup or rice water, but withholds fats, meat and cheese, and tomatoes and grapes. Also can give raisins and yogurt, mixed with crushed ice or snow.

There is a curious folk illness in children, with the symptoms of severe stomach pain, decreased appetite, and back inflexibility. The belief is that umbilicus "falls down" into the abdomen.

Certain women have the ability to cure this illness by holding the child upside down and slapping the bottom of the feet. A similar hernia-like condition can affect adults, where the umbilicus is believed to be "dislocated" from lifting heavy objects or other strenuous work. A specialist can right the problem walking on the abdomen or vigorously massaging the abdomen by hand. This treatment is not considered a cure, however, as the condition often returns. One other illness that some specialists know how to cure is a broken or dislocated coccyx, described as "bent," which can be straightened through rectal digital manipulation.

Out of superstition, people may hide a pretty baby, to protect from "evil eye," which was described as like "electricity" that comes from eye of someone who covets your belongings; even a car or horse may be hidden for this reason. When a child or adult is believed to be suffering from the cast of "evil eye," a Imam can be called for a blessing.

While there do not appear to be any traditional healers in Kurdish culture (except for those specific treatments noted above), the ranking Islamic figure, the Imam, is seen to have curative power through his spirituality. For example, if a child goes out at night and gets scared from evil spirits, the Imam can rid the child of fear through a blessing. Also, there is a charm, a quarter-sized piece of lead, on which the Imam writes or scratches, something short like "Mohammed," and on the other side "Allah." This is only for babies and children, to provide protection from evil spirits.

Similarly, the Imam is particularly sought after for a certain childhood affliction, "alamk," from evil spirits, which is detected by rapid pulse in the neck and legs, headache, decreased appetite, and pallor. The Imam (or other knowledgeable laypersons) checks the pulse, recites appropriate verses from the Koran, and then blows air on the patient.

There is also a type of amulet for children and adults. The Imam writes verses from the Koran, especially verses dealing with spirits, folds the long strip of paper into triangle, and puts in a blue envelope (black for adults). It is not opened but rather hung from a string around the neck. Or, for headache treatment, it can be worn under the scarf, called "nevished." These amulets are very commonly worn by people with mental problems, in which case it is worn under the clothing. The Imam receives payment for these amulets, although sometimes he says God will pay him in the other world.

There is also a larger version, "basband," which provides protection from bullets and other dangerous things. It is put in leather for protection from water and sweat. It is often used to protect travellers going through unknown areas or places with bad spirits at night. Furthermore, its properties last indefinitely.

Birth, child-rearing, aging, etc.

During pregnancy, we learned of no food prescriptions or proscriptions. There is a generalized Islamic taboo against the sexing of a child ("only God should know"), but some old women say that a more rounded stomach in pregnancy means a female baby.

A midwife generally assists with birth and cuts the umbilical cord, the stump of which is then tied with a string. Until it falls off, the stump is kept clean with a crushed seed mixture (also can mix with onions), which the mother changes 1-2 times a day. In the postpartum, after 40 days, there is a special bath, where lead melted in water is poured over the woman to relieve her from bad spirits. There is a postpartum sexual taboo until that time.

While birth control was considered in violation of Islamic law in Kurdistan, this view is changing as some younger married Kurdish women are accepting birth control, especially the IUD and the pill, and we know of tubal ligations being requested by some women. Alternatively, infertility is a growing concern for young couples in this country, as such a high social value is placed on having children. To this extent, we know of several young couples who are attending an infertility clinic. This is a gray area for Islamic law. According to one Kurdish friend, infertility treatments that do involve laboratory conception are acceptable. Children outside of wedlock is still strictly taboo at this point. Abortion is still considered in extreme violation of Islamic law and Kurdish culture.

In Kurdistan villages, most babies were delivered by midwives; in the U.S., midwives are known among the community, but provide little more than comfort to the pregnant women. Husbands here commonly accompany their wives to the delivery room.

Virtually all newborns were breastfed in Kurdistan, for at least one year and sometimes longer. Weaning would always occur at subsequent conception, the belief being the milk in pregnancy not healthy for the nursing child. Here breastfeeding is still common for Kurdish women, but mixed feeding with formula and bottles is becoming common among those women who work. Breastfeeding women typically cover themselves with a scarf in public. Manual expression of milk is not considered appropriate. For childrearing, since there is an emphasis on large families, much of the responsibility for toddlers lies with older sisters and grandmothers; older boys are not typically involved in childcare. In general, female children are much more supervised than males.

On aging, elders in general are afforded great respect in Kurdish culture. In Islam, one is directed to afford the same care to one's aged parents as they cared for you in childhood. There is an Islamic expression that says, "If the parents do not forgive you, Allah will not forgive you." There is a Kurdish tradition that family gathers around a dying parent to ask for forgiveness. At death, the body is ritually washed by a Imam (for a male) or a devout older woman for females (who works under the direction of an Imam, reciting the correct Koranic verses, and the like) and covered with a white sheet, fitted to the body. This is typically done at a mosque but can be performed at a funeral home here. The body is then buried as soon as possible, typically the same day. The body is placed in the grave so that the head faces Mecca. At burial, family and friends gather, and the Imam recites from the Koran. Others read from the Koran as well, in the name of the deceased. In Kurdistan, a tape of certain verses from the Koran would be played continuously over loudspeakers. The funeral party then returns to the house of the deceased for prayers and a feast.

For at least three days to one week, the family stays at home to accept visitors. After seven days, the family prepares another feast for friends and villagers in order again to ask forgiveness for the deceased's past transgressions. This is followed by weekly graveyard visit to show respect and love, and a picture of the deceased is hung in the home. The holiday of Eid is also a time to visit the grave.

Health Risks in Refugees from the Middle East

Thalassemia

- Schistosomiasis
- Parasites (hookworm, amoebae, echinococcosis)
- Leprosy
- Tuberculosis
- PTSD

Recommended Laboratory and Other Tests for Refugees from the Middle East

- Nutritional assessment
- Stool for ova and parasites
- PPD

Hepatitis B surface antigen and hemoglobin or hematocrit should be considered.

Section eleven:

Laotian

Health Care Beliefs and Practices of Laotians Living in America

Laotian Refugees in New Hampshire

Resettlement of Laotian refugees began in late 1983 and continued through 1991. The largest number of Laotians was received in 1988 and was resettled principally in the Newmarket area. Some additional resettlement occurred in Manchester (15%) and Dover (15%) as well as through various church sponsorships throughout the state. Newmarket has since attracted many secondary Laotian migrants and now constitutes a sizable Laotian population in New England.

Little has been written about Laotian health care beliefs and practices in the Western world.

What has been written focuses almost exclusively on the Hmong, an ethnic group from the highlands of Laos and other areas of Southeast Asia. It is our sincere hope that readers of this material will send additional information, corrections, and any other material of interest to health care providers involved with first or second generation Laotians in the Western world. Although this work focuses on lowland Lao (*Lao Lum*), readers should note that there are other ethnic and cultural groups from Laos living in America, including the Hmong, Mien, Tai Dam, and ethnic Chinese from Laos.

Background

Laos is a landlocked country surrounded by China, Vietnam, Cambodia, and Thailand. From its beginnings in the sixth century A.D., Laos has been ruled by competing kings and foreign powers (Thailand, Japan, France). Full independence was achieved in 1954 with the end of France's colonial rule of Indochina. Years of conflict ensued and in 1975, the communist Pathet Lao emerged in control of the country. Both lowland Lao and Hmong refugees began fleeing to Thailand. Most of the resettlement in the U.S. occurred between 1975 and 1985, primarily in California, Iowa, Minnesota, Texas, and Washington.

Laotians have tended to live in tightly knit communities to a greater extent than most other refugees from Southeast Asia. In several states there are now rural or semi-rural communities in which Laotians live in a traditional mutually assisting social structure. Many of the adults work in nearby towns or cities, while elders live more or less traditional lives. As with other first generation refugees or immigrants, assimilation has been difficult for many older Laotians.

Religion

Most Laotians practice Theravada Buddhism. There are regional variations in Laotian Buddhism, generally according to the area of Laos from which a person originated. Northern Laotian Buddhism is influenced by Burmese Buddhism, while central and southern Laotian Buddhism is influenced by Khmer Buddhism. Many Laotians also practice a mix of Buddhism and Brahmanism or *Phram*. The practice of both, as well as belief in spirits is seen in the relatively common approach to shrines: Inside the home is reserved for the Buddhist shrine; while outside may be found what appears to be a spirit (*Phi*) house (small house or shrine on top of a pole or column). Offerings of food are to spirits, while offerings of flowers are to Phram. In any case,

what a person does in life rather than his or her beliefs is the central canon. There are also strong elements of animism found among many Laotians. It is of little use to try to determine exactly what beliefs or combination of beliefs a Laotian might hold. The beliefs and symbolism of the traditions and faiths are combined and adapted to one another with no conflict whatsoever. Overall, however, the basic tenets of Buddhism guide at least most traditional Laotians. These tenets include the Four Noble Truths:

- To live is to suffer (*dukkha*) - all sentient beings suffer.
- The cause of suffering is desire, e.g., for happiness, for life, for permanence, for cessation of suffering, and so on.
- To cease to suffer, one must cease to desire.
- Cessation of desire (enlightenment or nirvana) may occur by following the Eightfold Path of right thought, right resolve, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration.

To follow this path to enlightenment, it is necessary to become and remain a member of the *sangha*, i.e., a monk. Realistically, few (at least in this life) are able to effectively follow this path, hence there is a focus on rebirth to a better state based on merit or karma (*kamma*) - especially related to fulfilling responsibilities to society. The ethic of Buddhism is centered around the four "Palaces of Brahma" or virtuous attitudes: Loving-kindness, compassion, sympathetic joy, and equanimity.

Please note that although Buddhist temples or *Wats* have statues of the Buddha, according to the teachings of the Buddha, these are not to be worshipped. Rather, the teachings are to be followed. The same holds true for images of the Buddha worn around people's neck or displayed in their homes.

Health Care Beliefs and Practices

Background: Health care beliefs and practices are significantly related to Brahmanistic and animistic beliefs. Illness may be attributed to the loss of one of the thirty-two spirits (think also in terms of souls) thought to inhabit the body and maintain health. The loss of a spirit may be due to being startled when walking alone, having an accident, after travel, or other causes. As with other Southeast Asians, "winds" also play a role in health and illness and bringing the winds into balance restores health or well-being.

Laotian (and other Southeast Asian) views of physical and mental wellness are also tied to a person's ability to sleep and eat without difficulty. Moreover, in Asia, only poor people or strict vegetarians eat large amounts of vegetables. Those who can afford meat are inclined to eat beef more than fish or chicken. Some traditional or popular commercial medicines are intended to increase both appetite and sleep. With respect to types and amounts of foods consumed there are often important educational issues to address with Laotian patients - especially as life-span is extended among Laotians living in the Western world.

Access to care remains a significant problem for many Laotians. Barriers to obtaining and effectively utilizing health and other services include:

- Language barriers are often an issue for older Laotians, especially those from a rural background. Because health care situations present unique challenges in understanding and often fine points or gradations in decision-making, even the presence of a family member who speaks English and Laotian may not be sufficient for some circumstances.

- Cultural issues present a sometimes difficult to identify and understand problems in understanding. Laotians may not understand a Western health care system (a culture in itself) and Westerners may not understand Laotian culture. Once in the health care system, Laotians may experience deep feelings of isolation and a kind of cultural depersonalization.
- Transportation is often a problem when either all adults in a family are working or the family is poor.

Health histories may be incomplete for several reasons, the most basic of which is a reluctance to volunteer information. Such reluctance has its origin in a cultural value of privacy in personal matters, especially related to family, sexual, and illness (vulnerability) issues. Trust or its lack is a major issue. With trust based on relationships, one might assume that the history will evolve over time, rather be complete in one or two interviews.

In general, persons who are sick will look first to the family and/or community for understanding of the problem and treatment. Traditional treatments may be tried first; or, if the loss of spirit is thought to be the problem, a ceremony performed by a family member, elder, or, if possible, an *acharn* or teacher/healer. The purpose of the ceremony is to call the spirit back to the body. Another route of treatment is to go to the temple, where prayer and lustral water will be used to address the problem. The last resource is to seek treatment at a clinic or hospital. Note that traditional practices are often continued while utilizing western medicine.

Travel seems to bring increased vulnerability, hence spirits are called to the body before and after traveling. A family member may perform the ceremony before travel, but an *acharn* is preferred for the ceremony after travel as there is thought to be a high likelihood of spirits staying behind.

Most Laotians focus on acute illness and otherwise do not place high value on disease prevention and health promotion. Seeking health care from clinics or hospitals is usually deferred until family, community, and spiritual resources are exhausted. Using clinic or hospital as a last source of care, coupled with reticence in complaining results in some patients presenting with advanced illness.

Mental illness will in many cases be ascribed to spirit loss. To seek care from a Western source indicates the likelihood of an ongoing and very difficult problem. The issues that affect most other health problems are magnified in the case of mental illness. One can assume deep individual and family distress among Laotians seeking care for mental illness.

Traditional treatments or indigenous practices: The following treatments for illness include procedures similar to those used by other Southeast Asians:

- *Khout lom* or coining is the use of a coin and mentholated medicine to rub the chest, back, upper arms, or neck in one direction with resulting ecchymosis. This releases the "wind" that may be causing the illness.
- Pinching in a prescribed manner (rubbing the temples, pulling forward to the eyebrow and nose, and pinching the nose) is used to relieve headache.
- Cupping is performed by fixing a piece of cotton in the bottom of a glass, lighting the cotton on fire, and placing the open mouth of the glass on the sick person's back. This creates a vacuum (and contusion) and thus draws the wind from the body. In one session, the procedure is carried out three to four times bilaterally down the back on either side of the spine with six to eight circular contusions resulting.

- Massage and manipulation is performed by elders and others with knowledge of healing techniques.
- Traditional Lao medicines are available in America, with some of these found or grown locally. Most are classified as "cool" as opposed to western medicines which are usually classified as "hot." Gathering such substances includes prayer and other prescribed means of respectfully taking them from the earth or elsewhere. Most such medicines are imported from Thailand, Laos, or elsewhere in Southeast Asia.
- Chinese medicine is widely available from both stores and individuals. In some cases, the medicine or combinations of medicines are soaked or dissolved in vodka (called "wine") and thence consumed in small quantities. Commercial preparations from Asia and elsewhere are also used by many Laotians.

Spiritual healing practices: It will by now be obvious to readers that Laotian views of health, illness, and healing are complex and multidimensional, and encompass to a very strong degree, spiritual components. Spiritual or spirit-based practices are related to *Phram* beliefs rather than Buddhism, but many of these practices will occur in the context of Buddhism. Evidence of the spiritual or spirit components is seen in several phenomena:

- The involvement of monks and *acharn*, as well as family in spirit-based practices is seen throughout illness and health-related aspects of life such as birth and death.
- Some Laotians wear *katha* (or *katout*), which is a string passed through a small cylinder or cylinders of gold or brass. The metal is inscribed with Pali prayers called *To Dham*. These are not viewed as decorative jewelry, but as potent and sacred talismans which are made by monks or holy men. *Yarn* refers to the magical protective tattoos found on the chest, back, and arms of some men; or to pictures and words on fabric which may be carried or put over a door. Buddha or bodhisatva images are worn on a chain around the neck by some Laotians.
- One will sometimes encounter Laotians with one or more pieces of string tied around the wrist. This also has spiritual and protective meaning and derives from a practice in Laos of wearing around the wrist twisted palm leaf on which is written *To Dham*. These are thought to prevent loss of spirits.
- A small bag worn on a string around the neck is called *haksa*. The *haksa* is given by parents or grandparents and affords protection to the wearer.

In general - as is so with people of any culture - health care providers should be aware that traditional practices and beliefs of Laotians are dynamic and changing. In some cases, there may be little or no reliance on traditional practices. In other cases, illness will result in a turning back to more traditional practices, especially as it becomes apparent that Western medicine does not have all the answers.

Interacting with Laotians

Healthcare issues: Respect for individuals, families, and the culture is critical. Respect includes being polite as most people might define politeness. Respect also encompasses respecting the privacy of individuals, families, and the culture. Thus health care providers might avoid asking questions that are not germane to the problem at hand - especially in early stages of the relationship. Except when vital, personal questions are best deferred until there is a working relationship. When a personal question is necessary, it might be prefaced with assurance that the

question and answer are not for public discussion. If the information will not be charted, one might say, "This is between you and me. I will not talk about this with anyone else."

Respect also includes explaining procedures and medicines to patients. Traditional medicines are mixed, dosed, and prepared according to individual patient needs. That same model may be expected of Western medicines. It is thus a good idea to explain medications and dosing on an individual basis. Even for patients with limited English skill, it is wise to write (print or type) instructions for medications or treatments. The patient may not read the information, but he or she will find someone in the community who will read and explain what is written.

Some Laotians value the relating of symptoms more than the health history. Explaining links between questions or problems will help in eliciting information. Falling back on the relationship may also help. One might say, "Remember as much as possible. Help me." Regardless of what techniques are used, remember that the history will evolve over time as the relationship (hopefully) evolves.

When there is a terminal illness, it is usually a good idea to ask the patient how much he or she wants to know about the diagnosis and prognosis. The entire family will want to be present for the patient's last days. If the patient is hospitalized and is Buddhist, they should be told directly that a monk will be welcomed by the institution. The presence of a monk is helpful to the patient and the family.

A Laotian proverb: Nobody can control when a woman delivers a baby. Nobody can control when a monk disrobes (leaves the *sangha*). And nobody can control when a person dies. There may thus be an acceptance of fate with the perspective that what happens now is all related to the past (including past life) and whatever one is born to is what one is born to.

Social issues: As noted earlier, significant numbers of Laotians have created more or less traditional communities in the U.S. The extended family is the central social unit within the community. Home and family are headed by the husband or oldest man, with elders of both sexes given great respect. Some health care decisions will be made by an elder rather than the patient - even when the patient is an adult. Physicians have great status, and health care providers may note that older patients will listen to a physician to a greater extent than a younger family member.

When visiting a Laotian home one should note the shoes lined up just outside or inside the front door and despite being told "never mind" go ahead and remove the shoes before going into the home. Many homes will have both a mat on the floor and chairs, a couch, etc. It is well to sit on or below the level of the oldest person there. In other words, if an older person is sitting on the floor it is impolite for the visitor to sit in a chair.

Laotians tend to be reserved in most interactions (and all health care interactions). Effusiveness and expression of strong feelings - including strong positive feelings - is not valued. Fussing over and complementing children and infants is not good form. In the case of infants, praise and complements may bring ill fortune; and with children, result in self-centeredness. Children should remain quiet and respectful in interactions with elders, including visitors. As much as possible do not use children to translate for adults. Doing so puts both parties in an untenable social situation of the child showing superiority to the adult.

The head is the highest (literally and figuratively) and thus one should not touch another's head, and preferably not his or her shoulder either. It is also impolite to point one's foot at another or sit with one leg crossed over the other so that the bottom of the foot or toe is pointed toward

another. It is generally understood that it is necessary to touch other people's head during the course of some physical examinations.

Modesty is highly valued, especially in women from waist to knees - and most especially in younger women. Double gowning of hospitalized patients should be practiced as much as possible. Pelvic examinations of unmarried women should not be a routine practice, especially by male providers. In part because of issues of modesty, we find resistance to breast self exams among Laotian women. Please see our work on cancer screening for other barriers to BSEs. The traditional means of salutation (coming or going) is called *wai*, which involves placing one's hands together as if praying and inclining the head. The height at which the hands are held depends on the social or spiritual status of the person being greeted, with the hands held higher for persons of greater status. Western greetings are well accepted, except that many women are not comfortable shaking hands with men.

As noted at the beginning of this work, we present this information with the sincere hope that it will be helpful to nurses, physicians, social workers, and others seeking to provide quality services to Laotians. We ask that readers contact us if they see a need for additional information or wish a correction made. We are thankful for the presence of the Laotian people in the United States and we pray for peace and freedom in Laos.

Health Risks in Refugees from Asia

- Nutritional deficits
- Hepatitis B
- Tuberculosis
- Parasites (roundworm, hookworm, filaria, flukes, amoebae, giardia)
- Malaria
- HIV
- Hansen's disease
- PTSD

Recommended Laboratory and Other Tests for Refugees from Asia

- Nutritional assessment
- Stool for ova and parasites
- Hemoglobin or hematocrit
- PPD

VDRL should be considered

Authors: Leck Keovilay and Charles Kemp

Section twelve:

Liberian

Liberian Refugees and Immigrants

Liberian Refugees in New Hampshire

37 Liberian refugees have been resettled in New Hampshire since 1997 in the communities of Peterborough, Manchester and Concord.

Introduction

Liberia is a diverse country, and one that has undergone rapid socio-cultural change even in the last 25 years. This makes generalizations about "Liberian people" and "Liberian culture" somewhat difficult and overly simplistic. A Liberian from the capital city, for example, may feel much closer to American culture than to that of someone from the rural hinterland. All Liberians have, however, been touched in some way by the incredibly bloody conflict that was the Liberian civil war. The following is written in an attempt to share some of the common experiences Liberians suffered during their war and elucidate some of the social and cultural responses to it. Liberia is located on the "grain coast" of West Africa, between 6 and 9 degrees north of the equator, bordering Sierra Leone, Ivory Coast, and Guinea. It has vast resources of iron ore, timber, diamonds, and gold, but due to both the conflict and widespread corruption, most Liberians have never benefited from these. There are approximately 16 different ethnic groups indigenous to the country, including Kpelle, Bassa, Gio, Kru, Grebo, Mano, Krahn, Gola, Gbandi, Loma, Kissi, Vai, and Bella. "Americo-Liberians" (those descended from former slaves) compose about 5% of the population. Infant mortality rates in the country are high, estimated at 108.1 deaths / 1,000 live births (CIA World Factbook 1996). Life expectancy at birth is 56 years for men; 61 years for women. The average woman bears 6.23 children in her lifetime. Literacy rate for those older than 15 years is 53.9% for men, but only 22.4% for women.

A Brief History of the Conflict in Liberia

The Liberian conflict has early historical roots when freed American slaves resettled on the coast of West Africa in the 1820's. The settlers generally regarded themselves as superior to the "tribal" peoples of the interior, and over time established civil controls to bring rural areas increasingly under centralized control, located in the coastal capital Monrovia. The national army became the main tool to enforce this control. By the 1970's, Liberian presidents came under increasing political pressure to reform, yet the entrenched political patronage system that had developed, coupled with a depressed worldwide economy, made reforms ineffective.

In 1980, an uneducated junior officer in the army, Samuel Doe, led a coup with the support of his own Krahn ethnic base. Instead of instituting wide-ranging reforms, however, Doe began using the state solely as a means of personal enrichment. The Doe years are remembered by most Liberians as being particularly repressive - not merely brutal, but "marauding six years of rape and plunder by armed marauders whose ideology is to search for cash and whose ambition it is to retain power and accumulate and protect wealth" (Sawyer, 1995, p. 176). To maintain a personal grip on power, Doe armed the Krahn and Mandingo ethnic groups under the guise of the Armed Forces of Liberia (AFL) to spread terror into the countryside.

In 1989, Charles Taylor, an American-educated Liberian economist trained in guerrilla warfare in Libya and head of the National Patriotic Front of Liberia (NPFL), crossed into Liberia, and began to attack government troops. The Doe government had become so hated that the Gio and Mano peoples of the county reacted very positively to Taylor, and violence began to spread out

of control. Armed bands claiming allegiance to the NPFL began to engage in ethnic violence against anyone suspected of being Krahn or Mandingo. Doe was eventually caught by a splinter NPFL group, and graphically mutilated on videotape, the sale of which spread all over West Africa.

In 1990, the Nigerian-led peace keeping force ECOMOG landed in Monrovia in an attempt to hold the capital as a "safe one." A third faction was formed in 1991 by Liberians who had taken refuge in neighboring Sierra Leone, and became known as the United Liberation Movement for Democracy (ULIMO). So many civilians were armed (the UN estimates 60,000) that the leaders were unable to completely control their own elements. None of the militias could pay their forces regularly, so the fighters had to subsist on what resources they could procure by gun. The simultaneous break-up of the Soviet Union ensured a cheap and steady supply of automatic weapons (Kalashnikov rifles or AK-47s could once be bought in Liberia for between \$9-\$18 US). Most fighters were young, and settled in the resource-rich areas of the country, especially diamond-producing areas, agricultural areas, or places where humanitarian-aid convoys could be looted. They commonly used forced-labor to work for them, in agriculture, mining, cooking, or transporting and selling looted goods.

In 1993, 600 displaced people, mostly women and children, were massacred at the "Harbel" displaced-persons camp on the Firestone Rubber Plantation. This increased domestic and international pressure for a series of signed cease-fires, which, though never really effective, eventually did allow for country-wide elections in July 1997. As he had controlled most of the countryside of Liberia for much of the previous eight years, Charles Taylor easily won these, to become the newest Liberian President.

In the 8 years of conflict, over 150,000 people have died, or one out of every 17 Liberians. Many of Liberia's once 2.5 million people were forced to flee from their homes, giving Liberia the largest percentage of refugees and internally displaced people in the world. Although efforts have been made to disarm the warring factions, many feel that renewed fighting will remain a possibility for quite some time. Liberians are optimistic about reforms now being attempted, but the scars of distrust are deep.

Violence Against Women During the War

As is often the case in refugee-producing situations, women have been especially affected by war-related violence. Many were forced into sex during the conflict in order to feed themselves or their family, to get shelter or clothing, or for protection and safety. In one survey documented by the American Medical Association, 49% report experiencing one act of physical or sexual violence from a soldier or fighter during the war; 32% report they had been strip-searched; 17% report being locked-up, tied, or beaten; 15% report they had been raped; and 42% say they had witnessed a soldier kill or rape someone else (Swiss et al, 1998).

Extreme sensitivity should be taken in asking female patients about sex. Especially older Liberian women may even feel it inappropriate to be questioned about sex by a younger person. In addition, issues of "rape" carry considerable social stigma. The word itself may not be an exactly-translatable term into Liberian-English, hence one should use more general terms like "forced sex." Sensitive questioning should be prefaced by deferential remarks, such as "Excuse me, Ma, but . . ."

Communication and Health Care

Even though English is the "official" language of Liberia, important semantic differences exist between "Liberian English" and "American English" that necessitate extreme care in communication. For instance, seemingly simple and straightforward questions like "what has your child eaten today?" may often elicit a false negative answer. In this case it is necessary to understand the cultural context of "eating" in Liberia, in which the word "food" is often taken to mean "rice." Rice is THE staple food in Liberia, and "to eat" literally translates into Liberian English as "to eat rice." One researcher quotes a Gbande man: "A Gbande may eat bread, potatoes, cassava, plantain, or yams, and still consider himself virtually starved for lack of food if he has not had his bowl of rice" (Jarosz 1990).

It is recommended that, in case of any doubt, an interviewer use the most general term possible (Jarosz, for instance, in a nutritional survey, had to alter her wording to "Tell me everything you gave the baby from the time the baby woke up yesterday morning until the time the baby woke up today" (Jarosz, 1990).

Health Concerns and Beliefs

Infectious Diseases

Liberians in the U.S. or Europe are no more likely to suffer from endemic West African diseases than anyone else, although there is a high incidence of the sickle-cell gene. Liberians just arriving or visiting from West Africa, however, may suffer from a variety of tropical ailments, including latent schistosomiasis, chloroquine-resistant malaria, yellow fever, cholera, typhoid fever, hepatitis A or B, or STD's (especially gonorrhea, syphilis, Pelvic Inflammatory Disease/PID, or chancroid).

Nutrition and Body Weight

Especially Liberians from rural areas may have different body-imagery than the "ideal" lean Western type. A "healthy" body in Liberia is perceived as a stout one, and is also associated with wealth and prosperity; the stereotypical Liberian "big man" politician would probably be seen as obese and at-risk for heart disease by a Western nutritionist. The palm oil that Liberians prefer to cook their food with is high in saturated fats, but also high in vitamins.

Traditional Medicines

The use of indigenous medicines in Liberia is extremely common, and most individuals have some knowledge of certain plants that may be self-applied in times of sickness. Liberians also have an assortment of indigenous healers, or "native doctors," including herbalists, Muslim holy men, bone specialists, and increasingly, faith healers. The treatments are often complex rituals. For example, in bone-setting a patient's fracture, the leg of a live chicken is broken at same time. The practitioner then treats both fractures: oil is rubbed over the site, and small twigs are then wrapped around the wound, which has been covered in a chalky poultice. At the time that the chicken leg is healed, the patient is believed to be healed too, and the poultice removed. Most Liberians see no discrepancy in attributing the etiology of disease to both naturalistic (biological) and supernatural causes. The question of immediate "cause" may be commonsensical or biological, but the "why did this occur to me" may be attributable to sorcery, taboo violation, or some form of contagion (especially from breeze, cold, water, or dreaming). Consequently, Liberian refugees may commonly combine indigenous and biomedical forms of treatment simultaneously. If a physician suspects indigenous medication may be interfering with

his/her own prescribed treatment, the person in charge of decision-making for the sick person (perhaps a family head) may be sensitively asked what other forms of treatment are being concurrently given. Stay away from making value-judgments about the efficacy of the other treatment, as this may simply result in false information being given.

Sexually Transmitted Diseases

It would not be at all unexpected for recent Liberian refugees to suffer from STDs, as poverty and lack of economic opportunity can cause sexual diseases to be quite rampant in camps (see Henry 1998). In Liberia, STDs are most often treated by oneself or by non-Western or "traditional" healers, typically herbalists or Muslim holy men, who may enjoy wide respect for their abilities. The medications are most often ointments or teas, though less commonly an enema or vaginal implant may be used.

Condoms are not widely used among Liberians, for reasons of in-country accessibility and/ or widely held popular beliefs, such as that the condom may "slip off" during use and cause internal complications. Even in refugee camps with access to some degree of health services, condoms are often not practically available, or may be sold at a cost preclusive for the average "cash-poor" refugee to afford.

Female Issues

Female "circumcision" or "female genital mutilation" (FGM) is quite common in Liberia, and is practiced by an estimated 95% of all Liberian women (also see editor's note below). Obviously this is a sensitive topic, and one replete with highly charged emotional arguments from all sides "for" and "against." Westerners, and increasingly urbanized African women, decry the health effects of the operation, and the "humiliation" and "degradation" they interpret these women as suffering. Liberian women, however, typically view attempts to ban the practice as a direct assault on women and the highly secretive women's *Sande* society. This society is the only indigenous organization where Liberian women exert power in their own right without male interference. It is quite possible that a physician may be asked discreetly by a Liberian woman to perform this for her girl child. For a physician to personally decide how to respond to such requests, it becomes necessary, then, to understand the cultural context in which such a procedure takes place. In Liberia, a circumcised woman is considered a part of the women's society, a "clean" and "proper" adult eligible for marriage, capable of child-bearing, and eventually able to hold important societal offices.

FGM is performed in Liberia by the older "*Zoes*", the respected elders of the women's society. A *Zoe* usually also functions as a midwife, and typically commands considerable influence and respect in the community she serves. There are two main types of female circumcision practiced in Liberia: 1) Excision where the clitoris, and the labia minora are removed leaving the labia majora intact, and 2) Clitoridectomy only the clitoris is removed, leaving the labia majora and minora intact. FGM may be performed on a girl as early as age 3, but more often when they are immediately pre-pubescent. (Note: several states in the U.S. and other Western countries have passed legislation outlawing the practice of female circumcision.)

Editor's note: The above is written from the perspective of the article's authors. Out of respect to the authors, no editing was done on that section. Out of respect to women, I want to note (as the authors noted), that there is an increasing recognition in both Western and African quarters that female genital cutting is in no way beneficial to women. It is unlikely that all Liberian

women view measures to prohibit the procedure as "an assault on women." The procedure is painful and there are health risks from infection as well as long-term problems. The bottom-line purpose of the procedure is to deny women sexual pleasure and thus enforce fidelity. As of January 18, 1999, female genital cutting is banned in Burkina Faso, Central African Republic, Djibouti, Ghana, Guinea, Togo, Egypt, and most recently, in Senegal. The executive director of UNICEF said, "Senegal's action is of great significance because it reflects the resolve of African women to end a cruel and unacceptable practice which violates the rights of girls to free, safe, and healthy lives" (New York Times, 1/18/99, p. A7). A web site concerned with the issue is <http://www.fgm.org/>. C. Kemp

Common Medical Problems

Problems seen most commonly in newly arriving refugees from Liberia and other African countries (Ackerman, 1997; Gavagan & Brodyaga, 1998) are:

- Malnutrition
- Intestinal parasites (Enterobius, Trichuris, Strongyloides, and Ascaris)
- Filariasis
- Leishmaniasis
- Hepatitis B
- Tuberculosis
- Low immunization rate
- Dental caries
- Typhoid fever
- Malaria
- Trachoma
- Syphilis
- Dengue fever
- HIV infection
- Diarrheal illnesses
- Hansen's disease

Recommended laboratory and other tests include:

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD

Peripheral smear for malaria should be considered. Other problems that practitioners should be especially alert to are cervical cancer, ectoparasites, and post-traumatic stress disorder.

Authors: Doug Henry and Lance A. Rasbridge

Edited by Charles Kemp

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Section thirteen:
Nigerian

Nigerian Refugees and Immigrants

Nigerian Refugees in New Hampshire

Nigerian refugees were resettled in 1996 and then again in 1998 and 99. The majority of Nigerians were resettled in Manchester (60) and a single family in Concord.

Background on Country of Origin

Nigeria is the most populous black nation in Africa with an estimated 112 million people. Nigeria is located on the West Coast of Africa, along the Gulf of Guinea, occupying approximately 356,670 square miles (slightly larger than twice the size of the state of California). The country is a federal republic consisting of 30 states, and 543 local governments. Nigerians capital city, Abuja, is located in the center of the country.

In 1960, Nigerian achieved independence from British rule and a relatively peaceful and prosperous time followed. However, the large agricultural sector failed to keep up with the rapid population growth, and Nigeria, once a large exporter, now has to import food. Nigeria has large oil reserves, but since 1973 oil profits have diminished at a rapid rate, due first to political instability, and later to falling oil prices. A western style democracy was attempted in 1979, but collapsed in 1983. In 1993, attempts were made to restore the 1979 constitution, but this also failed. Currently, a repressive military regime controls the country.

The People

Nigeria is a complex cultural, linguistic, and social mosaic with over 250 ethnic groups speaking many different languages and dialects. Members of each ethnic group are typically concentrated in one area; however, many have migrated to urban areas, thus producing modern cities composed of mixed ethnic groups, with problems sometimes resulting. Ethnic rivalry and jealousies exist as part of the Nigerian culture although many ethnic groups are related to one another in some way.

Nigerians are basically classified into two groups: (1) Nilotic Africans (Arab-type) and (2) Black Africans; and the various ethnic groups fall into one of these two categories. There are four main groups of people in Nigeria, the Hausa (21%), Yoruba (20%), Ibo (17%), and Fulani (9%). The average population density in 1991 was 248 people per square mile, and approximately 35% of the total population lives in urban areas.

Major Ethnic Groups

Hausa-Fulani: Found predominantly in the northern states of Sokoto, Katsina, Kano, Bauchi, and Kaduna. Most are Muslim with their culture being greatly influenced by their religion. Their age-long traditions of testing manhood and the giving away young girls for marriage is still observed.

Yoruba: Found in southwestern Nigeria and most live in the states of Lagos, Ogun, Oyo, Ondo, Kwara, and part of Edo. Many are highly urbanized, but retain strong kinship bonds.

Ibo: Found in the southeast states of Anambra, Imo, Abia, part of Delt, and part of Cross River. The Ibo are known for their hard work and resourcefulness. Traditionally farmers, today a significant number of them have become traders.

Edo: This group is found in Benin (Edo) state.

Ijo: (also known as Zons): Found in the riverine areas of Ondo, Delta, and Rivers states. They are basically fishers with their home made on stilts over the water.

Ibibio: Found principally in mainland Akwa Ibom.

Kanuri: This group is found in Borno state. They have a long history and tradition as old as the Fulanis, but are found at the opposite end of the country.

Jukun: This group is known for being war-like and live primarily in Gongola and Benue states.

Nupes: Most live in the Niger state.

Note: There are many other smaller groups who are identified with either their tribal marks (scarring) or their mode of dressing. With modernization and intertribal marriage, many traditional ties and practices are changing or being lost.

History of Immigration

Immigrants to Nigeria are drawn from neighboring nations by economic opportunity. In 1983 Nigeria ordered all resident aliens to leave the country, ostensibly because of economic conditions. At that time about 700,000 Ghanaians left, along with many others from African and Asian countries. Since then, Nigerians have immigrated in large numbers to Europe and North America. In the 1990s, a few Nigerians came to Western countries as political refugees. Some of these refugees experienced extreme repression and torture.

Culture and Social Relations

Allegiance to family and kinship systems, as well as to village is strong. Marriage often occurs at an early age (at least for females) and childbearing also begins at an early age. Polygamy is legal and practiced in Nigeria, but there are decreasing numbers of polygamous relationships. Wealthy and/or powerful men tend to have more wives (as many as six or seven ñ which exceeds the limit of four imposed by Islam). Men are dominant among Muslims, Christians, and those who practice traditional religions.

In Nigeria, families tend to live together in one village or area of a town. Mothers are the primary care givers in the family, but receive help and support from the extended family. In most families men are dominant and make most of the decisions. The extended family system and the community have been an important support to parents. This traditional support for families is changing as a result of families moving from rural to urban areas in search of work or educational opportunities.

In Nigeria, significant numbers of children do not go beyond elementary school. Among Nigerians living in the west, however, the usual expectation is that children will graduate from college.

Communications

Although English is the official language, there are over 250 different languages spoken in Nigeria. The most widely spoken language is Hausa.

At least among immigrants and when interacting with westerners, Nigerians usually are soft-spoken. In contrast to some other refugee or immigrant groups, there is a tendency among some Nigerians to be very insistent about receiving services to which they feel entitled.

Religion

There is no state religion. About 50% of Nigerians are Muslim and 40% are Christian. The range of commitment, belief, and practice varies in each religion. Although most people practice Islam or Christianity, many also engage in practices derived from indigenous (traditional) religions. Islam is a monotheistic faith, i.e., belief in one God, Allah. It is based on the Qur'an which is considered to be the final and complete inspired word of God revealed to the prophet Mohamed by the angel Gabriel. The Qur'an is the authoritative scripture of Islam and along with the Hadiths (the Says and Doings of the Prophet Mohamed) is used as a guide for all matters of faith

and practice. All Muslims are expected to believe and practice the Five Articles of Faith and the Five Pillars of Faith. Islam is described in greater detail in the section on religions.

Health Care Practices and Beliefs

Traditional healers (sometimes called "surgeons") in Nigeria often focus on maintaining a balance between the invisible world of the deities, ancestral spirits of good or evil, and other beings inhabiting the "other" world. Spirit causation remains a significant part of the traditional medical system, and the presence of disease or illness may be seen as a warning sign that there is an imbalance with either the natural or the spirit world.

Traditional (magic or spirit-oriented) healers are thought by some Nigerians to belong to a special species of human beings with mystical powers and attributes, including the ability to commune with the spirit world and seeing through walls. Traditional medicine is often preferred over modern health-care practices ñ especially for culture-bound disorders such as "Ode Ori" (a disorder that includes a variety of somatic complaints, as well as symptoms of depression and anxiety). Modern-health care facilities are often sought as a secondary source of care, when traditional methods of healing have failed.

There also is widespread use of medicinal plants to treat illness in Nigeria. Studies of such plants, including those used for peptic ulcer, asthma, pain, and other problems show significant degrees of efficacy for many treatments. Other treatments, e.g., inducing vomiting or giving cow urine to treat upper respiratory infections, are harmful.

Among Nigerians in the west, these traditional beliefs seems much less an issue. Illness and health are seen as biomedical issues and treatment in clinics and hospitals is readily sought. One interesting and common belief among Nigerians is that epilepsy is a communicable disease, hence persons with epilepsy should be avoided.

Approximately 50% of adult Nigerian women have undergone female genital cutting during infancy, usually clitoridectomy. The practice is decreasing significantly, especially among urban women. Unsafe abortions are common in Nigeria and are a significant source of morbidity and mortality among younger women. Natural and traditional methods of contraception are preferred over barrier or artificial means.

Traditional Nigerian diets are high in fats and more traditionally minded persons view obesity as positive.

Health Care Problems and Issues of Nigerians in the West

Long-term sequelae of diseases endemic to Nigeria should be a concern when providing health care to newly arrived Nigerian immigrants or refugees in the west. Among the more common tropical diseases in Nigerian are:

- Onchocerciasis (a form of filariasis; also called river blindness) causes eye lesions/blindness, subcutaneous nodules, and pruritic rash. Onchocerciasis is caused by black flies (river flies) and is seldom seen outside of Africa and Latin America.
- Schistosomiasis causes obstruction, dysfunction, and pain in any of the many organs/systems that may be affected, including gastrointestinal, respiratory, genitourinary, hepatic, and other. Schistosomiasis is caused by freshwater parasites (flukes) living in feces-contaminated water. Flukes may live in a particular part of the host for as long as 20 years laying eggs and causing organ damage, especially in mucous membranes.
- Yellow fever occurs in Africa, but is unlikely to be seen in North America as the incubation period is 3-6 days. It is transmitted by mosquitoes and symptoms range from

mild flu-like symptoms to headache, fever, jaundice, nausea, vomiting, and hemorrhage (epitaxis, bleeding gums, hematemesis, or melena).

- Malaria is endemic to much of Africa Asia, and Latin America. The classic symptoms are severe fever, chills, sweats, and headache. In some case symptoms may not be as severe, and may also include diarrhea, abdominal pain, dyspnea, and myalgia. Splenomegaly is common. Less commonly, a grave condition, including hemolysis, jaundice, anemia, renal failure, and hemoglobinuria may also occur. Relapse occurs, but is less common in patients with the falciparum form of malaria common in Africa.

HIV and other STDs are common in Nigeria. Nigerian men have a high incidence of prostate cancer. Because of traditional diet patterns, the relative prosperity of Nigerians in the west, and other risk factors, cardiovascular disorders should become common among Nigerian men and women; and diabetes should also be a concern as middle age approaches.

Medical problems most commonly seen in newly arriving refugees from African countries (Ackerman, 1997; Gavagan & Brodyaga, 1998) are noted below.

- Malnutrition
- Intestinal parasites (*Enterobius, Trichuris, Strongyloides, and Ascaris*)
- Filariasis
- Leishmaniasis
- Hepatitis B
- Tuberculosis
- Low immunization rate
- Dental caries
- Typhoid fever
- Malaria
- Trachoma
- Syphilis
- Dengue fever
- HIV infection
- Diarrheal illnesses
- Hansen's disease

Recommended laboratory and other tests include:

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD
- Peripheral smear for malaria should be considered

Other problems that practitioners should be especially alert to are cervical cancer, ectoparasites, and post-traumatic stress disorder.

Authors: Mindy Early, Sharon McKinney, & Jenny Murray (Baylor University School of Nursing)

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Section fourteen:
Somali

Refugees from Somalia

Somali Refugees in New Hampshire

Somali refugees have been resettled in Manchester (17), Concord (13) and Laconia (2).

History

Like many other African countries, the area inhabited by ethnic Somalis has experienced great divisiveness since at least the mid-1800's, when the area was carved into multiple territories. France controlled the north, now known as Djibouti, Britain and Italy colonized areas further south, and still other regions were under the rule of neighboring Kenya and Ethiopia. In 1960, the Italian and British areas were united into an independent Somalia, and in 1977 Djibouti became a separate nation after receiving independence from France. The regions of Kenya and Ethiopia which contain large numbers of ethnic Somalis are sources of border disputes presently. The anti-colonial, pro-Soviet civilian government formed at independence was toppled in a coup led by General Mohammed Siad Barre in 1969. While popular at first, Barre's regime became increasingly oppressive and autocratic, leading to the birth of clan-based opposition militias. In 1988, full scale civil war broke out, leading to Barre's exile in 1991. However, up to the present, the clans have continued the bloody war amongst themselves, with no government being established. The continuous warfare, together with border clashes, has brought the Somali economy to near collapse. Mass starvation has ensued, and the level of inter-clan violence has become extreme, with rape and torture commonplace. An estimated 400,000 Somalis died during this period, and at least 45% of the population has been displaced by the fighting. Humanitarian relief forces from the U.N. and the U.S. attempted to intervene, but by Spring of 1994 all foreign troops had been withdrawn due to the instability.

Beginning in 1991, at least one million Somalis fled to the neighboring countries of Djibouti, Kenya, Ethiopia, Burundi and Yemen, adding to the already overwhelming populations of refugees in the Horn of Africa. While most remain in refugee camps, some numbers have been repatriated, and several thousand have been resettled to the U.S. and Europe. In particular, certain clan-based ethnic groups, the Benadir and the Barawans, have been selectively resettled en masse.

Language

Somali is the common language of Somalia, and since Islam is so widespread, Arabic is spoken by many Somalis. Additionally, educated Somalis are frequently conversant in Italian, English, and/or Russian, depending on their experiences with the former colonial powers. Some Somalis near Kenya can also speak Swahili.

Social Structure

While Islam and the Somali language unite all of Somalia, the societal structure is markedly fractionated by membership in patrilineal clans (descent through male lines). There are a few main clans, and multiple subclans, sometimes with geographical and even social class orientation. For example, the Benadir clan group is comprised mostly of merchants and artisans living in southern coastal areas. Another recently arrived group, the Barawans, lived in the Kismayu area, where they were predominantly fisherman and small-scale artisans like shoe cobblers. Much of the current strife in Somalia is centered around clan disputes, as allegiance to the clan far outweighs allegiance to a united Somalia.

Religion

Somalis almost universally can be categorized by their strong adherence to Islam, the Sunni sect in particular. Accordingly, the Islam religion shapes many aspects of Somali culture. For example, there is strict separation of the sexes, and women, including sometimes prepubescent girls, are expected to cover their bodies, including hair, when in public; facial veiling is uncommon in the U.S. However, women in Somali culture have considerable status, and many resettled refugee women are highly educated and held professional positions inside Somalia. Handshakes are appropriate only between men or between women. The right hand is considered clean, and is used for eating, handshaking, and the like; children are taught early to use only their left hand for hygiene during toilet training. Even in the U.S., Muslims prefer to wash with poured water after a bowel movement. Ritual cleaning of the body, especially before prayers, is dictated by Islam.

Devout Muslims pray five times a day to Allah; in reality, schedules in the U.S. do not always permit this. The most important holidays include Ramadan, where adherents fast from sunrise to sunset (pregnant women, the infirm, and children are typically exempt), and Eid, a social celebration which marks the end of the fast. Many religious holidays and events are marked by the ritualized sacrifice of a goat or lamb; sometimes resettled Somalis arrange for this practice through rural farmers. Islam particularly proscribes the consumption of alcohol and pork. Birthdays are not particularly celebrated by Somalis, and it is not uncommon for people to not know the exact date of their birth. At the time of immigration, birthdays are typically rounded off to the nearest year, e.g. 1-1-98, 12-31-62, etc. Alternatively, the anniversary of family members' deaths are observed and celebrated.

When death is imminent, a Muslim cleric, a sheik, is summoned to pray for the person's soul and recite special verses from the Koran. After death, the body is ritually cleansed and clad in white clothes for burial.

Traditional Medical Practices

There are traditional medical practitioners in Somalia, especially herbalists, bone-setters and religious practitioners. Herbal medicines are widely used in Somalia, especially for chest and abdominal symptoms; the herbal pharmacopeia is vast, and some recipes are closely guarded by practitioners. Healers treat psychosomatic disorders, sexually transmitted diseases, respiratory and digestive diseases, and snake and other reptile bites.

Another common practice is termed "fire-burning," where a special stick is burned and then applied to the skin. Concepts involving spirits, such as "evil-eye," where excessive praise or attention can attract evil spirits to an infant or child, can be viewed as causing illness. Ritualized dancing is used mostly for psychosomatic disorders, and Koranic cures as well. There is understanding about the communicability of some diseases, such as tuberculosis and leprosy, and isolation is sometimes performed.

Prenatal, Childbearing and the Postpartum Period

Somali families are typically large; seven or eight children is considered ideal. Contraception, and similarly, abortion, are anathema to most Somalis, given the strong Muslim belief that pregnancy is a blessing from God and should not be interfered with. Even sexing of the fetus is not encouraged, as it is God's will and cannot be changed. Prenatal care is sought by refugee Somali women here, although there is a marked preference for female examiners. Most women fear Caesarean section delivery, the perceived method of choice for American women, as it is thought that the surgery may impede subsequent pregnancies and render to postpartum mother

infirm. Alternatively, many women are concerned that episiotomies or even natural childbirth could damage the infibulation (see below) and must be repaired.

There is a culturally-sanctioned 40 day abstinence period, "afatanbah," in the postpartum, when the mother remains in her household and is assisted by female relatives and neighbors. Amulets made from garlic can be worn by the mother and newborn to ward off evil spirits during this period, and incense is burned for the same purpose. There is traditionally a naming ceremony during this period, but hospital procedures requiring birth certificates have changed this practice. Breast-feeding is the norm, in Somalia and in the refugee community here, sometimes for two years or longer. However, early supplementation with animal milks in Somalia or formula in the U.S. is not uncommon, and at least some women believe erroneously that colostrum is not healthy for the newborn. Infant care includes massages and warm water baths. Traditionally, an herb called malmal mixed into a poultice is applied to the umbilicus for a week or so; some researches report the availability of this herb in the U.S.

Health Risks in Refugees from East Africa

- Malnutrition
- Intestinal parasites (Enterobius, Trichuris, Strongyloides, and Ascaris)
- Filariasis
- Leishmaniasis
- Hepatitis B
- Tuberculosis
- Low immunization rate
- Dental caries
- Typhoid fever
- Malaria
- Trachoma
- Syphilis
- Dengue fever
- HIV infection
- Diarrheal illnesses
- Hansen's disease

Recommended Laboratory and Other Tests for Refugees from East Africa

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD
- Peripheral smear for malaria should be considered

Other problems that practitioners should be especially alert to are cervical cancer, ectoparasites, and post-traumatic stress disorder.

There were reports of malaria and a measles outbreak in the refugee camps in Kenya, but treatment was initiated before resettlement. Another concern for the resettlement providers is the common practice of corporal punishment of children, and less frequently, wives. Careful

counseling in orientation must be provided to explain the legal ramifications and definitions of abuse in this country.

Women's Health Issues

Similarly, the common practice of "female circumcision" is certain to create controversy here in the U.S. An estimated 98% of Somali girls 8-10 years of age undergo "female circumcision," where the clitoris and part of the labia is excised, ostensibly to keep women pure and chaste. (The more severe practice of circumcision and infibulation, where the labia is sewn together, is not as commonly practiced in Somalia as elsewhere in Africa).

Resettled refugees are warned of the illegality of this practice in the U.S., and Somali caseworkers here are quite emphatic that it is not being performed here. I have heard, however, some discussion that some girls would in the future be sent to Somalia for the procedure.

Benadir Refugees

Somali refugees from the Benadir ethnic group have recently been resettled to the U.S. in large numbers, and a detailed discussion of this particular group follows.

The Benadirs are a Somali ethnic group from the Benadir region of Somalia: the southern coastal region including Mogadishu. Unlike most Somalis, who are nomadic, the Benadir have a long history as urbanized merchants and artisans. The Benadir exhibit strong clan allegiance, through intramarriage and self-governance. They are devout Sunni Moslems, and are well known for their peace-loving, non-violent ways. For all these reasons, the Benadirs consider themselves a different, elite, class from other Somalis; consequently, they have been the targets of jealousy and animosity for centuries.

When massive internecine warfare erupted in 1990, the unarmed and non-aligned Benadir were caught in the middle. They suffered greatly at the hands of the other Somali clans: homes and businesses were destroyed, women were raped in front of male relatives, and countless were slaughtered. Those that could fled Somalia, for Kenya, Ethiopia and Yemen, and many died on the high seas during flight. Because of their vulnerability, even among other Somali refugees, the U.N. established a separate Benadir refugee camp, Swaleh Nguru, in Kenya.

With the camp population exploding (approximately 22,000 in 1996), health conditions deteriorating, their homes and livelihoods destroyed, and the likelihood that they could never repatriate to Somalia without persecution, resettlement overseas became the only durable solution for the Benadir plight. Since Spring of 1996, about 3,000 Benadir refugees have been resettled in about 20 sites throughout the U.S. Of these thousands, there are about a dozen major clans and many more subclans; family name usually corresponds to clan membership. The elder clan leaders serve as the cornerstone of Benadir society and should be included in all decisions surrounding Benadir resettlement.

Benadir refugees on the whole possess cultural characteristics that may complicate their resettlement experiences. Chiefly, they may be reluctant to be resettled in larger Somali communities, especially since persecuting clans may be represented. In our experience in Dallas, we have seen several different organizations coming forward claiming to be the representatives of the Somali community. Similarly, clan allegiance is so entrenched that secondary migration from the resettlement site frequently occurs. Likewise, many Somali refugees claimed fictitious family relations, such as disguising second wives as sisters or daughters, or even convenience marriages, when it was perceived to improve their acceptance for resettlement. Many of these artificial families immediately scatter to other areas to rejoin clan members upon arrival.

Furthermore, there will inevitably be frustration over the downward economic mobility Benadirs will initially face in starting over in the U.S. workforce.

Somali families are particularly large, sometimes ten or more individuals; housing laws in the U.S. will require these large extended families to divide into two or more apartments. And finally, Muslim proscriptions governing the interaction between the sexes will lead many Somali women to prefer female interpreters and health care providers.

Author: Lance A. Rasbridge, Ph.D.

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Section fifteen:

Sudanese

SUDANESE REFUGEES IN THE U. S.

Sudanese Refugees in New Hampshire

The Sudanese are currently the fastest growing refugee population in New Hampshire. While difficulties in processing refugee applications in East Africa indicate that the Sudanese will most probably not reach the same numbers as other refugee groups like the Vietnamese or the Bosnians, the number of Sudanese entering the country has been on the rise. The Sudanese program in New Hampshire began in 1996 and reached 124 refugees in 2000. While projections for 2001 are slightly lower there appears to be no end to the conflict in sight. Sudanese refugees have been resettled in Manchester (233), Concord (28) and some in Laconia (6).

The following is general information about Sudanese meant primarily to help medical personnel in the U.S. in treating these refugees. Complex societal practices and the enormous diversity of the Sudanese people have been reduced to generalities for purposes of easy understanding.

INTRODUCTION

The people of Sudan have endured great persecution and strife for generations. Political and religious oppression, famine, floods, locusts, and warfare are endemic to Africa's largest country, covering over one million square miles. Sudan is among the poorest countries and its citizens the least literate in the world. In Sudan, "the expected number of years to be lived in what might be termed the equivalent of "full health" is 42.6 years for men and 43.5 years for women. Sudan is thus 154th among 181 nations ranked by the World Health Organization (WHO) (WHO, 2000). Among all Americans, this "disability adjusted life expectancy" or DALE is 67.5 years for men and 72.6 years for women.

Civil war has raged in Sudan nearly continuously since independence from Britain in 1956. The religious war between the Islamic fundamentalists in the north, and the diverse African ethnic groups, many of whom are Christian, in the south, has devastated the country and its people. The Islamic government in the north has a long history of persecution of the Sudanese citizenry, especially the southerners. In the late 1980's, military leaders withheld internationally-donated food and relief supplies in the regions of the south already devastated by drought and warfare; the government in Khartoum frequently uses starvation as a warfare or political tactic. In 1988 alone, more than 250,000 Sudanese died of starvation. By 1989, inflation had risen by 80%, and the debt had risen to \$13 billion, and yet there was no plan by the government in the capital of Khartoum to rebuild the country. The corruption of the country's leaders prevented aid from such organizations as the United Nations, USAID, and UNICEF from reaching the rebel-held areas. The cities swelled with refugees fleeing the devastated countryside, and millions of Sudanese fled to the neighboring countries of Ethiopia, Uganda, Kenya, and Egypt. In 1993, it was estimated that 4,750,000 Sudanese found refuge in other countries, excluding the greater than 1,300,000 who died in the flight. From these camps, refugees from Sudan have been accepted for resettlement in the United States since 1990.

There are several different types of refugees from Sudan. The largest number in the United States are refugees from the south of Sudan, composed of various minority ethnic groups fleeing religious and political persecution, warfare, and starvation. Additionally, there are political dissenters from the north who escaped from the oppressive Muslim fundamentalist regime in

Khartoum. Many of these fled to neighboring countries, especially Ethiopia, to escape forced conscription, or in fewer cases, religious persecution, in particular against Bahaiís. The United Nations High Commissioner for Refugees (UNHCR) assisted these refugees in Ethiopia. Refugees from the south of Sudan come from the three different geographical regions, the Bahr-el Ghazal, the Upper Nile, and Equatoria, the latter containing Juba, the capital of the south. There is tremendous cultural diversity not only between the Sunni Moslem north and the animist (traditional) and Christian south, but within the southern region itself. Tribal affinity among the "Nilotic" groups (a reference to the thin physique and common ancestral language of those groups living along the Nile) is the norm, with infrequent intermarriage. Many ethnic languages are not mutually intelligible, although English, and to a lesser extent, Arabic, are the most widespread languages.

There are at least ten different ethnic groups from the south that are represented as resettled refugees in the U.S. (this is by no means an exhaustive list). The largest in number are the Nuer. Formerly a pastoralist group, the Nuer have suffered great destruction and strife as they are located most closely to the Arab-occupied areas along the Upper Nile. As the ethnic group is quite widespread and is divided into about ten subgroups or clans, there are several dialects of the Nuer language; many speak Arabic as well. Two other ethnic groups of lesser number also came from the Upper Nile region and are resettled in the U.S., the Anuak, and the Shilluk. Next to the Nuer, the second largest Sudanese population in the U.S. are the Dinka, who represent the majority group in southern Sudan. They originated primarily from the Bahr-el Ghazal region of southwestern Sudan, where they were pastoralists and agriculturalists. They speak Dinka, and secondarily Arabic and English. Like the Nuer, there is much diversity within the Dinka, with at least two dozen recognized subgroups, as well as great contrast between the missionized and pagan groups. Some other groups coming from this region include the Balanda and the Ndogo.

Finally, there are Sudanese refugees in the U.S. who originally lived in the Equatoria region in southernmost Sudan, the Azande, the Moru, and the Madi. All three groups were primarily agriculturalists, and are now predominantly Christian.

COMMUNICATION

Linguistically, Sudan is quite diverse, especially in the southern regions, where each tribe has its own language and sometimes several dialects. However, rudimentary Arabic language is spoken by almost all Sudanese, as it is the common language of commerce and discourse between tribes. In southern Sudan, English is only spoken by the educated minority. English was the official language until independence in 1956, when it was replaced by Arabic by the Khartoum government; English is still more common in the south.

Literacy is very low, especially since schooling has been disrupted by chronic warfare and strife. Dinka and Nuer are written languages, "romanized" by missionaries in this century, but can only be read by those with some schooling. Literacy in Arabic is less than the tribal languages, and English lower still. Hence, except with the educated, it is not beneficial to use written health or other materials.

In terms of social etiquette, there are some generalized distinctions between the Islamic north and the African south. For example, for Muslims, when greeting, men shake hands with men, but it is not culturally-appropriate for men to shake hands with women, except within the family. Respect should always be afforded to the man as the household head, but typically mothers will be more knowledgeable about children's health and can be addressed directly, especially with

southern families, where the rules of interaction are less rigid. Separation of the sexes is common to the Muslim north, and even homes are divided into male and female areas.

Muslim women from northern Sudan may be quite reluctant to be examined by a male physician, although most southern Sudanese women will view this as a medical necessity. In general, great diplomacy must be used in exchanges on gynecological matters. Sudanese women will frequently use euphemisms when referring to genitalia, or when English is poor, to avoid the topic completely.

Especially among the southern groups, relative age is of great importance in interpersonal relationships, determining not only the terms of address but also the manner of acting with others. For example, men of the same "age set" will call each other "brother" and will act informally with one another. Alternatively, someone older than you is afforded utmost respect, and is referred to as "uncle" or "aunty," or even "father" or "mother" if related by blood.

RELIGION

About 70% of the population of Sudan are Sunni Muslims, the vast majority in the north. About one-quarter of the peoples practice only "indigenous beliefs," and the remainder Christian; both these groups are found mainly in the south (Gray-Fisher 1994). While the Christians are a small minority, they tend to be the most educated. This Christian community is disproportionately represented in the resettled population, as their claims to asylum were the most well-founded. They tend to be rather fervent in their Christian beliefs here (Gray-Fisher 1994).

There is widespread belief in Sudanese culture, especially among southerners, in the spiritual realm and its manifestations on health and illness, although the beliefs vary greatly from one tribe to the next. The Nuer, for example, believe in a pantheon of Gods and spirits, both supernatural beings and spirits of animals, especially birds. During periods of epidemics or even individual health crises, oracles are sought out to identify the offended spirits and determine the proper recourse. Frequently an offering is presented or an animal is sacrificed in order to appease or drive away the evil spirit. A typical Dinka ceremony involves a spiritual elder praying over and then sacrificing a special white chicken in the presence of the afflicted. There is also a widespread belief in the concept of the "evil eye," where a malevolent person possessing supernatural powers can cast a spell on someone just by gazing upon them.

These spiritual beliefs and practices are observed mostly by non-Christians in the south and are sometimes sources of contention with the Christian community. In most cases, other available medical resources are resorted to when spiritual healing does not bring about the desired outcome.

HERBAL MEDICINES

There are multiple herbal and "traditional" remedies used by Sudanese (although lack of availability limits their use here in the U.S.). For example, a widely-used cure for migraine headaches is a certain chalky compound (clay, mixed with certain leaves and water) which is rubbed over the head. To relieve the symptoms of malaria, there is a certain root chewed like a stick. One common form is called "*visi ri*," a bitter shrub that bends its shoot to follow the sun. I have heard the testimonial of a highly educated southern Sudanese who swears this cure is more effective than chloroquine and other western drugs.

There are also certain leaves that are boiled and consumed to relieve malarial sweats; the same mixture can also be used to treat stomach disorders. For wounds, there are special leaves found in the bush which are tied over the wound like a plaster. These leaves may sometimes be burned and the ashes spread over the wound site.

Parasitism is very common amongst Sudanese, especially tapeworms, amoebas, bilharzia (schistosoma), and roundworm (Ascaris). To cure infection from Ascaris, leaves and roots are boiled to produce a bitter liquid, which when swallowed expels the worms. Thread worm infection, under the skin, is treated by slowly rolling the emerging worm on a stick until the whole worm comes out.

All these curative measures are particularly relied upon where there is no access to clinics. Most of these cures are not commonly used by resettled refugees, as they are not readily available here, nor are the specialists who are sometimes required to make them.

WESTERN MEDICINE

Resettled Sudanese in the U.S. experience numerous difficulties in accessing medical care, although to different degrees depending on background factors like educational level and prior exposure to biomedical care in Sudan. Language and cultural obstacles are obvious barriers, but also factors like name and birthdate discrepancies, and the general lack of previous medical documentation, greatly confound the encounter.

Most Sudanese have not had well care or medical checkups in Sudan and therefore present with medical conditions of which they were previously unaware. Common undiagnosed cases include diabetes, hypertension, food allergies, severe cases of depression, vision and hearing loss, and parasitism (Wakoson pers. comm.). Also, dental problems are also significant, especially as food habits change here in the U.S.

Sudanese routinely share over-the-counter medications or borrow prescription medicines from others for cases of similar symptomatology. This is a result of coping with chronic shortages of medicines and severely limited care facilities in Sudan, and of course it circumscribes expensive medical costs here. Similarly, Sudanese also tend to discontinue Western medicines as soon as symptoms resolve rather than completing the full course of treatment. Education on self-treatment and the importance of completed therapy is imperative for this population.

LIFE CYCLE

The following information pertains mostly to the southern Sudanese, and in some cases is specific to Nuer culture. References to northern Sudanese culture are noted.

Childbearing and infancy

During pregnancy, women frequently eat a special kind of clay, which is rather salty. When chewed, this type of clay is believed to increase the appetite and decrease the nausea associated with pregnancy. There are not really any specific food restrictions during pregnancy which are not otherwise observed, such as the taboo against eating snake.

At delivery, village midwives usually deliver at home, as few have access to hospitals, except civil servants and the wealthy. First-born boys are afforded special attention, and are usually raised in the maternal family's village. Virtually all women breast-feed, for about two years. Soft porridge made from sorghum and soups of boiled meat are believed to stimulate breastmilk production. At delivery, a cow or goat is frequently slaughtered to ensure enough meat for the postpartum period. Weaning typically occurs when the child is walking, or is otherwise ready as judged by the parents. Apart from cow's milk, a soft porridge made from fermented sorghum, mixed with a sour fruit, is commonly used as a weaning food (as well as a food for the infirm or elderly). In the general diet, sorghum is the most common starch, prepared in many different ways. Vegetables and greens, both wild and cultivated, make up a large proportion of the traditional diet, with meats including beef, goat, sheep, freshwater fish, and chicken (although chickens are generally more valued for egg production).

The system of naming children is rather complex. In some groups the child is named after the male lines, but traced either through the mother's or father's ancestry. A similar system gives the child the last name of the paternal grandfather's first name, the middle name being the father's first name, and the first or given name selected by the father. Christian children often have Biblical names and Sudanese names, used interchangeably. First names, when used, are commonly preceded by a title, like "Mr."

Birth dates are also quite confusing, as most southerners do not follow the Georgian calendar and at best know only the year and season of birth, and few tribal groups kept official records. In many cases, birth certificates have been lost or destroyed. In resettlement, commonly, a default date of January 1 is selected (Power and Shandy 1998). As age is a critical criterion for resettled refugees in receiving benefits and enrollment in school, incorrect birthdates can be a significant barrier for Sudanese refugees (Gray-Fisher 1994). Moreover, ambiguity in birthdates for children can confound immunization schedules and growth assessment for health care providers. Childrearing is traditionally the responsibility of all the women in the village; while the father takes considerable pleasure in his children, discipline is the responsibility of the mother.

Adolescence

In southern Sudan, while childhood is characteristically carefree, puberty as seen as the passage into adulthood and its responsibilities and is a marked occasion for both sexes. For girls, passage from childhood to adulthood is marked by the first menstruation, at which time the mother prepares her for her soon-to-be role as mother and home-manager.

For males, there is a complicated set of rituals which an entire village age-set progresses through, culminating in ritualized cutting of lines or striations across the forehead, especially among Dinka and Nuer. There is also a common traditional practice of teeth-pulling among the Dinka. Other groups have other types of rituals, often involving cutting marks. Circumcision is common among some groups, especially in the Equatoria region, but typically for hygienic rather than religious or cultural reasons. However, there is much variation even within groups.

In northern Sudan, circumcision for both sexes is widely practiced. For males, circumcision occurs shortly after birth in accordance with Islamic tradition. Girls too are "circumcised," where some or all of the clitoris and labia minora are excised, sometimes under crude conditions, ostensibly to keep the girls chaste.

Marriage

Marriage is typified as a sort of contract between the families involved, with the final approval left to the girl's side. The groom's family is required to pay a dowry to the bride's family, usually in the form of heads of cattle, to compensate them for the lost labor of their daughter. The exchange in the north is usually more in the form of money. While in the north there is preferential marriage to cousins and other relatives, in the south marriages are exogamous, meaning that the union can only be between peoples of different clans or villages, and hence formalizes political alliances as well. The wife does not take the husband's name. There are strict formalities regarding the interaction between the man and his in-laws. The newlyweds initially reside with the wife's family, until after the first child is born and weaned, at which time they move to the husband's village. Great emphasis is placed on the woman's ability to bear and raise children; birth control is typically antithetical to this cultural value. Divorce is possible but discouraged because of the exchange of property involved. Widowed women become the responsibility of the deceased's younger brother. Polygamy is practiced and is a sign of wealth and prestige but is uncommon in southern Sudan.

Death

Death is seen as the will of a spirit or God and is surrounded by the supernatural. Burial involves ceremonies meant to appease the spirits so that no more deaths occur. A period of several months mourning follows the death of a loved one. For Moslems, burial takes place as soon as possible. The body is taken to the mosque to be ritually cleaned and blessed by an Imam. The body is then carried to the previously-prepared grave in a funeral procession. Mourning lasts between three and seven days. Widows wear black clothes indefinitely, but may remarry.

Health Risks in Refugees from East Africa

- Malnutrition
- Intestinal parasites (Enterobius, Trichuris, Strongyloides, and Ascaris)
- Filariasis
- Leishmaniasis
- Hepatitis B
- Tuberculosis
- Low immunization rate
- Dental caries
- Typhoid fever
- Malaria
- Trachoma
- Syphilis
- Dengue fever
- HIV infection
- Diarrheal illnesses
- Hansen's disease

Recommended Laboratory and Other Tests for Refugees from East Africa

- Nutritional assessment
- Stool for ova and parasites
- Hepatitis B surface antigen
- Hemoglobin or hematocrit
- VDRL
- HIV
- PPD
- Peripheral smear for malaria should be considered

Other problems that practitioners should be especially alert to are cervical cancer, ectoparasites, and post-traumatic stress disorder.

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Mayen Ater

Hamid Abdalla

Author: Lance A. Rasbridge, PhD

Section sixteen:
Vietnamese

VIETNAMESE-AMERICAN MEDICAL PROFILE

Background on Vietnamese Resettlement in New Hampshire

The New Hampshire Refugee Program began in 1982 resettling primarily Cambodian and Vietnamese refugees. Over its nineteen-year history, 1,185 Vietnamese refugees have been resettled in the state. The number of Vietnamese entering the state reached its peak in 1995 when 214 refugees were resettled. The program has a long history of both church sponsored resettlement as well as non-profit center based resettlement creating a diverse demographics picture for the state. The majority of Vietnamese refugees, however were resettled in the Manchester area (928).

Background

The vast majority of the approximately 700,000 Vietnam-born persons living in the U.S. arrived here as refugees from 1975 to the present. While there are many shared cultural traits among all the Vietnamese-Americans, such as the Vietnamese language and strong emphasis on the extended family, there are also marked differences. This heterogeneity is represented largely by the refugee "wave" in which the individual or family arrived.

The first group of refugees to come to the U.S. in 1975 were educated and urban professionals (and their families) who were airlifted directly from Saigon. They were closely associated with American interests in Vietnam, so many spoke English and were familiar with American culture. This group has for the most part gone on to resume their professional lives in the United States, including serving as staff members of social service agencies which assist more recently-arrived Vietnamese.

In contrast, the second wave of Vietnamese refugees, arriving from the late 1970's through the mid 1980's, included a much higher proportion of merchants, farmers and other rural Vietnamese who escaped Communist Vietnam in small boats. These "boat people" suffered extreme hardship and loss through the refugee process, often remaining in harsh refugee camps for years. Many who came from rural origins or limited educational backgrounds have had a more difficult time adapting to urban U.S. life - while others from rural backgrounds found that intelligence and persistence are stronger than 100 generations of rural deprivation.

Finally, the third wave, continuing to arrive to the present, come to the U.S. under more "orderly" programs, typically on the basis of their statuses as political prisoners in Vietnam, or offspring of Vietnamese women and American fathers ("Amerasians"), two groups who faced serious discrimination in Vietnam. They come with their families; in the case of Amerasians, more often than not the father is unknown or otherwise out of the picture.

Because of their experience as refugees, Vietnamese-Americans on the whole are at high risk for many communicable diseases like tuberculosis, hepatitis B and parasitism as they arrive to the U.S. Over time, as many face accessibility barriers to medical care because of such factors as limited English skills, transportation difficulties, and cultural misunderstandings, they are at risk for more chronic problems like hypertension, heart disease, cancer and diabetes. In addition, many Vietnamese refugees also suffer mental health problems like post-traumatic stress disorder (PTSD), a result not only of the horrors they experienced as refugees but also due to the adjustment difficulties in attempting to retain their traditional values in the face of the dominant American culture.

Buddhism and Health

Although some Vietnamese refugees are Catholic or have been converted to other branches of Christianity, most Vietnamese follow Buddhist concepts. Buddhism on the whole is best understood not as a religion in the Western sense but more a philosophy of life, and it impacts profoundly on the health care beliefs and practices of Vietnamese. For example, Buddhists profess profound respect for elders and those in authority. This means that many Vietnamese in this country will rarely be confrontational with their American counterparts; in disagreement, a "face-saving" measure of avoidance or superficial acceptance is preferred to questioning or defiance, especially of those in positions of superiority, such as doctors and teachers. Even direct eye contact or physical positioning of elevation over one's superior is considered forward and impolite by some traditional Vietnamese.

Buddhism also teaches that life is a cycle of suffering and rebirth; if one lives life in adherence to the Buddhist path, one can expect less suffering in future existences. Buddhism stresses disconnection to the present, especially materialism and self-aggrandizement. Hence pain and illness are sometimes endured and health-seeking remedies delayed because of this belief in fate. Similarly, preventive health care has little meaning in this philosophy.

Another tenet of Buddhism holds that the family unit is more important than the individual, with less emphasis on the "self." Accordingly, health care decision-making is frequently a family matter. Concordantly, the family would typically be involved in treatment.

Respect for and veneration of ancestors is associated with Buddhism and Confucianism. The prospect of burial away from ancestral burial sites (pictured) is a source of significant distress to older Vietnamese. Difficulty visiting burial sites in Vietnam is also distressful.

Health Care Beliefs and Practices

Spiritual

The diagnosis of illness is frequently understood in three different, although overlapping, models. The first, the least common, is what could be considered supernatural or spiritual, where illness can be brought on by a curse or sorcery, or nonobservance of a religious ethic. Traditional medical practitioners are common in Vietnamese culture, both here and in Vietnam; some are specialists in the more magico-religious realm. This specialist may be called upon to exorcise a bad spirit, for example, via chanting, a magical potion, or consultation from and recitation of ancient Chinese texts.

The use of amulets and other forms of spiritual protection are also commonly employed by Vietnamese. For example, babies and children commonly wear *bua*, an amulet of cloth containing a Buddhist verse or is blessed by a monk, worn on a string around the wrist or neck. For spiritual illness of a more Buddhist etiology, religious practices may be intensified, such as the burning of incense at the home altar to appease the ancestors, or a Buddhist monk may be consulted for prayer.

Vietnamese traditionally do not have a concept of mental illness as discrete from somatic illness, and hence are very unlikely to utilize Western-based psychological and psychiatric services. Instead, most mental health issues such as depression or anxiety fall into this spiritual health realm and are treated accordingly. Similarly, physical expression of spiritually-based illnesses

(known as somatization) is common, and treatments overlap with the realms of health understanding which follow below.

Balance

Secondly, a very widespread belief is that the Universe is composed of opposing elements held in balance; consequently, health is a state of balance between these forces, known as "Am" and "Duong" in Vietnamese, based on the more familiar concepts of *yin* and *yang* in China. Specific to health, these forces are frequently translated as "hot" and "cold," although it is important to understand that these concepts are not necessarily referring to temperature. Illness results when there is an imbalance of these "vital" forces. The imbalance can be a result of physiological state, such as pregnancy or fatigue, or it can be brought on by extrinsic factors like diet or over-exposure to "wind," one of the body forces or "humors." Balance can be restored by a number of means, including diet changes to compensate for the excess of "hot" or "cold," western medicines and injections, and traditional medicines, herbs and medical practices. These practices and medications include:

1. Coining (*Cao gio*). "Catch the wind." A coin dipped in mentholated oil is vigorously rubbed across the skin in a prescribed manner, causing a mild dermabrasion. This practice is believed to release the excess force "wind" from the body and hence restore balance.
2. Cupping (*Giac*). A series of small, heated glasses are placed on the skin, forming a suction that leaves a red circular mark, drawing out the bad force.
3. Pinching (*Bat gio*). Similar to coining and cupping, the dermabrasion formed by pinching the skin allows the force to leave the body. (It should be noted that many of these practices are performed on young children, even infants, and the temporary dermabrasions they produce should not be confused with abuse or injury.)
4. Steaming (*Xong*). A mixture of medicinal herbs is boiled, the steam is inhaled, and the body bathed.
5. Balm. Various medicated oils or balms, like Tiger balm, are rubbed over the skin.
6. Acupuncture. Specialized practitioners insert thin steel needles into specific locations known as vital-energy points. Each of these points has specific therapeutic effects on the corresponding organs.
7. Acupressure or Massage. Fingers are pressed at the same points as with acupuncture, and together with massage, stimulate these points to maximize their therapeutic effects.
8. Herbs. Various medicinal herbs are boiled in water in specific proportions or mixed with "wine" and consumed, for example, in the postpartum, to restore balance.
9. Patent Medicines. These powdered medicines come packaged usually from Thailand or China and are mixed or boiled with water and taken for prescribed ailments.

Western

Thirdly, most Vietnamese-Americans also recognize the more "western" concepts of disease causation, like the germ theory. There is widespread understanding, for example, that disease can come from contaminants in the environment, even if full concepts of microbiology or virology are not grasped. Concomitantly, through decades of French occupation and more recently the American influence, even the most rural Vietnamese has come to know the life-saving power of antibiotics.

When Vietnamese enter the American health care setting, they do so frequently with the goal to relieve symptoms. In general, the Vietnamese patient expects a medicine to cure the illness immediately. When a medication is not prescribed initially, the patient is likely to seek care

elsewhere. In addition to the myriad of traditional healers and other traditional medicines and practices available to resettled Vietnamese, Western pharmaceuticals, especially vitamins and even antibiotics, are obtainable, either through specialized "injectionists," or from relatives in other countries such as France where some of these medicines are available without prescriptions.

Vietnamese frequently discontinue medicines after their symptoms disappear; similarly, if symptoms are not perceived, there is no illness. Hence preventive, long-term medications like anti-hypertensives must be prescribed with culturally-sensitive education. It is quite common for Vietnamese patients to amass large quantities of half-used prescription drugs, even antibiotics, many of which are shared with friends and even make their way back to family in Vietnam. Western medicines, especially oral medications, are held in general to be "hot" medicines, in their effect on the balance of the body. When medicines are prescribed for a condition like skin irritation, which is understood traditionally as a hot illness, the excess force erupting through the skin, a compliance issue may result. In this case, alternatives like a balm or poultice may better meet the patient's understanding of balance. Similarly, Vietnamese commonly believe that Western pharmaceuticals are developed for Americans and Europeans, and hence dosages are too strong for more slightly built Vietnamese, resulting in self-adjustment of dosages.

As mentioned above, Vietnamese hold great respect for those with education, especially physicians. The doctor is considered the expert on health; therefore, the expectation is that diagnosis and treatment should happen at the first visit, with little examination or personally-invasive laboratory or other diagnostic tests. In fact, a doctor who probes a great deal into symptoms may be held incompetent by some traditional Vietnamese for not being able to diagnose readily.

Commonly, laboratory procedures involving the drawing of blood are feared and even resisted by Vietnamese, who believe the blood loss will make them sicker and that the body cannot replace what was lost. Surgery is particularly feared for this reason. Overall, as health is believed to be a function of balance, surgery would be considered an option only of last resort, as the removal of an organ would irreparably alter the internal balance.

In sum, Vietnamese view health and illness from a variety of different perspectives, sometimes simultaneously. In other words, it is not uncommon for a sick person to interpret their illness as an interaction of spiritual factors, internal balance inequities, and even an infective process, for example. Accordingly, Vietnamese will combine diagnostic and treatment elements from all three models in order to get the maximum health benefits. This broad perspective suggests an understanding of mind-body interactions and predisposing factors to illness that Western medicine is only beginning to fully appreciate.

Health Risks in Refugees from Asia

- Nutritional deficits
- Hepatitis B
- Tuberculosis
- Parasites (roundworm, hookworm, filaria, flukes, amoebae, giardia)
- Malaria
- HIV
- Hansen's disease
- PTSD

Recommended Laboratory and Other Tests for Refugees from Asia

- Nutritional assessment
- Stool for ova and parasites
- Hemoglobin or hematocrit
- PPD
- VDRL should be considered.

Author: Lance A. Rasbridge, PhD