

# CULTURAL AWARENESS

## I. INTRODUCTION

Cultural awareness and competency is an essential part of working in a health care environment. Cultural competence is a set of attitudes, beliefs, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations<sup>1</sup>. Health-related beliefs, disease prevalence, and treatment efficacy are all part of the health related issues of different populations that providers should have awareness on. Avoiding stereotypes is also an essential part of cultural awareness. It is important to remember that diversity is exists in all groups.

## II. CULTURAL AWARENESS POINTERS

Some important points that providers should remember about cultural awareness include<sup>2</sup>:

- Clinicians need to “check their own pulse” and become aware of personal attitudes, beliefs, biases, and behaviors, that may influence (consciously or unconsciously) care of patients as well as interactions with professional colleagues and staff from diverse racial, ethnic, and sociocultural backgrounds.
- Every clinical encounter is cross-cultural. Developing partnerships with patients and maintaining “cultural humility” can help clinicians to learn and better understand the historical, familial, community, occupational, and environmental contexts in which patient’s live.
- It should be understood that there is no “one” way to treat any racial and ethnic group, given the great sociocultural diversity within these broad classifications. We need instead to have a framework of interventions that can be individualized and applied in a patient- and family-centered fashion.
- Clinical and preventative care needs to be evidence-based, flexible, authentic, and ethical. We need to appropriately tailor interventions to patients, families, and communities.
- Cookbook approaches about working with patients from diverse sociocultural backgrounds are not useful and instead risk potentially dangerous stereotyping and overgeneralization. Important intergenerational differences exist, and diversity is often greater within groups than between them.
- It is important to understand not only patient and community barriers to care, but also physician and health care system barriers to care. To eliminate racial

---

<sup>1</sup> Lavizzo-Mourney and Mackenzie. “Cultural Competence: A Journey” 1996.

<sup>2</sup> J. Betancourt & R. Like. “Editorial: A New Framework of Care” 2000  
RI Department of Health Family Planning Guidelines

and ethnic disparity, health care providers and organizations need to become more culturally and linguistically competent.

- We need to challenge and confront racism, sexism, classism, and other forms of prejudice and discrimination that occur in clinical encounters as well as in the society-at-large.

Through collaboration and achieving a better understanding and appreciation of our commonalities and difference, patients and physicians can become empowered to work together with others to eliminate racial and ethnic disparities in health care<sup>2</sup>.

### **III. UNDERSTANDING MINORITY, IMMIGRANT, AND REFUGEE POPULATIONS**

The following is basic cultural information about some regions and groups and their different cultural beliefs and practices. As a reminder, recognize that every patient is an individual. Stereotyping can lead to misconceptions about the individual seeking care.

#### **A. SUB-SAHARAN AFRICANS**

The continent of Africa has an immense variety of distinct languages and cultural traditions. Sub-Saharan Africa's sub-regions include: West Africa, East Africa, Southern Africa, and Central Africa. Africans who come to the United States often speak two or three native languages as well as one or more European languages. Religious traditions and practices are very diverse. Africans from one country or part of a Sub-Saharan African country may be Christians, Muslims, Bahais, Hindus, or Jews.

Although it is important to keep in mind the differences among people within a region and within a country, you may expect to find some of the following characteristics that occur commonly across national borders<sup>3</sup>:

- Family is defined broadly and may encompass people from the same village of origin, friends, and even distant blood relatives. Family ties may imply extensive monetary and other obligations.
- Some Africans have a religious or cultural tradition that encourages polygamy and/or large families.
- In some African regions, women head the household by themselves.
- Even between close friends, a greeting requires shaking hands and asking about the health of the individual and his/her family.

---

<sup>3</sup> The Providers Guide. <http://erc.msh.org>  
RI Department of Health Family Planning Guidelines

- Tension and/or conflict may be high among members of ethnic or religious groups living in proximity to each other.
- Males are circumcised in most countries.
- Females are circumcised in most (though not all) Sub-Saharan African countries.
- Despite regional difference in foods, most African countries grow at least one root crop that provides a starchy staple food. Many people prefer cooked vegetables to raw ones, and it is common to season some foods with hot peppers.

### **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Sub-Saharan Africans<sup>3</sup>:

- Sickle cell anemia occurs in populations originating from Africa, India, Saudi Arabia, and Sicily. In the US, 0.3% of African Americans are homozygotes and 8-13% are heterozygotes. Sickle cell anemia has been shown to provide some protection against malaria.
- Lactose intolerance is common among Africans.
- Frequent relapse of P. Vivax malaria is common. Relapse of P. Ovale is less common, but can occur, even several years after the initial infection.
- Recent immigrants may be suffering from dental caries as a result of poor dental care in their home country or increased consumption of processed foods since their arrival in the United States.
- Parasites, such as hookworm, schistosomiasis, strongyloides, or giardia may be present and affecting overall health.
- Female Genital Mutilation (FGM) is regularly practiced in 28 African countries. Estimated rates of FGM range from 5% of women in Uganda to 80% of women in Egypt and 98% of women in Djibouti and Somalia. There are many severe health complications associated with this practice.

- Post-traumatic stress disorder may be present.

## **B. HISPANICS/LATINOS**

This region covers an area of more than 40 countries. Spanish is the major language of all countries in Latin America except for Brazil (Portuguese) and some countries in the Caribbean, where French, English Patois, and Dutch are spoken. Roman Catholicism is the major religion in the region and has an important influence on social life and traditions.

Some commonalities may be found among people from Latin America and the Caribbean<sup>3</sup>:

- Maintaining eye contact is valued.
- Friendly physical contact, such as touching the shoulder or upper arm, is common.
- Friendliness and treating other with respect is highly valued.
- Education, degrees, and titles are esteemed.
- Socializing and spending time with family and friends is a vital part of life.
- Cakes and sweets may be a regular part of the diet.
- Workers in the U.S. may send money back home to support family members.
- Children are highly valued and loved, and parental discipline may be light while they are young.

## **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Hispanics/Latinos<sup>3</sup>:

- Diabetes is twice as prevalent among Hispanics than among the majority population.

- Hypertension is common in Hispanic populations.
- Overweight and obesity are common in some Hispanic groups: for example, combined overweight and obesity are found among 63.9% of Mexican-American men and 65.9% of Mexican-American women. This contrasts to rates of 61% among European-American men and 49.2% among European-American women.
- The incidence of cervical cancer in Hispanic women is double that of non-Hispanic European-American women.
- Although Hispanics have a lower incidence of breast, oral cavity, colorectal, and urinary bladder cancers, their mortality from these is similar to that of the majority population.

## 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<sup>4</sup> 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 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<sup>5</sup>. 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 disagree 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

---

<sup>4</sup> Central Intelligence Agency. [www.odci.gov/cia/punblications/factbook](http://www.odci.gov/cia/punblications/factbook)

<sup>5</sup> T. de Paula, K. Lagana, & L. Gonzalez-Ramirez. "Mexican Americans" 1996. RI Department of Health Family Planning Guidelines

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 is 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.<sup>6</sup>. 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 regimens, 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 is 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.

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<sup>7</sup>.

## **SOCIAL RELATIONS**

---

<sup>6</sup> J. Zapata & R. Shippee-Rice. "The use of folk healing and healers by six Latinos living in New England" 1999

<sup>7</sup> L. Lieberman, E. Stoller, & M. Burg. "Women's health care: Cross-Cultural encounters within the medical system" 1997

Familism, the valuing of family considerations over individual or community needs, is a strong, almost universal value in the Hispanic community<sup>8</sup>. The nuclear family is the most basic and common social unit, but many extended families are 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 underreported<sup>6</sup>. 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.

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.

**Implications:** Many patients seeking medical care will have already sought help from family resources. 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 respect to all adults is important. Health providers should understand and comply with patient and family gender roles.

**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”<sup>9</sup>. 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<sup>7</sup>. Hispanics who follow these beliefs may not express them to health professionals.

---

<sup>8</sup> G. Juarez, B. Ferrell, & T. Borneman. “Perceptions of quality of life in Hispanic patients with cancer” 1998

<sup>9</sup> R. Spector. *Cultural diversity in health and illness*. 1996

“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, rhinitis, pneumonia, and colic. “Hot” diseases/conditions are characterized by vasodilation and high metabolic rate. Pregnancy, hypertension, diabetes, and acid indigestion are examples of “hot” conditions.

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

It seems 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<sup>10</sup>.

**Diet:** Obesity is a significant problem in Hispanic communities<sup>11</sup>. 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. Tortillas are eaten at most meals, and these too usually include lard as an ingredient. Although Mexican-Americans may be consuming fresh, natural ingredients, processed foods are more common. Meals tend to be large and “heavy”. Fast foods, both American-style such as hamburgers and Mexican such as tacos, are often eaten.

**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<sup>10</sup>. 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 a 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 postnatal period.

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.

---

<sup>10</sup> L. Hunt, N. Arar & L. Akana. “Herbs, prayers, and insulin: Use of medical and alternative treatments by a group of Mexican-American diabetes patients” 2000

<sup>11</sup> U.S. Department of Health and Human Services [DHHS], 1998

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. However, many Hispanic homes are warm and protective toward the children. Familism is a thread throughout Hispanic life, including 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<sup>10</sup>, 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<sup>12</sup>. 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<sup>13</sup>.

**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 this brief tool<sup>13</sup>:

#### **Brief Assessment of Patient/Family Perceptions of Health Problems<sup>4</sup>**

- What do you think caused your problem?

---

<sup>12</sup> N. Neff. Folk medicine in Hispanics in the Southwestern United States. <http://192.147.157.49/galaxy/Community/Health/Family-Health/Hispanic-Health.html> 1998

<sup>13</sup> T. Tripp-Reimer, P. Brink, & J. Saunders. "Cultural assessment: Content and process" 1984

- 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 person; 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 are<sup>13</sup>:

- 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<sup>14</sup>. 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<sup>11</sup>.

## **C. AFRICAN AMERICANS & HAITIANS**

Unlike other immigrant groups in the United States, African Americans did not come here of their own volition: they were brought here by force and held as slaves for generations. The legacy of their enslavement is that African Americans in the U.S. remain a lower economic level, receive less formal education, and have worse health status indicators than any other ethnic group.

---

<sup>14</sup>L. Chavez, F. Hubbell, & S. Mishra. "Ethnography and breast cancer control among Latinas and Anglo women in southern California" 1999

As with any racial or ethnic group, there are many differences in customs and beliefs among African Americans. However, some commonalities may be found<sup>3</sup>:

- There is often a tradition of involving the “whole village” or whole family in raising children.
- Many African Americans are heavily involved in key religious institutions, such as churches or mosques. Although the vast majority of African Americans are Christians, a growing number of people are turning to Islam.
- Many households are headed by women.
- There is often discomfort with and mistrust of the health care system. This may be linked to the common fear of being diagnosed with a life-threatening or debilitating disease or illness and with a common perception that diagnostic procedures are an invasion of privacy. This distrust of health care providers and the health care system may also be linked to the Tuskegee syphilis experiment, in which African American males were purposely not given appropriate medication so that the researchers could study untreated syphilis.

## **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among African Americans<sup>3</sup>:

- In the U.S., 38% of African American adults are hypertensive, compared to 29% of European Americans.
- African Americans have higher incidence of hypertension, sickle cell anemia, and diabetes than the majority population.
- The combined overweight and obesity rates for African Americans are higher than for European Americans; 65% of African American men and 56.5% of African American women are overweight or obese, compared to 61% of European American men and 49.2% of European American women.
- Sickle cell anemia can occur in this population. In the U.S., 0.3% of African Americans are homozygotes and 8-13% are heterozygotes.

- The cardiovascular disease (CVD) death rate for African American men and women far exceeds the rate for the majority population and for other ethnic groups.
- The prevalence of diabetes among African Americans is substantially higher than among the majority population, and the incidence of complications, including lower-limb amputations and end-stage renal disease is double.
- African American women are far more likely than women of the general population to be infected with HIV, and about 64% of all women with new HIV infections in a given year are African Americans.
- Ten percent of African American males suffer from a mild form of Glucose-6-phosphate dehydrogenase (G-6PD) deficiency.
- For men and women combined, African Americans have a cancer death rate about 35% higher than that for the majority population.
- Lactose intolerance is common among African Americans.
- Certain diseases, including prostate and breast cancer, may progress more rapidly in African Americans than on the general population.

#### **a. HAITIANS**

The Republic of Haiti lies on the western third of the Island of Hispaniola in the West Indies. Most of the population is black descendents of African slaves brought to the West Indies by French Colonists. Haitians come to the U.S. and to a lesser degree, France and other Western European countries, 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 new Haitian immigrants and refugees are adults or teens (with few infants or old people), and most are poorly educated.

#### **COMMUNICATION**

Most Haitians speak Creole, and the educated also speak French. Some Haitians will indicate agreement with a person of higher socioeconomic status rather than risk conflict in disagreement. Haitians are often very animated in tone of voice and touching the other person is common. 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 are Catholic, and many of these also believe to at least some extent in Voodoo. 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 and death.

## **HEALTH BELIEFS AND PRACTICES**

Educated Haitians or those with experience in modern health care are likely to have 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<sup>15</sup>. Changes in eating, living, or other habits may also influence health and illness. Illness may be seen as punishment from God, especially when a person's relationship with God is weakened and thus one's body is also weakened. A state of depression means generalized weakness, dejection, and worry that make one vulnerable to illness.

Haitian beliefs about health and illness may also be strongly influenced by life in Haiti where there is limited access 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 docteur fey, primary care clinic, and sorcerer.

In seeking health care, the primary focus among most Haitians is on solving a specific problem. In many 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. Traditional means of health promotion and disease prevention include<sup>16</sup>:

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

---

<sup>15</sup> J. Colin and G. Paperwalla. “Haitians” 1996

- Herbal teas and 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 rate of chronic illness such as diabetes and hypertension is extraordinarily high among Haitians and treatment is very difficult because of high rates of noncompliance<sup>16</sup>. Noncompliance may be due to difficulty understanding the nature of chronic illness, 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 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 developed locales. 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<sup>17</sup>.

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<sup>17</sup>.

#### **D. NATIVE AMERICANS/AMERICAN INDIANS/ALASKA NATIVES**

Many people in the general population assume that Native Americans, or American Indians/Alaska Natives share a common culture. In reality, there are rich cultural variations among the groups and subgroups of Native Americans and Alaska Natives. Greater than 60% of the Native American population live in urban areas, and less than one-third live on reservations<sup>18</sup>. At the same time, awareness among the diverse groups of Native Americans of the similarity of their economic, social, and health situations has created a social and political force that has greater strength and influence than do individual tribal governments. Furthermore, many tribal groups are increasingly successful in managing their resources and enhancing the living conditions for all members of their communities.

---

<sup>16</sup> R. Preston, et al. "Hypertension in Haitians: Results of a pilot survey of a public teaching hospital multispecialty clinic" 1996

<sup>17</sup> J. Thomas & L. DeSantis. "Feeding and weaning practices of Cuban and Haitian immigrant mothers" 1995

<sup>18</sup> L. William and T. McPherson. "Meeting the Health Needs of American Indian/Alaska Natives and Alaskan Natives" 2000

RI Department of Health Family Planning Guidelines

Some commonalities that *may* be anticipated<sup>19</sup>:

- Family and tribal affiliations and obligations are an important part of daily life for many Native Americans and Native Alaskans.
- Native Americans and Native Alaskans have a holistic perspective on life and on health in particular. They make great efforts to integrate physical, social, psychological, and spiritual ways of healing.
- Health of the individual is seen as integral to the health of the tribe.
- Many Native Americans who are living in reservation areas are living on land that was allotted to them because it was remote and economically unproductive.
- Residents of reservation areas may suffer from poverty, poor nutrition, stress on the structure of the family, and inadequate access to quality health. Further, reservation-based health care systems often must ration the care process because they lack the funding needed to completely cover health care costs. These factors have a negative impact on residents' health status.

## **COMMON HEALTH PROBLEMS**

Health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Native Americans/American Indians/Alaska Natives<sup>19</sup>:

- Native Americans/American Indian/Alaska Natives are almost three times as likely to have diabetes as non-Hispanic European Americans of similar age.
- Native Alaskan men and women suffer disproportionately higher rates of cancers of the colon and rectum compared to European Americans.
- The five-year survival rate for Native American women with cervical cancer is poorer than that for most ethnic groups.
- Lactose intolerance is common among Native Americans.

## E. ASIANS

Asia is the world's largest and most diverse continent. Religions in the region include Buddhism, Christianity, Hinduism, Islam, Sikh, Jain, Parsi, and many traditional faiths. Some Asian ethnic groups exist only in small areas, while others, particularly Indian and Chinese groups, have migrated throughout the region, often retaining their cultural identities in their new homes. The majority of Asians living in the U.S. come from China, Vietnam, India, the Philippines, and Cambodia, with smaller numbers of immigrants from Tibet, Laos, Thailand, Korea, Japan, and Indonesia. They have immigrated to the U.S. for many different reasons, including educational opportunities, work, civil strife, war, and political repression.

Among this extremely diverse group, there are some possible commonalities you *may* want to consider<sup>4</sup>:

- Hard work, acceptance of what life brings, respect for nature, self-control, respect for elders, and loyalty to family are highly esteemed cultural values for many Asians.
- Many Asian societies are traditionally patriarchal, and children are expected to show respect for their elders.
- Most groups prefer to marry within the same group.
- Most patients prefer a medical practitioner of the same sex, and many will expect that medical treatment will involve an injection or a prescription.
- Hostility, aggression, and other negative feelings are generally not openly expressed.
- Shaking hands may not be the polite way to greet someone—a slight bow or set of prescribed gestures may be more acceptable.
- It may not be considered polite to have eye contact with someone who is older or who is considered superior.
- Smiling expresses a great variety of emotions. As well as expressing happiness or pleasure, it can mask anger, frustration, embarrassment, disappointment, lack of knowledge, or unhappiness.

- Many older and some younger people from Southern China and other Asian regions will not make important decisions until they check with an astrologer or an almanac to find a lucky day and hour.
- Numbers are very important to Chinese; their lucky numbers are 3 and 8. For Cantonese speakers, the word for the number 3 sounds like the word for “life”. The word for the number 8 is the luckiest of all of them, since it sounds like the word for “prosperity”. Number 4 is the unluckiest number, because the word for number 4 sounds like the word for “death”.

## **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Asians<sup>3</sup>:

- Common sites of cancer among Chinese women are the lungs, breast, colon, stomach, and pancreas. Invasive cancer rates are much higher among Southeast Asian women in general than in the majority U.S. population.
- The rates of cervical cancer incidence and mortality for Vietnamese American women exceed those of any other minority or majority population in this country.
- Common sites of cancers among Chinese men may include the liver, colon, stomach, and nasopharynx.
- Newcomers may have hepatitis, intestinal parasites, malaria, and/or Hansen’s disease.
- Lactose intolerance is common among Asians.
- Some Asians may develop a severe form of Glucose-6-phosphate dehydrogenase (G-6PD) deficiency.

### **a. CAMBODIANS (KHMER)**

Once in the U.S., the Khmer have tended to follow one of several paths. Some have enjoyed financial success (through salaried jobs as often as 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 teaches tolerance of others, acceptance of life (non-attachment), and lays out a strong moral code. Many Buddhist attribute misfortune or accomplishment to actions in this or a past life. Evangelical Christian churches and The Church of Jesus Christ and Latter Day Saints (Mormon) are active in most Khmer communities as well. The success of these 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. This active outreach and caring is in contrast to the more detached Buddhist groups. Many Khmer are comfortable with attending both Christian and Buddhist worship.

## **HEALTH BELIEF AND PRACTICES**

In general, the Khmer are comfortable with western medicine and with traditional or indigenous healing practices, both spiritual and medicinal. Illness may be attributed to imbalance in natural forces. A common expression of the concepts is for people to note the influence of “wind” or *kchall* on blood circulation and this on illness. There may also be discussion of body conditions called “cold” and “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<sup>4</sup>:

- Acceptance of the illness or discomfort
- Difficulty accessing public or private health providers
- Difficulty traversing the healthcare system (especially 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 HEALTH 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. Here are some traditional practices<sup>4</sup>:

- Dipping a coin in Vick's Vapor Rub, or a similar mentholated medicine, and rubbing it in one direction on the patients' chest, back, and/or extremities. "Coining" or "dermabrasion" as it is referred to, is used to treat a variety of ailments, including fever, upper respiratory infection, nausea, weak heart, and malaise.
- Using the first and second fingers to pinch and thus bruise the bridge of the nose, neck, or chest to treat headache and malaise.
- Placing a small candle on the forehead, lighting the candle, and placing a jar over the candle is referred to as "cupping". The flame consumes the oxygen and creates a vacuum, thus causing a circular contusion. This is also used for headaches.

## RESPONSE TO WESTERN MEDICINE

Often traditional measures of healing 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 reluctance to be involved in preventative 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.

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 detection or disease screening.

For example, health care providers have seen small results from attempts to teach women to perform breast self-exam<sup>4</sup>.

## **b. LAOTIANS**

Laos is a landlocked country surrounded by China, Vietnam, Cambodia, and Thailand. There are many ethnic and cultural groups from Laos living in the United States, including the Hmong, Mien, Tai Dam, and ethnic Chinese from Laos. 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. The basic tenets of Buddhism guide at least most traditional Laotians. These tenets include the Four Noble Truths<sup>4</sup>:

- To live is to suffer-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.

The ethnic of Buddhism is centered around the four “Palaces of Brahma” or virtuous attitudes: Loving-kindness, compassion, sympathetic joy, and equanimity.

### **HEALTH CARE PRACTICES AND BELIEFS**

Health care beliefs and practices are significantly related to Laotians religious beliefs. Illness may be attributed to the loss of one of the thirty-two spirits 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<sup>4</sup>.

Laotians 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<sup>4</sup>:

- 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 than 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, a 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 a teacher/healer 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.

## **SPIRITUAL HEALING PRACTICES**

Laotians views of health, illness, and healing are complex and multidimensional, and encompass to a very strong degree, spiritual components. Spiritual or spirit-based practices will occur in the context of Buddhism. Evidence of the spiritual or spirit components is seen in several phenomena<sup>4</sup>:

- The involvement of monks, 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*, which is a string passed through a small cylinder or cylinders of gold or brass. The metal is inscribed with prayers. 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 around the neck by some Laotians.
- One will sometimes encounter Laotians with one or more pieces of string tied around the wrist. This is 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 included being polite as most people might define politeness. Respect also encompasses respecting the privacy of individuals, families, and the culture. This 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."<sup>4</sup>

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."<sup>4</sup> Regardless of what techniques are used, remember that the history will evolve over time as the relationship evolves.

When there is terminal illness, it is usually 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 patients' 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.

## **SOCIAL ISSUES**

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.

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. Children are expected to 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.

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 be a routine practice, especially by male providers. In part because of issues of modesty, there is resistance to breast self exam among Laotian women.

### **c. CHINESE**

The Chinese have a long history of out-migration from China; and as a result, there are few places in the world where there are not Chinese people living. It is not widely recognized (except by Chinese) that there is a long history of discrimination against the Chinese. Prior to 1965, most Chinese immigrants were working class; and after 1965, most have been professionals<sup>19</sup>. Currently there are significant numbers of Chinese entering western countries legally and illegally<sup>20</sup>.

### **CULTURAL AND SOCIAL RELATIONS**

The continuous primary theme or value in social structure among Chinese throughout history is the centrality of the family<sup>21</sup>. For the centrality of the family arise<sup>22</sup>:

- Filial piety (or duty)-manifested by respect and even reverence for parents.
- Conformance to evidence by adherence to family and societal norms, and especially by not bringing shame to the family.
- Family recognition through achievement-shown by individuals striving to succeed and not accepting praise for their achievement.
- Emotional self-control-manifested by reserved and formal public verbal and nonverbal communications. Arguments, disagreements, or demands are kept to a minimum.
- Collectivism-evidenced by people keeping the focus on family and community over self.
- Humility-manifested by a lack of striving for individual achievement except as achievement relates to the family.

Although extended families are the ideal and relatively common in China, nuclear families are also common-especially in the West.

Family structure is traditionally hierarchal and patriarchal, with the oldest male the primary decision-maker in health and other matters. Older children have precedence over

---

<sup>19</sup> K. Chang. "Chinese Americans" 1999

<sup>20</sup> K. Braun & R. Nichols. "Death and dying in four Asian-American cultures: A descriptive study" 1997

<sup>21</sup> P. Chin. "Chinese Americans" 1996

<sup>22</sup> B. Kim et al. "Cultural value similarities and differences among Asian American ethnic groups" 2001  
RI Department of Health Family Planning Guidelines

younger children and male children over female<sup>21</sup>. In family matters there also is significant influence from elders-including women. Families tend to be very private, and few are willing to discuss family issues or conflict with non-family members.

The family is often the first and sometimes only source of health care. Health decisions may be made by the family based as much or more on what is best for the family as on what is best for the patient<sup>23</sup>. In most Chinese immigrant homes, both Chinese and English are spoken. Many youth go to “Chinese school” where they learn etiquette, calligraphy, and other cultural matters important in maintaining the culture in a foreign land.

## **COMMUNICATIONS**

China is an enormous country with at least 58 indigenous ethnic groups, a number of which speak different languages or dialects<sup>24</sup>. There are seven major Chinese language groups, with numerous dialects within each. The seven groups are Mandarin (spoken by the largest number of people), Cantonese, Hakka, Xiang, Min, Gan, and Wu.

Communications are complex and based on context, social status, intuition, and other matters not readily discernible to Westerners. For example, if a young patient is asked by an older health provider if she or he would like a glass of cold water, the answer would likely be yes, even though cold drinks traditionally are undesirable to ill persons. In general, yes-no questions should be avoided when possible, as the polite response is nearly always, “yes”.

## **RELIGION**

Religion, as commonly practiced among many Chinese, blends religious beliefs and practices with philosophical systems. Religion (Buddhism) and philosophical systems (Taoism and Confucianism) are integrated with cultural identity to the extent that it is difficult to understand or examine one without the other<sup>25</sup>.

The primary philosophical influences on Chinese culture are Confucianism and Taoism. Confucianism teaches the proper relationship of people to one another, i.e., child to parent, student to teacher, and so on. Confucianism, then, is the basis for veneration of ancestors and respect for elders. Taoism teaches the proper relationship of people to nature, yet also addresses in a deep way, the relationship of people to one another. Thus Buddhism, Confucianism, and Taoism all affect the health/illness experience and health decision-making.

## **HEALTH BELIEFS AND PRACTICES**

---

<sup>23</sup> K. Tong & B. Spicer. “The Chinese palliative patient and family in North America: A cultural perspective” 1994  
<sup>24</sup> F. Yusuf & M. Byrnes. “Ethnic mosaic of modern China: An analysis of fertility and mortality data for the twelve largest ethnic minorities” 1994

<sup>25</sup> M. Kagawa-Singer & L. Blackhall. “Negotiating cross-cultural issues at the end of life” 2001  
RI Department of Health Family Planning Guidelines

Medicines and foods are often considered as either “hot” or “cold”. Western medicines are more often hot than cold; while traditional Chinese medicines may be either. Food properties are sometimes subject to debate with respect to which are hot and which are cold. Hot foods are generally high in protein, fat, and calories. Cold foods include cold drinks, fruits, most vegetables, and soy products<sup>26</sup>.

Traditional Chinese medicine (TCM) is an important concept in health practices of Chinese culture. TCM is based philosophically on Taoism and operationally on a channel (meridian) system, in which various body channels carry vital or life energy called qi or ch’i, blood, and other body fluids<sup>27</sup>. There are numerous channels, with internal organs connected to these channels, and acupuncture points determined by the channels. Imbalance or disruption in the channels leads to illness; and the treatment goal of TCM is to restore balance. The two primary means of TCM treatment are acupuncture and the use of compounds<sup>28</sup>. While some of the latter are herbal in nature, heavy metals are also used, and may, in some cases lead to toxicity—most commonly lead and mercury poisoning<sup>28</sup>. In the West, the practice of medicinal TCM is not as open as in Asia, but there are TCM practitioners and medications available in most large metropolitan areas.

Another concept important to understanding Chinese approaches to health and illness is a belief in western allopathic medicine. In China, TCM and western medicine may be practiced side by side, with patients utilizing one or the other—or both—according to illness or patient inclination<sup>29</sup>. Indeed, in much of Southeast Asia, a typical pharmacy has one (physical) side of the business devoted to Western medicine and the other side devoted to compounding and dispensing TCMs.

## **PREGNANCY AND CHILDBIRTH**

Prenatal care is highly valued among Chinese women, as evidenced by the third highest rate among women in 17 ethnic groups in the United States in seeking prenatal care in the first trimester of pregnancy<sup>29</sup>. TCM remedies may be used for nausea, fatigue, edema, and other conditions of pregnancy.

Postpartum, many women stay in the house for 30 days. They avoid cold foods, drinks, wind, water and any other cold substance or contact, diet based on balance, abstinence for physical work, and abstinence from excessive pleasurable activities (e.g. sex, parties, etc.). bathing (and especially washing the hair) is limited and may include a warm bath with an alcoholic beverage<sup>30</sup>.

## **DYING AND DEATH**

---

<sup>26</sup> S. Chan et al. “Special postpartum dietary practices of Hong Kong Chinese women” 2000

<sup>27</sup> G. Nestler. “Traditional Chinese medicine” 2002

<sup>28</sup> E. Ernst & J. Coon. “Heavy metals in traditional Chinese medicines” 2001

<sup>29</sup> W. Leigh & M. Lindquist. *Women of color health data book*. Undated

<sup>30</sup> N. Cheung. “Chinese zuo yeuzi (sitting in for the first month of postnatal period) in Scotland” 1997  
RI Department of Health Family Planning Guidelines

End-of-life care for Chinese patients and families centers around family and communications<sup>31</sup>. Symptom management may be complicated by patient and family reluctance to complain and respect for others-especially those in positions of authority. Barriers to pain and other symptom management by family caregivers may also be related to other issues, including a lack of knowledge about pain and pain management, fatalism, fear of addiction, desire to be a good patient, and fear of distracting the physician from treating the disease<sup>32</sup>.

Communications related to end of life issues are often complicated by reluctance to discuss prognosis and in some instances, diagnosis. To a greater extent than in other cultures, it remains a norm among Chinese patients and families for the family to withhold information or even lie to the patient and for the patient to pretend that she or he does not know what is really happening<sup>33</sup>. The family is expected to help prepare the body for burial. Traditionally, there is always an older relative or person from the temple to instruct the oldest son or daughter on what to do regarding washing and dressing the body.

## **HEALTH PROBLEMS AND HEALTH SCREENING**

China is a vast country and conditions and health problems vary widely. Infectious diseases have been greatly reduced over the past several decades, e.g., reported cases of measles dropped from 1.2 million in 1980 to less than 90,000 in 2000. However, China is one of 22 countries worldwide designated by the World Health Organization (WHO) as “high burden” for tuberculosis. The number of TB cases in China is the highest in Asia, but the rate (per 100,000) of new cases in China is 18<sup>th</sup> among 41 Asian countries<sup>34</sup>. With declining rates of infectious diseases, the rates of chronic non-infectious diseases (e.g., cancer and cardiovascular disease) are increasing. Infectious disease risks for new immigrants from China<sup>35</sup>:

- Amebiasis
- Dengue Fever
- Filariasis
- Gnathostomiasis
- Hemorrhagic fever with renal syndrome
- Hepatitis
- Histoplasmosis
- HIV/AIDS
- Hookworm
- Leprosy

---

<sup>31</sup> S. Tang. “Taiwan” 2001

<sup>32</sup> C. Lin. “Barriers to the analgesic management of cancer pain: A comparison of attitudes of Taiwanese patients and family caregivers” 2000

<sup>33</sup> A. Kleinman. *The illness narratives* 1988

<sup>34</sup> World Health Organization. <http://www-nt.who.int/whosis/statistics/dale/dale.cfm?path=statistics.dale&language=english> 2002

<sup>35</sup> T. Hawn & E. Jung. “Health screening in immigrants, refugees, and internationally adopted orphans” 2003  
RI Department of Health Family Planning Guidelines

- Malaria
- Schistosomiasis
- Strongyloidiasis
- Trachoma
- Trematodes
- Tuberculosis

## **F. PACIFIC ISLANDERS**

Pacific Islanders are a highly diverse population indigenous to the thousands of islands in the Pacific Ocean. They comprise more than 19 different ethnic groups with different histories, languages, and cultural traditions. The three largest Pacific Islander groups in the U.S. are Hawaiians, Samoans, and Chomorros (primarily from Guam). Three-fourths of the Pacific Islanders living in the U.S. reside in California and Hawaii.

Commonalities among Pacific Islanders *may* include<sup>3</sup>:

- Many individuals ascribe to a holistic worldview, emphasizing the interconnectedness of the individual, the family, the environment, and the spiritual world.
- The family, village or community, and church may play a prominent role in the life of the individual.
- Pacific Islanders often live in ethnic enclaves or tightly knit communities of Pacific Islanders.
- Ancestors and elders are usually treated with deference.
- Interpersonal and social behavior is based on mutual respect and sharing.
- Many Pacific Islanders have a basic distrust of Western approaches to health care and treatment. They rarely respond positively to health education and treatment based on scare tactics to motivate behavior change.
- Low income and poverty are risk factors that contribute to this population's health status

## **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of

the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Pacific Islanders<sup>3</sup>:

- Native Hawaiians have the highest mortality rate of any U.S. racial or ethnic group for cancers of the breast, lung, ovary, and stomach. They also have the highest mortality rates for leukemia and non-Hodgkin's lymphoma.
- The mortality rates for heart disease, cancer, and stroke among Hawaiians are higher than for the total United States population.
- Risk factors associated with heart disease, cancer, and stroke are high among Pacific Islanders and include hypertension, obesity, smoking, alcohol consumption, and diabetes.

## **G. EASTERN EUROPEANS**

The countries of Eastern Europe have experienced invasions, war, and domination by internal and external groups for millennia. Many groups from this region feel a strong sense of national pride, even if they do not have a nation to call their own. Many of these regions are now separate countries, yet they still contain diverse groups within their borders. Religions in the region include: Orthodox Christianity, Roman Catholicism, Islam, and Judaism.

The commonalities below may apply more accurately to more recent immigrant groups from this region<sup>3</sup>:

- Emotions may be expressed publicly, and crying and physical touching are often acceptable ways of showing emotion.
- Patients may not feel comfortable about being asked too many personal questions, and note taking by a provider may be viewed with suspicion.
- A sick person is often encouraged to communicate her/his suffering with others.
- Relatives give moral and physical support to each other.
- Several generations may live together.
- Food is appreciated, and a good appetite is admired.

- Smoking is common among men, and awareness of the hazards of second-hand smoke may be low.
- Medical treatment may be considered incomplete without a prescription.
- There is little awareness of the importance of exercise.
- Some adults may use alcohol excessively.

## **COMMON HEALTH PROBLEMS**

As immigrants and refugees enter the United States, health care providers need to be more aware of health problems that they may encounter. Providers must also be aware of the impact that different backgrounds, environments, and experiences may have on the occurrence of specific health problems or on the progress of a disease.

The following is the susceptibility to health problems among Eastern Europeans<sup>3</sup>:

- Diseases of the digestive system in men are more common in this population than in the majority population.
- Smoking and weight may be problems.
- Women have higher rates of musculoskeletal complaints than the majority population.
- Tay-Sachs disease occurs in 1/3600 infants of Ashkenazi Jewish heritage.

## **I. PORTUGUESE**

In the late 1800s, large numbers of Portuguese individuals began to immigrate, often first working on whaling ships leaving from the Azores or Cape Verde Islands and settling in Hawaii, California, or New England<sup>36</sup>. At voyage's end they settled in such port towns as Providence, Warren, Bristol, and Newport. They became the pioneers and the beacons that inspired a more massive Portuguese migration to southeastern New England in the

---

<sup>36</sup> Library of Congress. The Portuguese in the United States. <http://www.loc.gov/rr/hispanic/portam/>  
RI Department of Health Family Planning Guidelines

period from the 1890s onward. Then, as one historian has phrased it, "the loom replaced the harpoon" as the tool of the typical Portuguese immigrant<sup>37</sup>.

In the second half of the 19th century, many Portuguese, Cape Verdeans and Azoreans immigrated to Fox Point in search of factory and waterfront jobs. By the end of the 19th century, almost 2,000 Portuguese immigrants had settled in the neighborhood, often crowded into low-income rental units. Predominantly Catholic, this immigrant community eventually erected its own church, Our Lady of the Rosary (1885). Portuguese immigration to Fox Point and other areas of Providence and southeastern Massachusetts was heavy throughout the first part of the 20th century until 1924, when immigration laws halted the flow almost completely<sup>38</sup>.

With the enactment of new immigration legislation in 1921, new arrivals dropped tremendously, picking up again in the 1950s after earthquakes devastated the Azorean island of Faial. The immigrants came largely from the Azores, but also from Cape Verde and Madeira, later from mainland Portugal and occasionally from other parts of the Portuguese empire, including Macau<sup>39</sup>.

The 2000 Census lists 1,177,112 persons of Portuguese ancestry in the United States. States with the largest Portuguese-American populations include: California (330,974), Massachusetts (279,722), Rhode Island (91,445), New Jersey (72,196), and Florida (48,974). In Rhode Island, persons of Portuguese ancestry currently make up 8.7% of the state's population<sup>40</sup>.

The often described profile of the Portuguese American family is that of a family-oriented, hard-working family. Therefore, it is of no great surprise that about 70% of all Portuguese American families own their own home and have contributed greatly to the revival of neighborhoods by restoring distressed properties. They are proud of their heritage and are undoubtedly Americans<sup>41</sup>.

#### **a. CAPE VERDEANS**

Cape Verdean migration to the United States in the 19th and early 20th centuries was composed of the islands' poorer classes. In 1922, the U.S. government restricted the immigration of peoples of color, greatly reducing Cape Verdean immigration. The new

---

<sup>37</sup> Rhode Island History, Chapter VII, Boom, Bust & War, 1900-1945.  
<http://www.rilin.state.ri.us/studteaguide/RhodeIsland>

<sup>38</sup> Fox Point, Providence Neighborhood Profiles.  
<http://www.umassd.edu/SpecialPrograms/caboverde/foxpoint/foxpoint.html>

<sup>39</sup> Rhode Island History, Chapter VII, Boom, Bust & War, 1900-1945.  
<http://www.rilin.state.ri.us/studteaguide/RhodeIsland>

<sup>40</sup> The Portuguese in America. <http://www.euroamericans.net/euroamericans.net/portuguese.htm>

<sup>41</sup> Danbury, Connecticut Portuguese Cultural Center. Background.  
<http://www.portugueseculturalcenter.com/background.htm>

regulations also prevented Cape Verdean Americans from visiting the islands for fear being denied reentry to the United States. The two communities thus were relatively isolated from each other for approximately 40 years<sup>42</sup>.

In 1966 the U.S. government relaxed its regulations, and a new wave of Cape Verdean immigration began. The new arrivals in Boston, Brockton, and Scituate, Massachusetts, Pawtucket, Rhode Island, Waterbury, Connecticut, Brooklyn, and Yonkers, New York, and other communities on the East Coast met a Cape Verdean-American ethnic group whose members looked like them, but differed culturally. Separated for so long, the groups knew little of each other's recent history or treasured memories<sup>43</sup>. Today, Dorchester, Massachusetts; Brockton, Massachusetts; and Pawtucket, Rhode Island are the fastest growing new Cape Verdean communities in the United States<sup>44</sup>.

## COMMUNICATION AND LANGUAGE

Immigrants have come to the U.S. primarily because of economic hardships in Cape Verde. They are seeking opportunity in the form of better jobs and education. The earlier whaling industry and later cranberry bogs attracted Cape Verdeans to the New England area. Most of the immigrants were impoverished farmers who hoped to secure a better future for themselves back in Cape Verde by their labor abroad. Many Cape Verdeans came to the U.S. to work and save money for 10 or more years before eventually moving back to Cape Verde and providing a better life for their family in their home country. Today, many immigrants make the U.S. their home but visit Cape Verde often and continue to help loved ones back in Cape Verde by sending money and supplies when possible<sup>45</sup>.

The Kriolu language in Cape Verde is probably the oldest of the many different Creole languages still spoken in the world today. It arose in the 15th century as a consequence of Portuguese slave trading on the west coast of Africa. Initially, business was conducted in a pidgin language based on Portuguese. Africans taken by the Portuguese on the Coast as slaves were brought to Cape Verde for transshipment to the plantations of the New World. The Kriolu of Cape Verde is enriched by concepts, structures, and cadences from the languages of the many Africans who were brought there. After independence in Cape Verde in 1975, Portuguese remained the official language in Cape Verde and Kriolu is designated as the national language<sup>46</sup>.

---

<sup>42</sup> Raymond A. Almeida. Nos ku Nos: The Transnational Cape Verdean Community <http://www.umassd.edu/specialprograms/caboverde/cvtransnat.html>

<sup>43</sup> Raymond A. Almeida. Nos ku Nos: The Transnational Cape Verdean Community <http://www.umassd.edu/specialprograms/caboverde/cvtransnat.html>

<sup>44</sup> Cape Verdean History & Culture. [http://www.spiamedia.com/cape\\_verde.html](http://www.spiamedia.com/cape_verde.html)

<sup>45</sup> Cape Verde. [http://www2.bc.edu/~brisk/capeverde.htm#Cape\\_Verde](http://www2.bc.edu/~brisk/capeverde.htm#Cape_Verde)

<sup>46</sup> Manuel da Luz Gonçalves. Cape Verdean Kriolu in the United States. <http://www.umassd.edu/specialprograms/caboverde/cvkriolu.html>

There are several dialectal varieties of Crioulo, which can be roughly divided between the varieties spoken in the Leeward Islands and those spoken in the Windward Islands. Crioulo has significantly contributed toward a definition of national culture in the Cape Verdean Islands. It has also helped sustain a sense of shared cultural identity among Cape Verdeans in other parts of the world.

Crioulo is primarily an oral language and as such has many oral traditions. These include: social talking; sparring with friends; vivid storytelling; mourning openly at a funeral; *mornas*, which are spontaneous poems, songs, and dances used to express the hardships and hopes of Cape Verdeans; and *mantenhas*, orally-delivered messages used as a primary means to communicate and maintain relationships between Cape Verdeans in the U.S. and those back home. These oral traditions continue to link Cape Verdeans throughout the world.

Although Crioulo is the national language of Cape Verde and is spoken by the majority of society, it is not officially used in educational settings. Portuguese is the language of choice in educational circles and lessons are conducted in only this language in Cape Verdean schools. Crioulo is used in school but informally; i.e., talking with peers..

Most Cape Verdeans in the U.S. are bilingual (Crioulo/English) and some (depending on birthplace) are trilingual (Crioulo, Portuguese, and English). Crioulo is used frequently by many Cape Verdeans in the U.S. and its use is dependent on the situation. Some Cape Verdeans speak Crioulo in many aspects of their lives (school, work, with family, friends, and so on). It is used in schools primarily in Crioulo/English bilingual classes and informally in mainstream classes and common areas to communicate with peers. Most Cape Verdeans find that learning and using English in the U.S. is important, and English is often the preferred language. However, when communicating with elders, Crioulo is the preferred language<sup>47</sup>.

## RELIGION

Cape Verdeans are predominately Catholic, which has greatly influence Cape Verdean culture<sup>48</sup>. Cape Verdeans held a Catholic tradition since the middle 15th century, yet the early American Catholic churches were not very welcoming to immigrants of a different color or language. Most of the early black population in America belonged to the Anglican Church. This isolation was unusual for the Cape Verdeans whose cultural heritage was comprised of Italians, Africans and even Jews who had fled to the island after the Inquisition. This multi-ethnic upbringing led to multiple skin colors within the fabric of Cape Verdean life, which was quite different from the more rigid homogeneous Yankee traditions<sup>49</sup>. Today, about 80% of the population in Cape Verde is Catholic<sup>50</sup>.

---

<sup>47</sup> Cape Verde. [http://www2.bc.edu/~brisk/capeverde.htm#Cape\\_Verde](http://www2.bc.edu/~brisk/capeverde.htm#Cape_Verde)

<sup>48</sup> Cape Verde. [http://www2.bc.edu/~brisk/capeverde.htm#Cape\\_Verde](http://www2.bc.edu/~brisk/capeverde.htm#Cape_Verde)

<sup>49</sup> The ethnicity of Blackstone Valley. <http://www.blackstonedaily.com/bvpeople.htm>

<sup>50</sup> Cape Verde. [http://www2.bc.edu/~brisk/capeverde.htm#Cape\\_Verde](http://www2.bc.edu/~brisk/capeverde.htm#Cape_Verde)

## **CULTURAL AND SOCIAL RELATIONS**

Respect for cultural heritage and common historical experience is an important public virtue in the Cape Verdean community. People who enjoy the community's deepest respect are those who achieve economic success "in American terms and who remember where we came from". Until the 1960s Cape Verdeans had not aggressively sought participation in the local political institutions of southern New England. People voted and paid taxes but seldom expressed their needs to City Hall. As in many of America's communities of color, politics began to change in the 1960s. By the 1970s, Cape Verdeans had begun to enter into political coalitions with African American and Latino groups. In Massachusetts, Rhode Island, and Connecticut, Cape Verdeans have been elected to the state legislatures.

In Cape Verde, 71% of the population is Creole (mulatto, 28% are African, and 1% is White<sup>51</sup>. Most Cape Verdean Americans agree that being Cape Verdean in America would always be a difficult negotiation of culture, identity, and political alliance. Are the Cape Verdes "Atlantic" islands or "African" islands? Are Cape Verdeans Cape Verdeans or Portuguese or both? <sup>52</sup>.

### **b. AZOREANS**

#### **CULTURE**

Azorean culture is family based<sup>53</sup>. Family means survival to the Azorean peasant because everyone is needed to work the land in order to provide food, shelter, and clothing for everyone. Raising healthy children means a continuation of the family and hence the culture. This cultural tradition was transferred to the United States with the immigrants.

Women are considered working equals on the islands because of the manual labor required. They work with their husbands in the fields and around the homestead. In New England, Azorean women have worked away from their home, typically in the factories. This exception is allowed culturally because her employment is necessary to the family.

The Azorean family is strongly male-dominated which causes stress in the immigrant family in America. There has always been respect for the elderly in the Azorean culture.

Azoreans are generally friendly and each individual will have several personal friends. A relative is trusted before a friend because "blood is thicker than water". In America, friends cannot be in the same occupation because the Azorean is a strong competitor. A

---

<sup>51</sup> Cape Verde. [http://www2.bc.edu/~brisk/capeverde.htm#Cape\\_Verde](http://www2.bc.edu/~brisk/capeverde.htm#Cape_Verde)

<sup>52</sup> Raymond A. Almeida. Nos ku Nos: The Transnational Cape Verdean Community  
<http://www.umassd.edu/specialprograms/caboverde/cvtransnat.html>

<sup>53</sup> Azorean Culture & Assimilation. (<http://www.library.csustan.edu/bsantos/culture.html>)

father will like his son to succeed, but he does not want him to be more successful than he is.

The immigrant Azorean has made the best effort to keep their culture intact. Azoreans often live in conclaves isolated from American society. Their system of immigration of bring family and friends to the United States and settling them in the same locations keeps the Azorean culture alive. This way the language can continue, their tradition of religion and celebration remains.

## **RELIGION**

To be Azorean is to be Roman Catholic. It is part of the culture. Women are the spiritual motivators in the Azorean culture. Men are basically inactive church members but expect their children and women to attend. The church however, is the nerve center of the traditional Azorean society. It provides not only spiritual aid but social and cultural support as well. Many of the Azorean celebrations are church-related and church gatherings are contacts for people and especially children who will someday marry.

## **COMMUNICATION**

The names of many Azoreans were changed when they entered the United States. Mostly illiterate, they couldn't write their names so when an immigrant official asked for a name, he usually wrote what he heard or changed it to something recognizable in English. Teachers and census takers did the same thing. Joao became Joe or John. Mello became Miller. Pereira became Perry.

Immigrant Azoreans tend to give their children traditional Portuguese names, such as Joao or Maria, but some wanted to Americanize their children quickly by giving them standard English names, such as Charles or Alice. Second and subsequent generations gave their children English names dropping the Portuguese forms altogether.

In New England, Azoreans had to learn English because their supervisors in the factories spoke English. They had to learn basic English to understand their work and communicate with others. In fact, the better English that one spoke, the better position one would get at work.

The first generation immigrant will speak some of his new country's language. The second generation is generally bilingual, while the subsequent generations will not speak the old country's language at all. Public education was the basis method of acculturation.

### **c. BRAZILIANS**

Brazilian heritage is rich in its mixture of Portuguese, French, Dutch, German, Italian, Japanese, Chinese, African, Arab, and native Brazilian Indians. Brazilians do not consider themselves Hispanics despite similarities in their ethnic features. Their native

language is Portuguese, not Spanish. Many Brazilians in the United States are *escondidos*, hidden or officially referred to as undocumented aliens. These people rarely seek health services for fear of being discovered. Most Brazilians are concentrated in communities around Boston, Massachusetts; New York, New York; Newark, New Jersey; and Miami, Florida<sup>54</sup>. Rhode Island has a small Brazilian community that is generally mixed in with the Portuguese and Cape Verdeans in Pawtucket, Central Falls, and West End of Providence<sup>55</sup>.

The major reason for migration among Brazilians is the economy. Most immigrants who come to the United States are under the age of 30. There are more males than females, and most are representative of the middle and lower-middle classes. There are relatively few second- and third-generation Brazilians where both the mother and father have immigrated to the United States. Ultimately, their desire is to receive a green card so that they may work legally and later return to Brazil to buy a house or condominium. Some send money to Brazil to help their family. One of their greatest aspirations is to return to their homeland within a few years as a wealthy person. Toward this end, they subsist in urban slums without privacy and think only of earning money. They frequently leave behind children, wives, and family to become slaves of work in any type of situation. The legal minority includes those who have married and raised families and those Brazilians who are government attaches.

In Brazil, the poor often cannot afford public education that is available to all. Lack of money, transportation, accessibility, and time create insurmountable barriers. Although the literacy rate in Brazil has improved recently to 81 percent, underprivileged classes often have no education beyond the fourth grade. Young people from interior regions commonly sign their papers with a thumbprint.. Generally, public schools are poor in disciplining students and enforcing punctuality; they also lack necessary supplies and other resources.

Brazilian immigrants are underemployed. It is common knowledge that many Brazilian immigrants often give up their professions to earn money as illegal domestic workers, waiters, cab drivers, and so on. Even these low-paying jobs pay more than what can be earned in Brazil. Immigrants often migrate to large cities where there are many networks for finding "under-the-table" wages.

---

<sup>54</sup> Marga Simon Coler. Brazilian-Americans. <http://www-unix.oit.umass.edu/~efhayes/brazil.htm>

<sup>55</sup> Paul Pence, Managing Editor. Rhode Island Rhodes Magazine. [www.riroads.com](http://www.riroads.com)

## LANGUAGE

Portuguese is the official language of Brazil and continues to dominate the Brazilian communities in the United States. Brazilian Portuguese is different from its mother language in the meanings of certain words, accents, and dialects. Dialects vary among Brazilians.

Brazilians have a difficult time adapting to English if they have not had good training before entering the United States. Especially difficult is language intonation and the pronunciation of certain words. Many undocumented Brazilians find employment within the Brazilian community where they may never have to learn the language. Regular employment is difficult when one is unsure of the language and others are aware of one's foreign accent.

## COMMUNICATION

Many Brazilians continue to be of "proper" old world orientation where true feelings are not divulged for fear of hurting the receiver of the communication. Everything is said to be *tudo bom*, great, almost in a stoic sense. However, in the intimate circle of family and/or compatriots, the sharing of thoughts and feelings is common. Young adult and adolescent Brazilians in the United States are generally more acculturated because of their desire and need to assimilate into the new culture. Among this group, there is probably more intergenerational communication than intergenerational and transcultural communication when it comes to sharing thoughts and feelings.

## CULTURAL AND SOCIAL RELATIONS

Like many of their Latin-American cousins, Brazilians frequently use touch and maintain eye contact. Women kiss each other on both cheeks when they meet and when they say good-bye. At times, women and men kiss in the same manner. Men shake each other's hands and slap each other on the back with the other hand. This gesture frequently ends in an embrace. Children are kissed and there is much touching. The kissing of a child frequently includes the combination of a kiss and smell (*beijo e cherinho*). Spatial distancing is close. Facial expressions and symbolic gestures are commonplace.

In Brazil, temporality is oriented to the present because of the unpredictable future. This orientation to the present can be seen in the use of language, in which telephone lines "fall" [fall down] or, as Brazilians also say, electricity "falls" [power outage]. Therefore, for emotional survival, the time factor must necessarily be oriented toward the present. However, most Brazilian immigrants are future oriented. Their immigration to the United States is for a specific reason such as obtaining an advanced university degree, earning money, or getting a green card.

Brazilians, in general, are not punctual. It is *o jeitinho Brasileiro para chegar um pouco atrasado*. Brazilians tend to arrive "a bit" late (from minutes to hours) especially for social occasions. Everyone seems to know that behavior of tardiness and builds his or her

plans around it. Lunchtime takes longer than the usual 2 hours and is frequently used to do errands. People take unexpected holidays and punctuality is not taken seriously.

Children who have no father are often given the mother's maiden name to which *da Silva* is added, denoting that the line of paternity is unclear. In day-to-day relationships, people are called by their first name or *Seu, Senhor* (more respectful) preceding the first name of a man or *Dona* preceding the first name of a woman. Mothers, grandmothers, or respected strangers are referred to as *A Senhora*, and fathers, grandfathers, and respected men are called *O Senhor*. In the same vein, God is always referred to as *O Senhor*.

The Brazilian society is one of *machismo* with the middle and upper classes being patriarchal in structure. As women are asserting their equality, more egalitarian relationships are becoming evident. Gender roles vary for Brazilians according to socioeconomic class and education. Lower socioeconomic households tend to be more matriarchal in nature with little change

Social status is very important in the Brazilian society. This is well demonstrated in the titles that people use with each other. Class separation is discretely maintained by literacy status.

In Brazil, the goal is one of family unity and success. In the lower socioeconomic class, the goal is survival. The goal for many Brazilian families residing in the United States is to make money to be able to return to Brazil. Family members living in the same household abroad pool their money so that priority needs can be met. Although a sense of responsibility and loyalty to family and country is strong, a sense of responsibility to political causes may be weak. Loyalty can be easily bought.

The elderly live with one of their children and nursing home placement is uncommon. They are respected, seen as the family counselor, and are always addressed as *O Senhor* or *A Senhora*. The elderly are included in family activities.

Brazilians are loyal to their extended families and help relatives. The extended family is very important in Brazil where a *jeitinho*, knack, is always procured for employing relatives in any type of service, from the government to a bank, or for helping a relative get into a special university or school. Family businesses are common, even in the lower-middle class where everyone pools their money to live comfortably.

Godparents are a very important family extension. Poor families frequently ask their *patron* or *patrona*, employer and wife, to be godparents to their child. Godparent responsibilities include clothing, schooling, and caring for the child in case of the parent's death. The godmother is called *comadre* by the mother and vice versa. *Compadre* is used in reference to the godfather.

Single-parent families are also becoming more commonplace in Brazil, which is overpopulated with women who may not have a chance for marriage, and thus decide to

have children out of wedlock. In middle-class families, the "no father" status is obscured by the child receiving the same middle and last names as the mother.

Brazilians are often treated as Hispanics, adding to their discomfort. Brazilians generally respect authority and are frequently more comfortable in an employment situation where there are well-defined rules and job specifications. There is generally a lesser sense of responsibility in Brazil than in the Euro-American culture.

The "typical" Brazilian is a *moreno* with brown skin and eyes and black or brown hair. However, from the southern states of Brazil are individuals with *cabelos louros*, blond hair, and *olhos de azul*, blue eyes. Oriental Brazilians, the majority of whom emigrated from Japan in 1908 in hopes of finding a better economic future, now total more than 1.2 million. Most live in the State of Sao Paulo. It is not unusual to see a Japanese first name with a Portuguese last name, or vice versa. In actuality, diverse gene pools of native Indians and a multitude of other nationalities make it impossible to actually describe a typical Brazilian.

Brazilians are fiercely proud of their genetic mixture of Portuguese, French, Dutch, German, Italian, Japanese, Chinese, African, Arab, and Aboriginal blood. The southern states of Brazil were settled mostly by Germans and Italians. However, there has been much intermarriage among these groups.

## **HEALTH PROBLEMS**

People living in the tropical Amazon valley may be afflicted with malaria, trypanosomiasis (Chagas' disease), and other rare tropical disorders. However, it is uncommon for people from this region to emigrate to the United States. Besides malaria and Chagas' disease, schistosomiasis, dengue fever, typhoid fever, Hansen's disease, hepatitis, and tuberculosis are present in various parts of Brazil. No data were found addressing the overall health conditions for Brazilians residing in the United States. Of the principal causes of death reported in the mid-1980s in Brazil, the highest mortality rate recorded was for heart diseases followed by cerebrovascular diseases, malignant neoplasms, accidents, perinatal conditions, influenza, and pneumonia. With the exception of accidents, all causes of death showed a higher mortality rate for females than males. In the Brazilian North and Northeast, cholera remains endemic. Because intestinal worms are common in Brazilian immigrants, parasitic diseases should be considered when health assessments are undertaken.

Interviews have substantiated that the incidence of gastrointestinal diseases increases when Brazilians first move to the United States. Changes in eating habits from the long and ample midday dinner to fast foods have left Brazilian-Americans with gastric complaints. Different methods of milk pasteurization along with a genetic tendency toward lactose intolerance can contribute to some of these gastric problems. Many Brazilian stomachs do not tolerate the American salad bar. Interviewees also report an increased incidence of allergies, especially in children of Brazilian immigrants.

Socioeconomic class, age of immigration, and racial mix of Brazilians make it impossible to postulate the hereditary and genetic diseases of this immigrant population. Cited mortality figures of Brazil might give a clue to some possibilities. However, this would have to be specifically studied given the variables of the immigrant population. One would also have to include variables such as diet and activity of immigrants and compare lifestyles in their place of origin to provide validity. A number of interviewees cited that entering Brazilians, at first, tend to "get fat" on the diet irregularities and environmental change. However, as persons become assimilated into the North American lifestyle, weight gains are generally resolved.

The only endemic disease following Brazilians to the United States and for which documentation is found is acquired immunodeficiency syndrome (AIDS). Brazil ranks third in the number of AIDS cases reported in the Western Hemisphere during the mid-eighties.

## **HEALTH PRACTICES AND RISK FACTORS**

Because Brazilian immigrants frequently settle in Brazilian enclaves in large cities in the United States, they are subject to the same risk factors as any socially vulnerable urban subpopulation. The greatest risks are violence, drugs, and crime. Adolescents run the risk of resolving their adolescent identity crises by either banding together or joining Hispanic gangs; perhaps, having been forced into the latter by the United States classification system of their ethnic groups.

Because cigarette smoking is a part of the Brazilian culture, smoking is a high-risk behavior among Brazilians living in the United States. Among males, drinking hard liquor is also prevalent. Accessibility and use of street drugs and an individual's desperate search for quick money are other identifiable high-risk behaviors and often involves living in crowded ghetto conditions where rent is inexpensive. The undocumented status of Brazilian immigrants places them at a high risk for nonassimilation into the culture of the community in which they live.

Another risk factor, especially for adolescents, is that of contracting AIDS or other sexually transmitted diseases. This high-risk factor is the consequence of the promiscuous sex life permitted in the United States.

Health-seeking behaviors among Brazilians living in the United States are increasing. Safe sex is frequently sought to prevent AIDS. Brazilians are becoming increasingly aware of the value of exercise and good nutrition, although both become less important when weighed against their desperate search for money. Although many immigrants are aware of the ill effects of smoking and recreational drugs, loneliness and frustration are deterrents to stopping these habits.

Most Brazilians do not talk about their illnesses unless they are very serious. Generally, illness is discussed only within the family. Many Brazilians feel that talking about an illness such as cancer negatively influences their condition.

Brazilians tend to shun hospitals and when they are hospitalized; their family comes with them and stays with them around the clock. In Brazil, there are folk stories of people who have had their organs, limbs, babies, and children stolen or killed at university hospitals for medical students to practice their anatomy or for rich people to receive quick and healthy transplants. These stories promote the reluctance among some Brazilians to seek health-care in hospitals. In Brazil, the hospitalized patient is often brought food from home. Brazilian families are eager to participate in patient care and, thus, are taught various procedures.

## **DIET**

Food is important in the celebration of all rites among Brazilians. Food and its counterpart, hunger, are often viewed as symbols that determine social relations. The mainstay of the Brazilian-American's diet continues to be rice, beans, and farina. Roast beef, fresh chicken, and seafood are sought when it is not too expensive. Meats and fish are prepared in Brazilian style. *Cafe de manha*, breakfast, typically consists of bread with *cafe com leite*, half coffee and half hot milk. Sometimes *cuscus*, a dry cornmeal mush, is served with milk. Fruit, fruit juices, and scrambled eggs with or without sliced hot dogs are common special breakfast fares among middle-class families. Sometimes sweet potatoes and yams grace a breakfast table.

*O almoco*, dinner, is eaten at noon. This heavy meal, consisting of beans, rice, and farina, often includes *puree*, mashed potatoes, and *macarrao*, pasta. Desserts such as *pudim de leite*, custard; various cornmeal pastries; fruit; and *doce*, a sweet paste made by boiling sugar and fruit or fruit pulp, are common, especially during late June when the holidays of St. Anthony, St. John, and St. Peter are celebrated. A typical vegetable salad consists of finely cubed carrots, potatoes, and *shushu*, a summer squash-like plant. A fruit salad with finely cubed fruits is also common. *Almoco* in a middle-class home has at least one course of meat, chicken, and/or fish. Beef is preferred very well done.

In Brazil, *Goma*, a manioc starch, fills the stomach. In fact, the manioc root may be viewed as the symbolic plant, which, when made into gruel, fills babies' stomachs for mothers who can no longer provide breast milk because of chronic malnutrition. This gruel is used by the middle and upper classes as a traditional satisfier for hungry babies. *Comidinhas*, little foods, are often classified as luxury foods for the rich and filling foods for the poor.

Brazilian-Americans have become vitamin and health food conscious. Although this luxury is often not available to those who have immigrated for fast money, legal residents generally become consumers of health foods. The preference, especially among young Brazilian women, is to rely on vitamins instead of a heavy diet to help them remain thin.

Lower socioeconomic classes frequently experience nutritional deficiencies. Infant deaths due to dehydration are common. Undocumented Brazilians who are here to earn fast

money may experience malnutrition. Fruit juices are expensive and special foods that are common to the Brazilian diet are hard to procure in the United States.

Food limitations are imposed by expense and inaccessibility of Brazilian mainstay foods. However, many Brazilian communities in the United States have ethnic markets and restaurants. Large chain supermarkets often carry a section of ethnic foods, some of which are not very expensive.

## **PREGNANCY**

Although Brazil is predominantly a Catholic country, birth control is taught and used. Women are encouraged by their physicians and/or clinic personnel to have tubal ligations to prevent unwanted pregnancies. Brazil is a fatalistic country, so unwanted pregnancies and abortions are, in the end, left in God's hands. Among the poor, there are herbal teas for bringing on late menstrual periods and teas for stimulating natural abortions. Mixed with fatalism is a strong sense of realism. Therefore, immigrants in the United States generally practice birth control so as not to interfere with their reason for coming to the United States. At times, single women try to become pregnant to facilitate their chance of permanency in the United States. This opportunity is greatly enhanced if the child is born in the States and has been able to attend school. Thus, fertility practices among immigrant Brazilians are a matter of convenience with a traditional fatalistic overtone.

Brazilians realize that there is an overpopulation problem and modern middle-class Brazilians like to have a *casal*, a boy and a girl, and stop there. Pregnancies are generally accepted fatalistically (God's will). Frequent topics of conversation among northeastern Brazilian women in the lower socioeconomic classes are pregnancy, abortion, stillbirths, and child mortality. The average woman has over nine pregnancies, several stillbirths and infant deaths, and raises four to five children. Pregnancies among immigrants are treated according to the mother's beliefs. There are tales of pregnant women returning home to their families to receive care and to have their babies in Brazil; and there are also tales of mothers who have expectations that their North American born child will have dual citizenship.

There are many restrictions related to pregnancy. Women are encouraged not to do heavy work and not to swim. There are taboos against having sexual relations during pregnancy. Some foods are to be avoided and specific foods are recommended during pregnancy. Taboos generally vary according to geographic region, socioeconomic class, and ethnic background.

Many Brazilian mothers prefer to give their baby powdered dry milk instead of breast-feeding. Middle-class women wish to regain their figures as soon as possible. Lower-class women often feel that their milk is *fraca*, weak. Breast-feeding is linked to a social stigma in that a mother who breast-feeds may often be thought of as abandoned or sexually unattractive. In the Brazilian culture, a postpartum woman eats chicken soup to help her body return to normal. She is also advised not to eat spicy foods or *repadura*, a

molasses candy, and not to drink *garapa*, sugar water; or *caldo de cana*, sugar cane juice, if she breast-feeds her infant.

## **DYING AND DEATH PRACTICES**

Responses to death and grief depend on the family. To a poor family, a continuously suffering person is rescued. The fatalistic expression, "It was God's will" helps the grieving among the rich and the poor. Older persons wear black for various lengths of time depending on the relationship of the family member. Frequently, the final portrait is hung in the family *chaper* or near the family altar, and prayers are recited. There is an eternal burning light. Relatives are honored on the anniversaries of their death, both at home and at *missas*, masses. Often, the family places an obituary of remembrance with or without a picture of the deceased in the local newspaper on the anniversary of their death. *Anojamento* is the term used for deep mourning or grief.

## **RELIGION**

Although predominantly a Catholic country, various Protestant sects are making inroads into the Brazilian culture. Jewish temples and synagogues and various Eastern religions are also present in Brazil. Spiritualism often occurs in the form of Afro-Brazilian sects and the Western Universal Church of the Reign of God. Spirits and souls are called to intervene in the various problems of health, life, and death. Aside from the *curandeiros*, folk healers, there are special healers who exorcise and pray for the wellness of their clients. Saints are asked to help and people wear medals or little pouches of special powders around their neck. Although most traditional religions are represented in Brazil, prayer is an individual matter. The family altar is a common site of prayer. Frequently saints and "Our Lady" are asked for intervention.

The meaning of life is found in religion, economy, fatalism, and reality. For some, life is *uma luta*, a battle. For others, life is an almost hedonistic attitude. Most of the males drink and are jolly on weekends. The upper classes enjoy whiskey and other types of hard liquor. The lower classes have *cana*, *aguar dente*, or *cachaca*, alcoholic liquor made of sugar cane. Women and children dance their native dances the minute familiar music is played. The greatest source of strength for Brazilians is the immediate and extended families. Tradition and folk religion is another source of strength.

## **HEALING PRACTICES**

Brazilians are known for their practices of self-medication. Antibiotic, neuroleptic, antiemetic, and most other prescription drugs are easily obtained over the counter in Brazilian pharmacies. There are a sizable number of persons who use homeopathic medicines and herbs. Once in the United States, it becomes difficult to obtain the many drugs readily available in Brazil. Customarily, incoming Brazilians bring medicines requested by their friends, and thus maintain the circulation of medications not available to Brazilians living in the United States. Lexotan (bromazetan), for sleep, and Gardenal

(phenobarbatone), an antianxiety medication and sleep enhancer, are some of the drugs commonly sought.

Because Brazilians tend to self medicate, the procurement of necessary health care is often avoided or delayed. Consults with someone who has the condition or with friends who know someone who has a similar condition may be the first steps taken. A trip to the local pharmacist may be the second. A third response may be a desperate telephone call to Brazil asking for a particular medicine.

The focus of health care is slowly moving from the individual to the family and community. Brazilian immigrants are influenced by health promotion and prevention propaganda and are becoming increasingly health conscious when finances permit.

The Brazilian culture is rich in folk practices. These depend on geographic region, ethnic background, socioeconomic factors, and generation. Aside from traditional and homeopathic pharmacies, there are *remedios populares*, folk medicines, and *remedios caseiros*, home medicines. Folk remedies and traditional health-care practices are intermeshed when a serious illness may be treated best by traditional caretakers. Some take homeopathic *bolinhas*, little white balls, prepared specifically for certain ailments. In Brazil, *curandeiros*, folk healers, generally treat the poor who have little faith in the public clinics and their endless lines and long waiting periods. Use of herbs, roots, leaf teas, and salves are common cures for specific ills. Soaking garden vegetables in a tablespoon of vinegar or bleach and scrubbing with blue soap and water is common since cholera affects the populace.

## **HEALTHCARE ISSUES**

At times, support services for legal and/or undocumented Brazilians are hard to find by immigrants who do not have language skills or the self-esteem to become assimilated into the culture of their newly found environments. In fact, language is considered to be one of the major problems for these immigrants. They neglect to learn English and get by in their underworld community. This behavior is detrimental to accessing health-care facilities. Frequently, these Brazilians lack health insurance and are not candidates for Medicaid.

In addressing the problems encountered by seropositive and AIDS patients, language is cited as one of the principal barriers for Brazilians. Those with a good command of the language can more readily incorporate new technical terms into their vocabulary. Another barrier to health care for Brazilians in the United States is the cost of health care. This, combined with lack of knowledge about the health-care system and facilities, impedes both legal and illegal residents.

Brazilians generally do not like to talk about pain. However, once the emotional barrier is removed, they feel relieved to be able to discuss their discomfort. Many pain-relieving medicines are available without a prescription in Brazil. Frequently a person requiring

these on a regular basis can request friends or friends of friends to bring a supply from Brazil.

Brazilians do not work if they are really ill. Sickness is a neutral role and is considered socially exempt. This role is free of guilt, blame, and responsibility. It is often seen as something that just happens. Among the lower socioeconomic class, especially those in the Northeast in Brazil, the term "*nervios*" refers to an all-incorporating illness. Nervios is the ever-present folk diagnosis that identifies the weakness, craziness, and anger that is associated principally with hunger. This diagnosis reveals and simultaneously conceals the truth of an existence of a struggling people.

The folk health field has many types of health-care practitioners. There are *curandeiros* who are divinely gifted; *rezadeiras*, praying women, who help exorcise an illness; card readers who can predict fortunes; *espiritualistas* who are able to summon souls and spirits; *conselheiros*, counselors or advisors; and *catimbozeiros*, or sorcerers. Additionally, the *mae* or *pai de santo* are head priestesses or priests from the African-Brazilian Umbanda or Xango religion. All have the power to heal their believers.

Brazilians in the United States tend to respect physicians and nurses. The medical profession does not restrict according to gender. Generally Brazilians seek a good physician rather than base their choice on the professional's gender. Some women prefer female physicians in gynecology and obstetrics<sup>56</sup>.

#### **IV. COMMON HEALTH PROBLEMS AMONG NEWLY ARRIVED IMMIGRANTS AND REFUGEES**

Newly arrived immigrants and refugees should be screened for a number of conditions that are commonly found in developing countries<sup>3</sup>.

##### **Tuberculosis**

- In the U.S., being foreign born is the most important risk factor for tuberculosis (43% of cases in 1999 were foreign born). People whose country of origin is Mexico, China, Vietnam, Korea, or the Philippines comprise the majority of cases of TB among the foreign born.
- In 1999 the TB case rate for foreign-born people was 29.2 per 100,000 and 4.0 per 100,00 for people born in the U.S.

---

<sup>56</sup> Marga Simon Coler. Brazilian-Americans. <http://www-unix.oit.umass.edu/~efhayes/brazil.htm>

- All refugees and immigrants applying for permanent visas in the U.S. are required to be screened for both TB and HIV. Anyone with a temporary visa (i.e., student, tourist, work visas, etc.) is not required to be screened.
- If a refugee tests sputum-positive for TB, he/she will be held until treatment is completed. Immigrants are barred from entry until they are no longer contagious and do not need to have completed treatment prior to admission into the U.S.
- Multi-drug-resistant TB is especially common in the Soviet Union and South Africa.
- Having HIV/AIDS is also a tuberculosis risk factor.

### **HIV/AIDS**

- All refugees and immigrants applying for permanent visas in the U.S. are required to be screened for HIV.
- People with HIV infection are at greater risk for developing active TB than those who are HIV negative.
- Sub-Saharan Africa currently has 24.5 million adults and children living with AIDS. In Botswana 36% of adults (ages 15-49) are infected with HIV. To put this in perspective, 0.61% of adults in the U.S. are infected while 8.57% of adults in sub-Saharan Africa are infected.

### **Hepatitis B**

- In some parts of the developing world (including sub-Saharan Africa, most of Asia, and the Pacific), people infected with the Hepatitis B virus most often contracted the disease during childhood. In these regions, 8% to 15% of people in the general population become chronic carriers; in the same regions, liver cancer caused by Hepatitis B is either the first or second most common cause of cancer deaths in men.
- High rates of Hepatitis B are also found in the Amazon and the southern parts of Eastern and Central Europe.
- In the Middle East and the Indian sub-continent, about 5% of people are Hepatitis B carriers. Infection is less common in Western Europe and North America, where less than 1% is chronic Hepatitis B carriers.

## **Parasites**

- Intestinal parasites such as ascaris, strongyloides, hookworm, tape worm, giardia, E. histolytica, trichuris, flukes, and schistosomiasis-as well as hematological parasites such as leishmaniasis, trypanosomiasis, and Plasmodium (malaria)-are common in people living or traveling throughout the developing world. Malaria and hookworm infestation are often leading causes of anemia in new arrivals.

## **Incomplete Immunization**

- Immunizable diseases such as rubella, measles, Hepatitis B, and diphtheria are common in adult immigrants and refugees as well as children, due to incomplete immunization among adults.

## **Post-Traumatic Stress Disorder**

- Many countries of origin of immigrants and refugees to the U.S. have experienced or are currently experiencing intensive civil strife and armed conflict. People who are arriving from Liberia, Burundi, Rwanda, Republic of Congo, Angola, South Africa, Cambodia, Vietnam, Myanmar, East Timor, Sri Lanka, Bosnia, Kosovo, Chechnya, El Salvador, Columbia, and Guatemala, for example, may have witnessed or been victims of violence and atrocities. A large number of women have been raped and others may have been forced to witness the torture and execution of loved ones. These people may suffer from post-traumatic stress disorder.

## **Malaria**

- Relapses of Plasmodium vivax and Plasmodium ovale may be seen in people who have lived or traveled in sub-Saharan Africa, Asia, and parts of Latin America. Some people who have lived in endemic areas for most their lives may have only minimal symptoms. Primaquine (the treatment for the prevention of relapses) is contraindicated in people with Glucose-6-phosphate dehydrogenase (G-6PD) deficiency.

## **Lead Poisoning**

- Elevated lead levels are often seen in immigrant and refugee children coming from areas where pollution from vehicles using diesel and leaded fuel is high (most cities in the developing world).

## **Female Genital Mutilation**

- Female Genital Mutilation (FGM), also referred to as female circumcision or female genital cutting, is regularly practiced in 28 African countries, 5 countries on the Arabian Peninsula, Indonesia, and Malaysia. FGM constitutes all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons. Please note that it is important to approach the subject of FGM with your patients in a culturally sensitive and responsive manner. Some women are deeply upset about having undergone this procedure; others believe that the procedure is a normal part of life.
- FGM is classified according to four types:

Type I:

Excision of the prepuce with or without excision of part or all of the clitoris.

Type II:

Excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III:

Excision of part or all of the external genitalia and the stitching/narrowing of the vaginal opening (infibulation).

Type IV:

Unclassified. Includes pricking, piercing or incision of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

- Estimated rates of FGM range from 5% of women in Uganda to 80% of women in Egypt and 98% of women in Djibouti and Somalia. There are many severe health complications associated with this practice.

## **V. COMMON BELIEFS & CULTURAL PRACTICES**

Although modern medicine is widely available in the United States today, individuals from minority and immigrant cultural groups may choose to use folk or traditional treatments before or concurrently with modern health care. Health providers can benefit from an increased awareness and understanding of the different health beliefs and treatments of their patients.

The first step in this aspect of cultural awareness in health care is to be sensitive to the role that folk or traditional medicine may play in a patient's health strategy. A provider must have tolerance of and respect for diversity in order to elicit and fully understand the patient's story and provide appropriate treatment. It can be very helpful to ask patients what they think may have caused an illness and what they are already doing to treat it. It is equally important to ask patients whether the prescribed medical intervention conflicts in any way with their beliefs and traditional practices.

The following is a useful cultural awareness tool for providers when working with patients who are using traditional medicine:

*A framework for culturally competent clinical practice*<sup>57</sup>

**Explanation:**

- What do you think may be the reason you have this problem?
- What do friends, family, and other say about your symptoms?
- Do you know anyone else who has had or who now has this kind of problem?
- Have you heard about/read about/seen it on TV/radio/newspaper?
- If patient cannot offer an explanation, ask what most concerns them about their problems.

**Treatments:**

- What kinds of medicines, home remedies, or other treatments have you tried for this illness?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.
- What kind of treatment are you seeking from me?

**Healers:**

- Have you sought any advice from alternate or folk healers, friends, or other people who are not doctors for help with your problems? Tell me about it.

**Negotiate:**

- Try to find options that will be mutually acceptable to you and your patient and that incorporate the patient's beliefs, rather than contradicting them.

**Intervention:**

- Determine an intervention with your patient that may incorporate alternate treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general and/or when sick).

**Collaboration:**

---

<sup>57</sup> S. Levin et al. "Appendix: Useful Clinical Interviewing Mnemonics" 2000  
RI Department of Health Family Planning Guidelines

- Collaborate with the patient, family members, other health care team members, healers, and community resources.

## **VI. ADAPTING TO LIFE IN THE UNITED STATES: IMPLICATIONS FOR IMMIGRANT AND REFUGEE HEALTH CARE**

Immigrants and refugees come to the U.S. for many reasons: seeking educational and economic opportunities denied them in their country of origin, and/or escaping the ravages of civil wars, regional conflicts, and natural disasters. They may have faced religious, ethnic, or political persecution. They may have endured terrorization by violent groups, imprisonment, and torture, and thus may be suffering from somatization of psychosocial distress, post-traumatic stress disorder, and other mental health problems often experienced by immigrants and refugees. Official refugees have been granted refugee status by the U.S. State Department; however, many immigrants without refugee status may also have faced hostile conditions in their homelands.

Refugee and immigrant patients may feel thankful for the opportunity to make a new life for themselves and their families, but they may also feel a profound sense of grief or loss for the life they will probably never return to. They may embrace their new home, or they may feel fearful and try to hold on as much as possible to their old way of life. Some immigrants and refugees arrive with an idealized vision of the U.S. that does not match the reality of the life they find—and they are consequently disappointed. For example, most immigrants expect to work when they come to the U.S., yet they may have to work at jobs that are far below the educational, economic, and social status they had in their home countries.

## **VII. THE PROCESS OF ADJUSTING TO A NEW CULTURE**

Intergenerational conflicts can be pronounced in immigrant and refugee families, as the younger generation adopts U.S. customs more easily than the older generation. The process of adjusting to a new culture has been described as having four distinct stages: Euphoria, Negativity, Gradual adjustment, and Biculturalism<sup>58</sup>.

The amount of time that an individual spends in these different stages varies considerably. Many people never completely adjust to their new culture, and may remain in the negativity or gradual adjustment phases for years. Others, especially children, may move quickly into biculturalism, causing intergenerational conflict with their parents or grandparents, who may adjust more slowly.

These stages of cultural adjustment can have a very real impact on your patients' mental, emotional, and physical health. Being aware of these stages may give you a better perspective on what your patients may be going through as they adjust to living in the United States.

---

<sup>58</sup> J. Betancourt et al. "Caring for Diverse Populations: Breaking Down Barriers" 2000  
RI Department of Health Family Planning Guidelines

Health care providers can help refugee and immigrant patients. The emotional attitudes and mental states of these patients can have implications for their health care. Health care providers may help their patients by<sup>59</sup>:

- Showing respect for their past and their particular cultural, religious, and other practices.
- Taking time to listen, to elicit each patient's view of her/his illness and the type of treatment she/he expects, and to empathize.
- Encouraging patients to seek out community and other resources that may help them adapt to their new home.