Champlain Valley Area
Health Education Center

Cultural Competency For Health Care Providers

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Goals of this Manual

- To provide a comprehensive, yet easily understood definition of cultural competency.
- To raise awareness of the increasing diversity in Vermont and the new populations joining our communities.
- To offer resources to help providers become better acquainted with different populations.
- To help providers use the information in this manual to comfortably assess patients and provide the best care possible.
- To assist providers with their own sense of understanding by offering links to self-assessment tools and continuing education opportunities.

Acknowledgements

This resource was designed for health care providers to support the promotion of cultural competency in their practice. It is by no means meant to be completely comprehensive but rather to provide a general overview and to offer select resources for further study.

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Cultural Competency and What It Means

What is cultural competency in health care?

There is no universally accepted definition of cultural competency in health care. In general, it is a set of skills that allow someone to increase their understanding and appreciation of cultural differences between groups. There are many different things that make up a person's cultural identity including: country of origin, language, education, spiritual traditions, family traditions, diet & nutrition, traditional medical practices, attitudes about illness and death and migration experiences, to name a few.

In simple terms, cultural competency is the ability to interact successfully with patients from various ethnic and/or cultural groups. Ideally, health care providers should obtain cultural information about a patient and apply that knowledge in the course of their care.

Why is cultural competency important?

America is a country of many races and cultures, and with each passing year, more health care providers are recognizing the challenge of caring for patients that speak different languages or that have different cultural backgrounds. Understanding someone's cultural background assists in creating an individual and comprehensive plan of care for the patient as people with different cultural backgrounds may have diverse perspectives on health and wellness. Research has shown that good communication between patients and health care providers is directly linked to patient satisfaction, treatment adherence and positive health outcomes.

Becoming culturally competent is an *ongoing* process. It is important to realize that as society moves forward and grows more diverse, we must grow with it.

Helpful Definitions

Culture:
The beliefs, social practices, and characteristics of a racial, religious, or social group.

Diversity:
A notion of being different from one another because of distinct characteristics, qualities, backgrounds, and beliefs.

Ethnicity:
Refers to belonging to a group of people that share common and distinct racial, national, religious, linguistic, or cultural heritage.

Minority:
A group having little representation or power in society.

Race:
Biologically, race refers to a population that differs from other populations of the same species by traits that are passed from ancestors.

Vermont Statistics

(2005 U.S. Census)

- Total Population: 623,050
- White 97.7% (608,703)
- Black or African American 0.8% (5,023)
- Asian 1.1% (6,743)
- American Indian and Alaska Native 0.4% (2,581)
- Hispanic or Latino 1.1% (6,769)
- Other races 0.1% (960)

BURLINGTON

(2000 U.S. Census)

- Total Population: 38,889
- White 92.3% (35,883)
- Black or African American 1.8% (693)
- American Indian and Alaska Native 0.5% (182)
- Asian 2.7% (1,031)
- Hispanic or Latino 1.4% (546)
- Other races 0.5% (211)

Between 1990 and 2005

- The number of self-identified African American residents in the state of Vermont grew by 157%.
- The number of self-identified Asian residents in the state of Vermont grew by 110%.
- The number of self-identified Hispanic and Latino residents in the state of Vermont grew by 85%.
- The number of self-identified American Indian or Alaska Native residents in the state of Vermont grew by 52%.

* See appendix A for demographics by Vermont county

Where Vermont fits in:

- Vermont is federally recognized as a safe haven for refugees by the U.S. government.
- Every year, refugees and immigrants from countries all over the world resettle in Vermont.
- Vermont is seeing a profound increase in its aging residents and has representation from GLTBI (Gay, Lesbian, Transgender, Bisexual, and Intersex), homeless, and deaf populations.

Knowing statistics about Vermont helps to emphasize the importance of understanding and being culturally competent. It is obvious by these numbers that although Vermont is 97% white, diversity is increasing. Unfortunately, it is not true at this time that health care is equal for all. The good news is that one by one each provider can become more culturally competent and work toward a common goal to ensure optimal health care for patients.

To further demonstrate the need for increased cultural awareness, consider the current disparities in health, identified by the U.S. Health and Human Services.

Healthy People 2010, a program developed by the U.S. Department of Health and Human Services and the Office of Disease Prevention and Health Promotion, aims to abolish the ethnic and racial disparities in:

Infant mortality
- Infant mortality is **two times** greater in blacks than in whites.

Cancer screening and management
- Cancer deaths in the black and Latino populations are disproportionately high.
- Cervical cancer is **five times** more likely in Vietnamese women than white women.

Cardiovascular disease (CVD)
- According to the U.S. Office of Minority Health, CVD has the highest rates of death and disability in minority and low income populations.
- African Americans have the highest rate of blood pressure when compared to other ethnic groups and tend to develop hypertension younger than others.

Diabetes
- Native Americans have the **highest** rates of diabetes and heart disease in the U.S.

HIV and AIDS
- Since 2001, AIDS has been the leading cause of death for African Americans between the ages of 25 and 44.
- In 2006, over 2 million people in Africa succumbed to AIDS and as of 2005, more than 24.5 million people were living with HIV in Africa.

Child & adult immunizations and health care
- Minorities are less likely to be immunized.
- Minorities are less likely to have regular check ups

Vermont Refugee and Immigrant Information

Statistics from the Vermont Department of Health show that of the more than two million refugees that have relocated to the United States since 1975, more than 4,000 have been resettled in Vermont. Also, there are many immigrants who have come to the U.S. and Vermont searching for better opportunities. Because of this influx of different populations, health care providers in Vermont must be educated about the types of populations that might seek health care, and about the medical issues common to those populations.

The purpose of this section is to provide insight into the United States refugee program and to differentiate between refugees, immigrants, and asylum-seekers as defined by the United States Committee for Refugees and Immigrants. Also, based on data from the Vermont Refugee Resettlement Program, information is provided on those populations that have the largest representation in Vermont, and therefore are most likely to be encountered.

What is a refugee?

In general, the U.S. Committee for Refugees and Immigrants define a refugee as someone who has fled his/her country because of fear or persecution due to race, religion, nationality, membership in a particular social group or political opinion. Knowledge of international affairs makes it easy to see that war, abused power, torture, and inequality often plague the countries where many refugees once lived. Refugees, therefore, enter other countries under special circumstances, considered to be exempt from certain laws in place for immigrants.

How do refugees and immigrants differ?

While refugees have left their home countries because of fear or danger, immigrants leave for many other reasons. Immigrants are often subject to strict United States laws and arrive under many different circumstances, both legal and illegal. Legally, most immigrants arrive with work or student visas hoping to eventually apply for U. S. citizenship.

Refugees seek safety in other countries and go through a process where the United Nations and the U.S. State Department review their case and accept them as a refugee. When refugees first arrive into their new country, they are put under "refugee status," which makes them eligible for work, school, housing, health care, and other services. After one year refugees are able to apply for legal permanent

residence (LPR or green card). They can apply for citizenship five years after obtaining an LPR card.

What is an asylum-seeker?

While it may seem that any refugee can find safety in the United States under the application process, this is not true. In fact, only a very small percentage of refugees in the world actually find protection from the United States. Asylum-seekers are considered those who enter the United States by many different methods, including student visas, as tourists, or even illegally using false documents. Once in the United States, asylum-seekers, who are not detained at the U.S. border and are looking to stay, may file their case and apply for refugee status.

Vermont refugees

The VRRP has been keeping data on refugees in Vermont since 1989. Over the last 18 years refugees from more than 25 different countries have resettled in the counties of Vermont and begun new lives. Beginning on page 24, selective background information is presented on those populations that have arrived in significant numbers to Vermont, especially in the last five years. Using summarized information researched and published by Culture Grams ™ and the *Pocket Guide to Cultural Health Assessment*, several aspects of life in foreign countries is explored.

If the patient is from a country not listed, there are plenty of resources that can be utilized to find information on statistics, languages, country background, health beliefs and practices, economy, education, and much more. Visiting a local library would be beneficial, as would research using reliable sources, such as those listed below.

Culture Grams

Culture Grams has information on over 200 countries in the world, all U.S. states, and 13 Canadian provinces and territories. Information is represented in the form of fact sheets, which can be accessed in electronic or printed form for a small fee.
www.culturegrams.com

CultureMed

CultureMed offers direct links to bibliographies specific to a country. Bibliographies contain articles, books, and websites that discuss cultural competency and special health care considerations for 15 different countries.
htpp://culturemed.sunyit.edu/

EthnoMed

This site contains helpful information about various cultures commonly encountered as refugees in the United States. Each section provides information about a population's culture, common illnesses and health practices, including some patient education materials.
http://ethnomed.org

Cultural Orientation Resource Center

A cultural orientation site with cultural profiles and background information on many of the main refugee populations in Vermont.

www.cal.org/co/

Pocket Guide to Cultural Health Assessment

A valuable, well-written guide filled with important facts about more than 180 countries. Although this manual provides information on language, religion, and location, its major emphasis is placed on how specific cultures relate to health care. Practices, beliefs, common ailments, treatments, and even culturally accepted behavior are included.
D'Avanzo C, Geissler E. *Pocket Guide to Cultural Health Assessment*. St.Louis: C.V. Mosby, 2003.

Refugee and Immigrant Service Providers Network (RISPNet)

Contact the State Refugee Coordinator for information on this group that meets monthly to discuss educational, social and health care service issues and opportunities for local refugee and immigrant communities.

(802) 241-2229

Vermont Department of Health Refugee Health Program

The Refugee Health Program helps facilitate the healthy transition of newly arriving refugees by providing a coordinated approach to health care services and by offering primary care providers supportive training. The program also develops provider reference materials that include information on country-specific health risks, current assessment standards, treatment protocols and cultural variances.

http://healthvermont.gov/local/rhealth/refugee.aspx

Refugee Health Care: A Handbook for Health Professionals

The Refugee Health Care Handbook has been developed for general practitioners and other health workers who care for refugee people. The book provides insights into the cultural and ethnic backgrounds of the main refugee groups in New Zealand, some of which are also seen in Vermont, and also provides guidance to health professionals on conducting culturally sensitive consultations and effective use of interpreters.

www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/d85ce7cd090faaa4cc256b050007d7cb?OpenDocument

How does Vermont provide assistance?

As a United States safe haven for refugees, Vermont has two main organizations that aid refugees in their pursuit of a better life.

The Vermont Refugee Resettlement Program (VRRP)

The VRRP is the only refugee resettlement agency in the state of Vermont and is based out of Colchester. Considered a field office of the U.S. Committee for Refugees and Immigrants (USCRI), they aid refugees in finding housing, work, education, and health care services in whichever county they resettle in.

(802) 655-1963 www.vrrp.org

Vermont Refugee Assistance and The Vermont Immigration Project

In Montpelier, Vermont Refugee Assistance (VRA) works with asylum-seekers in Vermont. Those that come to Vermont without the proper paperwork are often detained and prevented from applying for residency in the U.S. VRA provides services in four main areas: legal support, transit support, humanitarian aid, and advocacy. Asylum-seekers are assisted by VRA staff in finding lawyers, filling out applications, traveling, and working with the Vermont Congress and United Nations to help them stay in the U.S. In addition, VRA provides clothing, food, shelter, language, and legal assistance for asylum-seekers in Vermont.

(802) 223-6840 www.vermontrefugeeassistance.org

Health care screening

As refugees and immigrants enter Vermont, it is important to keep in mind that different countries and populations have different health concerns and practices. While it may be true that the United States invests much of its research and health care funding toward fighting diabetes and cardiovascular disease, these same diseases are not necessarily of the same priority in other countries. Aware of these differences, the Center for Disease Control (CDC) requires that all refugees and immigrants arriving in the U.S. first undergo a health screening.

The CDC requires all immigrants, refugees, and some nonimmigrants to have a physical and mental health examination by an *abroad* physician before their arrival to the United States. These medical exams, as described by the CDC, entail:

- A physical exam
- A mental health exam
- A skin test and chest x-ray for tuberculosis
- Blood tests for syphilis
- Blood tests for HIV (applicants 15 years and older)

In addition to the health screen, immigrants and refugees must show documentation of vaccinations against vaccine-preventable diseases. Vaccine-preventable diseases, as outlined by the CDC include:

- Mumps
- Measles
- Rubella
- Polio
- Tetanus and diphtheria toxoids
- Pertussis
- Haemophilus influenzae type B
- Hepatitis B

The health screening is vitally important for admission to the United States. Those who are found to have a physical or mental health concern, a communicable disease of public health significance, are drug abusers or addicts, or are unable to present immunization documentation may not be admitted without a waiver. Those diseases which are considered of public health significance include:

- Tuberculosis
- Human Immunodeficiency Virus (HIV)
- Syphilis
- Chancroid
- Gonorrhea
- Granuloma inguinale
- Lymphogranuloma venereum
- Hansen's disease (leprosy)

Usually, after passing the initial health screen outside of the U.S., immigrants and refugees are then subject to a health screening in the state in which they relocate. The Vermont Department of Health works with various organizations to ensure that refugees have access to primary care providers and obtain a domestic health screening within 30 days of arrival.

Delivering Culturally Competent Care

Value the client's cultural beliefs

It is import to understand that although you are working with an individual, your patient's personal identity is influenced by the culture which they are part of.

Often times in health care, there are personal and sensitive issues that need to be addressed in order to obtain the information needed for the best care. Placing value on each individual's beliefs can help determine the underlying cause of an issue.

What should the provider do?

Become familiar with and develop a basic understanding of the ethno-cultural groups that might be encountered in your practice. Recognize that in addition to gaining information from direct questioning of the patient, you can learn a great deal from observation alone.

- What language is being spoken in your waiting area?
- How is the patient interacting with their family members?
- Does the patient address staff by their first name or in a more formal matter?
- Is there a religious affiliation listed on their demographic sheet?
- What social or religious centers are within short distance to your office?
- What is the patient's sexual orientation?
- What is the educational and reading level of the patient?

Anyone working in health care should always:

- Show respect and dignity for every patient, whatever their age, gender, religion, class, sexual orientation, ethnic or cultural group.
- Accept the rights of patients to participate in or refuse care.
- Be aware of their own personal beliefs that may keep them from giving quality care to people of other cultures.
- Be willing to include health beliefs and traditional practices from other cultures into treatment plans.
- Create health education materials that address the language and cultural beliefs of the patient.

Consider asking the patient the following questions when offering care:

- What do you call this illness?
- What do you think caused this problem?
- Why do you think 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 get?
- What are the most important results you hope to get from this treatment?

Be aware of stereotyping

While information about specific cultures can help in understanding a patient, this can sometimes lead to stereotyping a person. No one should assume that a patient from a specific racial or cultural background will necessarily have the same traditions or beliefs often associated with that race or culture. There are many factors that go into a person's cultural identity including socioeconomic status, education, age, religion, gender and urban or rural living area.

Remember…

- Empathize with your patient
- Do not stereotype
- Be educated about the types of populations you might be seeing
- Communicate effectively, through interpreters if necessary
- Be understanding
- Listen

Those working in health care should learn to see the patient and his or her family as unique while keeping in mind the need to find out the extent to which a patient follows traditional health beliefs and practices in order to provide the best possible care.

Developing a trusting relationship

As with any patient you see in your practice, the best health care results from a trusting relationship between provider and patient. There are many things that patients have in mind when coming to see a health care team and in order to cover all of the patient's concerns, it is important to take a good history. A good history,

however, requires that sensitive and even embarrassing topics be brought into the discussion.

Appreciate that while it may not be hard for some patients to discuss personal information, it can be very difficult for others, especially those not familiar with medicine in Vermont or in the United States.

Being familiar with different cultural backgrounds will help you to understand the varying beliefs of your patients. Also, using effective communication will be critical in getting the information you need, while not offending patients from different cultures. Together, sensitivity, listening skills, and cultural awareness can help to form the trusting relationship you need to help your patient and encourage them to share information with you.

Effective Communication

The best medical care comes from high quality communication between the health care team and patients. If communication is hindered, this can lead to many complications, such as delayed care, wrong treatment, and frustration for both the patient and the providers. Research shows that effective communication builds lasting relationships between providers and patients, ensuring that patients are more likely to disclose information, return for future visits, and comply with medical advice.

By now, your office may have an interpreter plan in place for appointments with non-English speaking patients. Having a plan will make patient encounters run more smoothly and ensure that the patient does not miss any important information. As Vermont becomes more diverse, you will see more patients who do not speak English, but still need medical treatment. There are ways that you can be prepared for this situation:

Make an effort to hire a diverse staff

- Members of your health care team who can speak more than one language can be valuable in helping the patient communicate, especially when patients come to your office and interpreter arrangements have not yet been made.
- Seeking medical advice in a new country can be intimidating. Having someone in the office who speaks your language can be comforting and may make the transition go more smoothly.

Use interpreter services

- In both Vermont and nationwide interpreters are available in almost every language that you might encounter. Preparing for your patient ahead of time is important, as it involves having an interpreter plan in place.
- Interpreters are trained to make communication easier and to help providers relay important medical advice to patients.

Keep brochures and health care information handy

- Fortunately, many pamphlets have been written in different languages to make it easier for those who do not speak English.
- These brochures can ensure that your patients leave the office with information that they can refer to in the future.

Keep in mind that you may also need interpreters and health care information for blind and deaf patients. American Sign Language interpreters and health information in Braille are also accessible through interpreter services.

Where to get pamphlets in other languages:

Vermont Refugee Health Program Translated Fact Sheets

Over 20 fact sheets on healthy living and specific diseases available in English, French, Russian, Serbo-Croation/Bosnian, and Vietnamese.
http://healthvermont.gov/local/rhealth/rh_fact.aspx

The 24 Languages Project

Electronic access to over 200 health education brochures in 24 different languages. This is a project of the Spencer S. Eccles Health Sciences Library, in partnership with the Utah Department of Health, the Immunization Action Coalition, the Association of Asian Pacific Community Health Organizations, and many others to improve access to health materials in multiple languages.
http://medlib.med.utah.edu/24languages/

Healthy Roads Media

This site contains free audio, written and multimedia health education materials in a number of languages. Produced by a consortium of Midwestern organizations.
http://www.healthyroadsmedia.org

Foundation for Healthy Communities

A New Hampshire based organization which has medical forms and health information available in several languages.
www.healthynh.com/fhc/resources/translateddocuments.php

Hello Ní Hao Hola **Bon Giorno** Goedendag Jambo

Chao Guten tag Namaste Hej Dia Duit Bom dia

Interpreter Services

In addition to having bilingual or multilingual staff members and educational materials printed in different languages, interpreters can be used to make communication with the patient more effective. Many non-English speaking patients will have family members or friends with them for their appointment who can speak English. **Generally, it is NOT recommended that family or friends be used as interpreters, as objectivity can be compromised and family and friends may be influenced by their own thoughts.**

It has been shown that adequate language services for patients who do not speak English leads to greater access to health care for these patients. In addition, language services improve the quality of care, health outcomes, health status, patient satisfaction, and enhances resource utilization by these patients.

National Standards for Culturally & Linguistically Appropriate Services in Health Care from the U.S. Department of Health and Human Services (these are current federal requirements for all recipients of federal funds).

- Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/ consumer with LEP (limited English proficiency) at all points of contact and in a timely manner during all hours of operation.
- Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Health care organizations must ensure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Calling an interpreter using the telephone services

There are a few different options for obtaining interpreter services. Many providers find telephone services helpful and less expensive than hiring an interpreter for individual appointments. Phone services are abundant, especially for medical purposes and there are interpreters available for almost any language. However, some consider these services to be less effective than having an interpreter in person, because nonverbal clues are missing from the telephone conversations.

Hiring an interpreter

In addition to using telephone services and staff members to interpret, there are interpreters in Vermont and throughout the U.S. that can be hired, or contracted. Be prepared when calling to schedule an interpreter. Have the date, time, and language ready as early in advance as possible, to ensure that someone will be available when you need them. Also make sure to inquire about the cost, as costs will vary depending on the situation that arises.

Local Interpreter Services Resources

Community Health Center of Burlington

The Community Health Center in Burlington (CHCB) has gained great knowledge about interpreters in its years working with refugee and immigrant populations. Contact the CHCB for information about who they work with and recommend, and to discuss what issues have come up in the past and how they were able to solve them.

Jon Bourgo (802) 864-6309
www.communityhealthcenterburlington.org/

Vermont Interpreter Referral Service (VIRS)

VIRS provides interpreter services for deaf and hard of hearing patients in a variety of settings, including medical. They also offer CART, or Computer Aided Realtime Translation services, which allows deaf and hard of hearing patients to read dialogue from a computer screen as the conversation takes place.

(802) 254-3920 or toll free (800) 639-1519
www.virs.org

Vermont Interpreting and Translating Services

The Vermont Interpreting and Translating Service is located in Colchester, VT as part of the Vermont Refugee Resettlement Program (VRRP) and provides professional interpretation and translation.

(802) 654-1706 or (802) 655-1963
http://www.vrrp.org/translation.html

Certified Languages International
http://www.clilang.com
800–237–8434

CyraCom
http://www.cyracom.net
520–745–9447

Language Learning Enterprises
http://www.lle-inc.com
888–464–8553

Language Line Services
http://www.languageline.com
800–752–0093, ext. 196

New World Language Services
http://www.phonetranslators.com
800–873–9865

Online Interpreters
http://www.onlineinterpreters.com
888–922–3582

Pacific Interpreters
http://www.pacificinterpreters.com
800–311–1232

SpectraCorp
http://www.spectracorp.com/emailers/languages.htm
800–375–7945, ext. 320

TELELANGUAGE Telephonic Interpretation Services
http://www.telelanguage.com/interpretation.cfm
888–877–8353

Tele-Interpreters
http://www.teleinterpreters.com
800–811–7881

A Tip for Local Health Care Providers:
When hiring an interpreter for a Medicaid patient, the provider is expected to pay the interpreter. The billing code for interpreter services is "T1013". A unit of service is 15 minutes of interpreting. Providers receive $15.00 for each 15 minute unit.

For Additional Information on Language Access:

U.S. Department of Health and Human Services

This website provides a multitude of resources on policies, laws, guidelines, and research in areas directly affecting cultural competency and health care for all.

(202) 619-0257 or toll free (877) 696-6775 www.hhs.gov

Addressing Language Access Issues in Your Practice: A Toolkit for Physicians

www.familydocs.org/assets/Multicultural_Health/Addressing%20Language%20AccessToolkit.pdf

AMA Office Guide to Limited English Proficiency Patient Care

www.ama-assn.org/ama1/pub/upload/mm/433/clinician_guide.pdf

The Top 10 Things to Keep in Mind When Working with Interpreters

Set goals and give background before entering the exam room. This will allow the interpreter to know what you are hoping to achieve in your meeting with the patient.

Agree on an interpreting approach. Determine whether you want the interpreter to interpret while you or the patient is talking or after the dialogue has finished.

Address the patient, not the interpreter. Maintain eye contact with the patient as if the interpreter is not even there.

Control the pace of your conversation. Ensure that there is time to effectively convey important ideas.

Do not "think out loud." Patients will wonder what is NOT being translated and might also understand more than they are able to speak.

Avoid medical jargon and idiomatic expressions.

Listen without interrupting.

Provide all of the information about diagnosis, testing, and treatment.

Confirm understanding and agreement. Ensuring that the patient understands what is being said is critical to their compliance. Also encourage the interpreter to clarify concepts he/she might not understand. You might want to have the interpreter interpret back to you whenever you are concerned about accuracy.

Use the interpreter as YOUR resource. Speak privately with the interpreter about his/her impression of the patient, comprehension, and dialogue.

Information on Specific Populations

Africans

Since its appointment as a refugee resettlement state, Vermont has provided a new beginning for several of Africa's refugees. Being a continent of great size and diversity, it is important to keep in mind that different regions of Africa have specific backgrounds, beliefs, and endemic diseases. For example, while HIV/AIDS is considered prevalent in sub-Saharan Africa, certain countries in Africa have higher rates than others. Stereotyping a patient from Africa as a patient with HIV or AIDS can compromise the health care of the patient and the development of a trusting relationship between the provider and that patient. However, patients should still be asked about their history pertaining to specific illness and tests should be performed when necessary.

Only those populations which have resettled in Vermont in significant numbers are included in this section about Africa. In addition, common infectious diseases and ailments according to geographic location have been provided, using information compiled from the Center for Disease Control and Baylor University.

North Africa:

Amebiasis, anthrax, boutonneuse fever, brucellosis, Crimean-Congo hemorrhagic fever, echinococcosis, Guinea worm disease, HIV/AIDS, hookworm, hymenolepiasis, leishmaniasis, malaria, malnutrition, plague, relapsing fever, Rift Valley fever, schistosomiasis, tapeworm, and tuberculosis.

East, West, and Central Africa:

Amebiasis, anthrax, boutonneuse fever, cholera, Crimean-Congo hemorrhagic fever, dengue fever, ebola hemorrhagic fever, filariasis, Guniea worm disease, HIV/AIDS, hookworm, hydatid disease, lass hemorrhagic fever, leishmaniasis, leprosy, malaria, malnutrition, paragonimiasis, plague, relapsing fever, Rift Valley fever, schistosomiasis, sickle cell disease, strongylodiasis, trachoma, typanosomiasis, tuberculosis, typhoid, typhus, and yaws.

South Africa:

Amebiasis, anthrax, HIV/AIDS, Rift Valley fever, schistosomiasis, and sickle cell disease.

Congolese

Background and Population:

Currently, what many refer to as the Congo consists of two separate territories, the Republic of the Congo, or Congo-Brazzaville and the Democratic Republic of the Congo also called Congo-Kinshasa. Geographically, both of these territories are part of western-central Africa.

From 1970 until 1997, the Democratic Republic of the Congo was named Zaire, under the leadership of Mobutu Sese Seko. War came to Zaire in 1994 when the civil war in Rwanda forced a million refugees into Zaire. Some of these refugees were armed and began to kill the people of Zaire, leading to the formation of militias and invasion by forces from Rwanda. This tension resulted in the development of rebel groups in the Congo and eventually the country saw its own civil war. A peace treaty was drawn up in 2002 and held by most participating parties, but there are still rivaling militias fighting in eastern Congo. Currently, the population of Congo-Kinshasa is 62.7 million.

Congo-Brazzaville saw its own civil war in 1993 when political and religious differences led to violent altercations. The first civil war resulted in the displacement of 10,000 citizens. In 1997 Congo-Brazzaville was faced with a second civil war between militia groups and supporters of the country's president, Lissouba. A peace agreement was instituted in 1999 and many refugees that had fled returned. The most recent population of Congo-Brazzaville was determined to be 3.7 million people.

Language:

The official language of both Congo-Brazzaville and Congo-Kinshasa is French, although each region also has indigenous languages. In Congo-Brazzaville, there are more than 54 different languages, but Monokutuba in the south and Lingala in the north are the most common. In Congo-Kinshasa, there are four main Bantu languages: Lingala in the west, Kikongo in the west and southwest, Tshiluba in central and southern regions, and Swahili in the east.

Religion:

In both territories, the majority of citizens are Christian and of those who are Christian, most are Roman Catholic. Smaller percentages are Muslim. In Congo-Brazzaville, about 50% of the population holds indigenous beliefs.

Greetings and Gestures:

In Congo-Kinshasa, shaking hands is common in urban areas. It is considered appropriate to shake hands with members of opposite and same sex, unless outside of urban areas, where men and women do not shake hands. Verbally, urban area populations greet by saying, *Mbote*, which means "hello." In eastern and some

southern areas where Swahili is spoken, *Jambo*, meaning "hello" is often the greeting of choice. All activity which involves hands (passing objects to one another, shaking hands) is done with the right hand as the left is used for personal hygiene.

Handshakes are also used to greet one another in Congo-Brazzaville although many also kiss each other on the cheek when meeting. Verbally, the greeting is dependent on what language is being spoken. "Hello" is *Mbote* or *Mbote na yo* most commonly. In both countries, hand gestures and body language can both emphasize or replace verbal language.

Family:

There is much variation in family structure, depending on the ethnic background of the family. In both Congo-Brazzaville and Congo-Kinshasa there are extended families living under one or neighboring homes. Extended families include parents, children, grandparents, cousins, aunts, uncles, etc. In both western Congo-Kinshasa and most of Congo-Brazzaville, the mother's brother is considered the dominant male although family itself is matriarchal. Other areas of the Congo have more patriarchal and polygamous families.

Diet:

Congolese in Congo-Kinshasa see large rates of malnutrition because food supplies are difficult to obtain. Staple foods are cassava, rice, potatoes, bananas, yams, beans, corn, fish, nuts, fruits, and vegetables. Foods are similar in Congo-Brazzaville, but fish and meat often accompany starchier foods.

Education:

In Congo-Kinshasa, civil war has drastically affected the economy and education. There are very few educational institutions and enrollment is very low. There are three public universities still in operation and several private institutions. Congo-Brazzaville has also been seriously affected by war. Supply shortages have led to the development of private institutions, but most cannot afford to utilize them. Generally, it is required to have an education beginning at age six and continuing until sixteen. A bachelor's degree is granted to those who complete six years of primary schooling and seven years of secondary schooling. Marien Ngouabi University is the country's only public university and offers degrees in medicine, law, and other fields.

Although both countries have seen damage to the educational infrastructure, adult literacy rates are relatively good. In Congo-Brazzaville over 90% of males and 80% of females are literates. Congo-Kinshasa is lower, with 81% of males and just 54% of female adults considered literate.

Health:

Both regions face similar health access problems and endemic diseases. Hospitals, when available, are in poor condition and lacking necessary equipment and medications. Under these poor circumstances, most people, especially those in rural areas, turn to traditional healing. People of all levels of education, social status, and

economic status consult traditional healers, and often consult both physicians and traditional healers concerning the same ailment. Traditional treatments include herbs, plants, and prayer. It is common for sick people without access to health facilities to sit in churches waiting to be cured by God.

Because of their similarities in many aspects of life and history, both Congo-Brazzaville and Congo-Kinshasa face similar endemic diseases. Most common are infectious diseases which include: malaria, tuberculosis, diarrheal diseases, leprosy, HIV/AIDS, and parasitic infections like schistosomiasis, onchocerciasis, and trypanosomiasis. HIV/AIDS rates are significantly high, with about 7.5% prevalence for adults between ages 15 and 49.

Many think that illness, particularly mental illness, is brought on by curses or by punishment from God. Mental illness is of particular concern because people believe that even with treatment, mental illness will never disappear.

Congolese people have great trust in physicians in nurses, who are paid poorly and often hard to find. Many areas are staffed only by nurses, who often earn higher salaries than doctors. Public health education has made great strides as a mission of the Ministry of Health. Tuberculosis in Congo-Kinshasa has a high detection rate of 70% and a treatment rate or 75%. Unfortunately, the seriousness of HIV/AIDS was doubted when first discovered and most inhabitants did not change behavior until famous actors and musicians died from complications of the disease. There are no government-run HIV/AIDS programs, but private attempts have been made to educate the public. Still, a great deal of work in this area is needed.

Special Considerations

- Eye contact is accepted in most regions of Congo-Brazzaville and Congo-Kinshasa.
- Planning and conception of time are not especially valued and so meetings may be missed or patients may be late. However, it has been shown that those educated with Christian backgrounds have been taught that punctuality is a virtue.
- Greetings vary by region. In both Congo-Brazzaville and Congo-Kinshasa, it is common to shake hands. *Mbote* or some variation of this phrase means "hello" and is a widely accepted verbal greeting.
- Many endemic diseases have resulted from years of poverty, war, and inadequate health care. Common medical ailments include: parasitic diseases, diarrheal disease, tuberculosis, HIV/AIDs, malaria, and leprosy.
- Although Congo-Brazzaville and Congo-Kinshasa are similar in geographic location, history, and many cultural practices, it is important to inquire about information directly relevant to the patient being seen.

Somali

Background and Population:

Somalia is a country with an estimated population of 8.9 million people. The actual population, however, it difficult to obtain due to the nomadic lifestyle of some and the fact that more than one million have fled the country seeking refuge. In fact, most of the children in the U.S. were born in Kenya in a refugee camp called Kakuma. Somalia's location has proven historically problematic at times, as conflict over borders and boundaries has led to periods of violence, famine, and disease. In addition, war between neighboring Ethiopia and Eritrea led to the formation of militias and invasion into Somalia as the rivaling Ethiopia and Eritrea fought over Somalia's alliance. Ethiopia withdrew from Somalia in January of 2007.

Ethnically, Somalia is 85% Somali, 5% Bantu, and 10% Arab and smaller minorities. In the past five years, Vermont has provided refuge for hundreds of citizens of Somalia, with the majority of Bantu ethnicity.

Language:

Major languages include Somali, Arabic, English, and Italian. The Somali language has three different dialects and until recently was unwritten. **Most of the Somali that have been resettled in Vermont speak Mai Mai.**

Religion:

More than 97% of Somali are Sunni Muslim. A very small number are Christian.

Greetings and Gestures:

Greetings vary in Somalia, depending on the region. A common greeting accepted in most regions, however, is *Nabad*, which means "peace." Generally, people of the same sex shake hands, but those who are of opposite sex and not of the same family do not touch when meeting. Body language is incorporated with speaking language to mean certain things or to place emphasis on speech, making it more dramatic.

Family:

The people of Somalia are affiliated with clans. While children take their father's name and become part of his clan, mothers keep their maiden names and their position in their own clan.

Diet:

Nomadic and farming lifestyles predominate in Somalia, leading to a diet dictated by location and availability. Northern Somalia is home to many nomadic populations, who eat plenty of meat and milk. Southern Somalia and farming areas eat lots of vegetables, millet, and sesame. Diet is also influenced by religion and

economic status. For example, strict Somali Muslims eat grains, fish, fruit, and vegetables but cannot eat anything from animals that have eaten other animals.

Education:

The formal education system has been significantly impacted by war, much of it being destroyed. Literacy and language skills are of great concern for this population as only 50% of male and just 26% of female adults are literate.

Health:

Somalia does not have a structured health care system, as many hospitals and clinics were damaged in war. Traditional medicine is widely practiced. Illnesses are often blamed on angry spirits within an ill person. To heal the patient involves settling these spirits, often by having healing ceremonies, eating special foods, reading the Koran, and burning incense. Common healing practices include "fire burning" or applying heated sticks to the skin, herbal remedies, prayer, and blood letting. Fire burning is a common treatment for hepatitis, malnutrition, and pneumonia. Blood letting, similar to extreme phlebotomy, consists of taking copious amounts of blood from the patient in attempt to remove their illness with the blood.

War and its resulting poverty, lack of education and insufficient health care has lead to many health complications in Somalia. Those of major concern include tuberculosis and cholera, which is endemic in most of the country. Respiratory infections, malaria, and diarrhea-related complications cause most childhood deaths and measles outbreaks are responsible for high infant mortality. The incidence of HIV/AIDS is significantly less than other African countries, but data has been difficult to collect and the World Health Organization predicts significant increases.

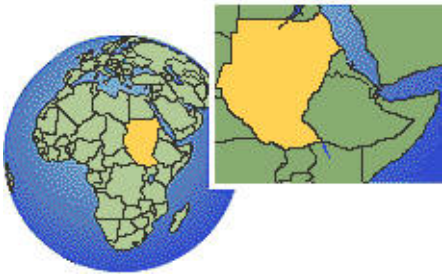
Mental health is poorly understood and usually not acknowledged. However, post traumatic stress disorder (PTSD) and depression are inevitable in a country with such a violent background. PTSD has also been attributed to chewing khat, which is a hallucinogenic leaf.

Health care professionals including nurses and physicians are well respected in Somalia. As the United Nations and other organizations work to provide aid and support to the country, its residents are being exposed more to primary care and Western medicine. In addition, in lieu of an expected coming AIDS epidemic, HIV/AIDS awareness is being implemented.

Special Considerations

- Direct eye contact is considered rude and therefore unacceptable. Physical contact is prohibited between those of opposite sex, unless members of the same family.
- A common greeting consists of a handshake (between members of the same sex) and a verbal exchange of *Nabad*, meaning "peace."
- Common health ailments include: tuberculosis, cholera, respiratory infections, malaria, and measles (infants). Mental health, although not acknowledged, is of particular concern because of Somalia's violent history.

Sudanese



Background and Population:

Civil war came from irreconcilable differences in religion and politics in the 1980s and was followed by almost twenty years of hostility and bloodshed. Hundreds of thousands of refugees left Sudan in an attempt to escape violence and drought, which created uninhabitable living conditions. A peace treaty in 2002 was drafted in an attempt to end fighting, but conflict in Darfur, a region of Sudan, continued. It is estimated that by 2005, more than 2 million people were displaced. Most recently, in another attempt at peace, a contract was signed in 2006 between the government and rebel groups in Darfur. However, several other rebel groups did not sign the treaty. The current population of Sudan is an estimated 41 million.

Language:

The official language is Arabic, although it is said that only half of the population speaks it. In all, there are over 100 different languages spoken, many of them tribal dialects. English is spoken by more educated citizens, living in the south.

Religion:

More than 70% of the population is Sunni Muslim, concentrated mostly in northern and central Sudan. While 5% identify as Christian, the remaining 25% are of indigenous religions.

Greetings and Gestures:

Northern and southern Sudan differ slightly in their accepted greetings. Northern Sudanese are considered more formal and those of the same sex shake hands. The northern verbal greeting is generally, *Salaam alaykum*, which means "peace be upon you." In the south, most greetings are verbal, although shaking hands does occur, even between men and women. Because of the language differences throughout Sudan, verbal greetings vary greatly. In the south, *Gwon ada*, which means "How are you?" is often asked.

Family:

Like many customs in Sudan, different ways of life are lead by northern and southern inhabitants. The south allocates more rights and freedom to its women while in the north, males are dominant. In general, men work and lead the family while women take care of the home and the children. The household itself is extended, often housing three generations of males and their families.

Diet:

The traditional Sudanese diet consists of meats such as beef, chicken, goat, and mutton. Meat is often unavailable, however. Others eat fish, millet, vegetables,

potatoes, fruits, and breads. Alcohol has been outlawed, but beer is often drunk by those in the south. Malnutrition is common.

Education:

It is generally required that children complete at least nine years of education, although many do not due to poor, overenrolled school systems and the need to provide more income for the family. The University of Khartoum is a four year university with courses taught exclusively in Arabic. Only 71% of male and 52% of female adults are literate.

Health:

Decades of fighting have left Sudan with few operating health clinics and hospitals. Research done by the University of Khartoum has found that most citizens of Sudan consult traditional healers before seeing a doctor. Healing, dependent on the ethnic group, might include ceremonies, reading from the Koran, dances, and the use of roots or plants. Illness is often thought to be caused by possession by demonic spirits or by someone giving the "evil eye."

Because Sudan has over 500 tribes and 57 ethnic groups, health disparities differ between groups. Endemic to the country, however, are malaria, tuberculosis, leprosy, cutaneous and visceral leishmaniasis, and schistosomiasis. Sickle cell anemia is common amongst the Messeyria tribes. In northern Sudan, cases of heart disease and diabetes are increasing. HIV/AIDS according to the World Health Organization is estimated to be 0.99%, or about 400,000 people ages 15-49.

Mental illness is extremely feared as it is thought to result from demonic possession. Treatment for mental illness is extreme and can include being kept in solitary confinement with only bread and water. While in confinement, the patient is beaten repeatedly to drive the demonic spirit from their body. Mental illness is an important health issue to be addressed.

The need for health education and awareness has been recognized as a major deficit in Sudan. As a result, the Federal Ministry of Health works closely with Sudanese television stations to broadcast health-oriented information to the homes of Sudanese families. Programs to educate about diabetes and breast cancer are also being developed.

Special Considerations

- Eye contact is prohibited in certain situations. Women, for example, are not permitted to keep direct eye contact with unknown or holy men.
- Accepted greetings vary by region. Generally, in northern areas, *Salaam alaykum*, or "peace be upon you" is exchanged with a gentle handshake between those of the same sex. In the south, handshakes are less frequent and the verbal exchange is often *Gwon ada*, or "how are you?"
- Common health ailments include: mental health issues, malaria, tuberculosis, leprosy, leishmaniasus, and schistosomiasis.

Bosnian & Herzegovinan

Background and Population:

A population of about 4.5 million people, Bosnia has seen much ethnic tension in its war ridden history. War and persecution left many of its citizens displaced. Because of its location and the religious beliefs of its people, Bosnia has not only been subject to a violent past, but to one of resulting diversity as well. Most of the population is Bosnian Muslim, Bosnian Serb, and Bosnian Croat. However, there are also smaller populations of Albanians, Roma (Gypsies), and others. Bosnian Muslims live mostly in the central and southern parts of the country while Bosnian Serbs dominate the region bordering Yugoslavia, in the northeastern and southeastern boundaries. Bosnian Croats have settled in the southwestern part of Bosnia, bordering Croatia.

Language:

The majority of Bosnians speak a Slavic language, classified as Serbo-Croatian. Keep in mind, however, that some citizens speak Hungarian, Albanian, Slovene, Romany, or other languages. Before hiring an interpreter, it is important to check with the patient and determine which language they are most comfortable with.

Religion:

Historical events, persecution, and personal identification have lead to three major religions in Bosnia. Historically, those with Catholic ancestors became Bosnian Croats, those with Eastern Orthodox backgrounds were considered Bosnian Serbs. Bosnian Muslims or Bosnjak comprise the majority of the population and identify as Muslim. There are also subsets of the Jewish and Protestant faiths.

Greetings and Gestures:

As often done in the U.S., shaking hands is considered an acceptable greeting when people meet. Bosnian Muslim women who are wearing religious coverings, however, are not addressed or offered a handshake for religious reasons. Family and friends call each other by their first names. After initial meetings, greetings may involve a kiss on both cheeks. *Dobar dan*, which means "good day," is a common verbal greeting.

Diet:

All three meals are represented in a Bosnian diet, although lunch is the main meal of the day. Bosnian Muslims often have meals in pie form (meat pies, cheese pies, cabbage pies, etc). Most Bosnians eat vegetables, soups, bread, and meats although strict Muslims do not eat pork. Nevertheless, diets are high in meat overall. Brandy is a common alcoholic beverage and wine is also prevalent, although wine is drunk less by Bosnian Muslims.

Family:

There are two main family dynamics in Bosnia, one rural and one urban. Rural families are patriarchal, where either the father or grandfather makes decisions and has a dominant role. The household itself includes not only parents and children, but grandparents as well. Urban households have less influence from grandparents and both the husband and wife work and share decision making. Adult children often live with their parents until married and even then, parents are financially supportive. In addition, children are expected to support elderly parents.

Education:

Bosnian children begin school when they are six years old and continue for at least nine years. After primary schooling, students can either continue in a vocational school, where they learn a trade, or can attend gymnasium, which is a university-prep high school. After the eighth grade, students must take and pass an exam which grants them a workbook. Without a workbook, students cannot get a job. Education is highly valued in Bosnia and is free to all citizens. Those who can afford university tuition can enroll for further education. Adult literacy rates are 99% for males and 94% for females.

Health:

Primary care is free to the citizens of Bosnia, although there are medications and procedures that require payment. Doctors are dominant in health care and are in charge of hospitals and outpatient clinics. Hospitals are often under equipped and private practices are too expensive for most citizens, although they are the most abundant health care facilities. Overall health care is considered holistic, and there is emphasis on vitamins, teas, and other home remedies, often due to a lack of affordable medications.

Residents of Bosnia face health disparities seen in many countries that face poverty and decreased access to clean water. Most commonly, Bosnia struggles with tuberculosis, cancer, lack of proper hygiene, kidney ailments, and heart disease. Smoking is extremely common and red meat is a large part of diet. PTSD and depression are also common because of experiences resulting from war and the resulting poverty. Although rising, HIV and AIDS rates are not considered high and blood supplies are not screened.

Special Considerations

- Eye contact is considered acceptable.
- Shaking hands and saying, *Dobar dan*, "good day", is the preferred method of greeting.
- Way of life is very relaxed and people sometimes forget or miss meetings.
- Common health ailments include: heart disease, PTSD, depression, tuberculosis, cancer, hygiene, and kidney problems.

Meskhetian Turks

Background and Population:

The Meskhetian Turks are a nomadic group that has had a recent increase in influx to the U.S. and to Vermont. Because of their background, a population number has been difficult to estimate. The darkly shaded countries in the map above are those with Meskhetian Turk populations.

Material taken from a publication by the Center for Applied Linguistics (CAL) was summarized for this section.

The best estimated population statistics put the Meskhetian Turk population between 350,000 and 400,000 as of 2005. The Meskhetian Turks reside in nine different countries, including Azerbaijan, Georgia, Kazakhstan, Kyrgystan, the Russian Federation, Turkey, Ukraine, Uzbekistan, and the United States. Originally, Meskhetian Turks lived in Meskhetia, a southern region in the country of Georgia. Over time, however, the population was discriminated against in various ways and forced into surrounding countries.

Historically, the Meskhetian Turks have experienced decades of persecution, especially in regions of Russia. Because of their nomadic ways, Meskhetian Turks were not permitted to gain permanent residence in areas of Russia and therefore were unable to work legally, own property, have access to health and social security benefits, attend higher education institutions, register for marriage and birth certificates, or obtain documents of identification. Without these basic rights, Meskhetian Turks were subject to poverty, deportation, and persecution which led to unbearable living conditions. It seemed that no matter where they tried to settle, Meskhetian Turks were subject to further discrimination and deportation. By 2006, the United States provided refuge to more than 9,000 Meskhetian Turks and by the end of 2007 it is estimated that another 3,000 will arrive.

Language:

Most Meskhetian Turks are multilingual. An Eastern Anatolian dialect of Turkish is spoken by the majority of people, but there are certain words in the main language that have been adopted from several others. CAL notes that most of the Meskhetian Turks residing in the Unites States speak Turkish, Russian, and the language of the country they lived in before moving to Krasnodar (southern Russia).

Religion:

Most Meskhetian Turks are Sunni Muslim, but many of those who settled in Russia are not strictly observant due to discouragement of religion by the Soviet Union. Those who identify with ethnicity originating in Georgia are generally Christian.

Greetings and Gestures:

"Hello" in Turkish is *Merhaba*, although the Meskhetian Turks speak a particular dialect of the Turkish language and there may be variations of this word. Studies

in Georgia have shown that handshakes are generally acceptable and eye contact is valued. However, Sunni Muslims do not make eye contact with members of the opposite sex. Checking with the patient to see what they are most comfortable with can make future greetings go more smoothly.

Family:

Meskhetian Turk families are extended, including grandparents, aunts, uncles, and cousins. Elders are the most respected and make all of the important family decisions. It is common for Meskhetian Turks to want to live in very close proximity to their family members when resettling in the United States.

Diet:

Daily diet includes potatoes, rice, vegetables, meat, eggs, cheese, sour cream, and honey. Observant Sunni Muslims refrain from eating pork.

Education:

Education is of great value to Meskhetian Turks. Discrimination, however, made educating children in the Soviet Union extremely difficult. Classrooms were often segregated and advancement was purposely unattainable for many. Children were also told that they would never qualify to further their education at the university level or to work, which significantly decreased their motivation to study. Literacy rates are difficult to estimate because of representation in so many countries.

Health:

Because Meskhetian Turks were unable to obtain Russian citizenship, they were not qualified to receive free health care from the government. In addition, many lived in rural areas and access to health care from such a distance was extremely limited. Many older Meskhetian Turks are resistant to health care in the United States and ask family and friends to send medications from Russia. CAL points out that many of the systems for obtaining health care in the U.S. are unfamiliar to Meskhetian Turks, which can be a challenge. For example, making appointments in advance and practicing preventative rather than curative medicine are frequent issues.

Special Considerations

The history of the Meskhetian Turks complicates the ability to pinpoint accepted customs. It is recommended that providers familiarize themselves with the basic history, but most relevant details should come from the patients themselves.

Common medical problems include dental problems and mental illness, as the Meskhetian Turks have experienced difficult pasts and high levels of stress. It is impossible to list endemic diseases as the Meskhetian Turks come from several different countries. For example, WHO estimates the prevalence of HIV/AIDS in Georgia to be less than 2% as of 2005, but in the Federation of Russia, where most Meskhetian Turks reside, the prevalence is between 0.8 and 1.7%. Knowing the country of origin of the patient makes this knowledge easier to access.

VIETNAMESE

Background and Population:

Vietnam is a socialist republic with a population of about 85 million people. Historically, World War II and the Vietnam War created difficult conditions for Vietnam, including a trade embargo by the United States which lasted for over 20 years, during which time the people of Vietnam experienced years of poverty, persecution, racism, and isolation. Thousands of families took refuge in other countries, including the United States, which houses several refugee and immigrant populations.

Language:

Major languages include Vietnamese, French, Chinese, English, and Khmer. There are also some citizens who speak Russian because of working in communist countries in the past.

Religion:

The majority of Vietnamese people are Buddhists (upwards of 60%). However, smaller percentages study Confucianism, Taoism, or Roman Catholicism.

Greetings and Gestures:

There is more emphasis on verbal communication and greeting than on body language, which is often considered improper. The typical greeting might include a handshake and a verbal, *Chao*, which means "greetings." It is considered inappropriate to touch a person's head as it is considered to be the center of the soul. Older adults, however, are permitted to touch the heads of younger children. It is also considered offensive to beckon another person by using only the index finger, as this gesture is used to call a dog. Instead, it is preferred to use all four fingers with the palm facing downward.

Diet:

Most meals include white rice, meats, salty fish or pork, vegetables, fruits, or soups. Food is placed at the center of the table and everyone shares all of the dishes.

Family:

Households typically include parents, unmarried children, and married sons with their families. Males are considered to be the dominant authority, but both males and females work and share responsibilities. Elderly are cared for by the family of the youngest married son, who often has inherited his parent's home.

Education:

Beginning at age five, Vietnamese children attend school Monday through Saturday. School is only free for the first six years. However, education is valued and children are encouraged to finish high school. Sadly, many drop out to begin

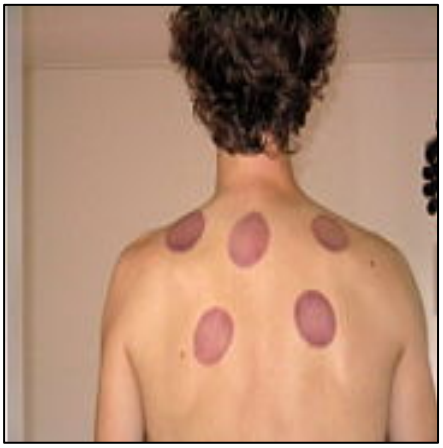
working. University education is free for certain students, but space is limited. Currently, private universities and secondary education facilities are increasing. Literacy estimates are 94% for males and 87% for female adults.

Health:

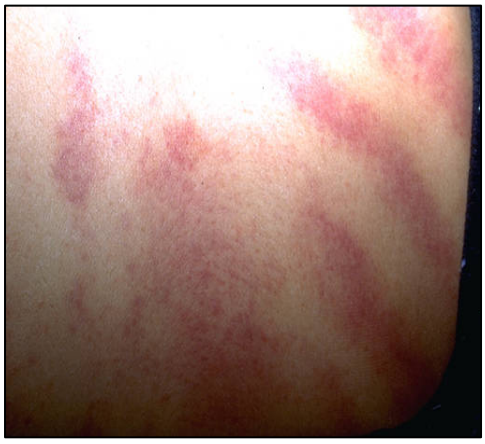
People from different regions of Vietnam have different beliefs about health and sickness. For example, many mountain people believe that sickness is a punishment from the gods while those in rural communities often place emphasis on imbalanced yin-yang or chi. Treatments can include magical, religious and Western medicine. Herbs, acupuncture, massage, and dermabrasive practices are common treatments. For example, cupping and coining are popular ways to draw illness out of the body. In coining, a coin is heated and rubbed all over the body. The Vietnamese believe that red welts or marks will only appear on those who are truly ill. Coining and other practices should be kept in mind for many Asian cultures and health care professionals should not be quick to assume contusions result from abuse or maltreatment.

Health disparities in Vietnam are mostly the result of poverty, inadequate access to clean water, pollution, and war. Because of the use of Agent Orange during the Vietnam War, birth defects were frequent. Polluted water, malnutrition, and poor access to medications and health care are only some of the factors causing high rates of dysentery, tuberculosis, choriocarcinoma, hepatitis, typhoid, dengue fever, Japanese encephalitis, cholera, and choloroquine-resistant malaria. HIV/AIDS rates in Vietnam are on the rise, with a recent World Health Organization estimate of about .25% for ages 15 to 49.

Specifically related to malnutrition and diet, it is common amongst Vietnamese to be lactose intolerant. Malnutrition is expected to affect more than half of the population.



Above, cupping marks roughly one day after treatment. Cupping uses heated air in attempt to suck out "bad winds" or unhealthy air currents from the body.



Above: Coining marks on a patient's back. In coining, a hot coin sometimes covered in boiled oil is rolled along a patient's skin to bring illness out of the body.

Mental health ailments can be a particular concern in the Vietnamese population, as their country's violent history has been difficult to bear. There is a strong stigma against mental illness, however, and many times emotional disturbances are actually manifested somatically.

The doctor-patient relationship in Vietnam is often dependent on the age of the doctor. Younger physicians might be considered incompetent and asked about their education as they have not yet acquired much experience. Older physicians, particularly those who have been practicing for more than 20 years, are considered experts. The oldest male in the family makes all of the health care decisions and patients are very rarely educated about their conditions. It is often considered more important to spare a patient's feelings than to tell them the truth about their medical ailment. Information on medications or diagnostic procedures is also not frequently communicated with the patient and so it is not uncommon for patients to be unfamiliar with their medical histories.

Special Considerations

- Direct eye contact during conversation is considered disrespectful.
- Although handshaking is accepted by many Vietnamese, physical touching, especially on the head, is often considered inappropriate. Common greetings include a handshake and a verbal, *Chao*, which means "greetings."
- Be sensitive to medical beliefs and practices, as some Asian cultures do not adhere to Western medicine. Researching ahead of time can prepare your office.
- Mental health issues are often stigmatized in Vietnamese culture, but it is important to recognize that they are common.
- Malnutrition and inadequate health care are common in Vietnam. Common health ailments include: typhoid, tuberculosis, cholera, dysentery, dengue fever, hepatitis, malaria, choriocarcinoma, and Japanese encephalitis.

Other Special Populations

While refugees are becoming an integral part of health care in Vermont, many others that make up the patient population do not necessarily speak different languages or come from different countries. The remainder of this manual presents information on several other special populations in Vermont and provides health care professionals with resources for more in-depth information.

Black or African American

African Americans have a long history in the United States and nationally, the U.S. Census estimates that African Americans comprise more than 13 percent of the total U.S. population. Census information shows a large percentage of African Americans live in ten main states, including: New York, California, Texas, Florida, Georgia, Illinois, North Carolina, Maryland, Michigan, and Virginia. In Vermont, population statistics from the VT Department of Health show that the percentage of residents who self-identify as black in Vermont has grown over 157% since 1990, bringing the most recent estimated total to 0.8%.

Research has shown that when comparing the health disparities of African Americans to other minority groups, there are important differences to recognize. Overall, these disparities contribute to a significantly lower life expectancy for African Americans in the United States, when compared to other racial groups. Census information estimates that African American males currently have a life expectancy of 69.5 years, more than six years less than white males, whose life expectancy is estimated at 75.7 years. White females have a life expectancy of 80.8 years, over four years longer than African American females, at 76.3 years.

FACTS: U.S. Department of Health and Human Services

- 2003 data show that African Americans had the highest age-adjusted death rate for heart disease, cancer, stroke, diabetes, homicide, asthma, influenza, pneumonia, and HIV/AIDS.
- In 2004, blacks were more likely to be clinically obese than Asian and Pacific Islanders. African American females were significantly impacted with more than 39% being considered obese.
- Lupus is three times more common in African American women than in white women. In addition, African American women develop symptoms at an earlier age and have more severe organ problems.
- African Americans have significantly lower rates of influenza and pneumococcal vaccination, especially among older adults.

Causes of Health Disparities

Education:

The Office of Minority Health (OMH) reports that a lower percentage of blacks earn a high school diploma. This is due to many contributing factors. In addition to having higher rates of poverty, many African Americans face discrimination and find it harder to continue their education. Less education can result in less understanding when it comes to healthy living.

Poverty:

In 2005, the U.S. Census determined that black households had the lowest median income ($30,858), only 61% of that of non-Hispanic white households ($50,784). Poverty contributes greatly to health care disparities as many cannot access adequate health care for financial reasons.

Insurance Coverage:

The OMH states that almost 20% of African Americans were uninsured as of 2005. Without health insurance, many people wait until a problem has developed before seeking care. In addition, proper care is difficult to obtain when insurance complications arise, as many providers do not see patients without proper insurance.

Discrimination:

The Alliance for Health Reform has determined that even when insured at the same level as whites, ethnic minorities in general receive health care of lower quality for the same health issues. In addition, studies have shown that, when asked, physicians rate African American patients as less intelligent, less educated, more likely to abuse drugs and alcohol and less likely to comply with medical advice.

Top Ten Causes of Death for African Americans

(U.S. Department of Health and Human Services)

1. Heart disease
2. Cancer
3. Stroke
4. Diabetes
5. Unintentional injuries
6. Homicide
7. Nephritis, nephrotic syndrome and nephrosis
8. Chronic lower respiratory disease
9. HIV/AIDS
10. Septicemia

Deaf and Hard-of-Hearing

The National Institute on Deafness and Other Communication Disorders (NIDCD) approximates that 28 million people in the United States have a hearing impairment. Furthermore, 2 to 3 out of every 1,000 children in the U.S. are born deaf or hard-of-hearing. Hearing loss is very common and can be the result of many different causes, including aging, disease, heredity, and the effects of noise. With loss of hearing, speech and language are often affected as well. This is especially true with hereditary deafness as children learning to speak are unable to hear the pronunciation of words.

In caring for deaf and hard-of-hearing patients, there are many important things to consider. Effective communication is essential to proper health care with any patient. For the deaf and hard-of-hearing, there are many ways to ensure that the patient is comfortable with the type of communication used in the office. First of all, providers should determine which method of communication is preferred by the patient. This will vary between reading lips, American Sign Language (ASL), writing, listening devices, and many others. Similar to other groups who face difficulty in communicating, deaf and hard-of-hearing patients are less likely to see physicians. Accommodating the patient will make the visit less stressful for them as they have purposely chosen a style they are comfortable with.

Like any other population, deaf and hard-of-hearing people often have similar heath issues related to their disability. Many of these issues are socially influenced, such as depression resulting from discrimination or difficulty in finding jobs. The National Center for Deaf Health Research, based out of the University of Rochester Medical Center, has been conducting research on the health of deaf and hard-of-hearing communities for several years. Studies have shown that this field is significantly lacking as previous research was not common. Information about health risk behaviors is incomplete, diabetes facts, and statistics on language style are poor as the U.S. Census does not record ASL users. Health implications have been identified in several areas, however.

The results of studies released in 2005 at the University of Rochester show that according to the National Center for Deaf Health Research:

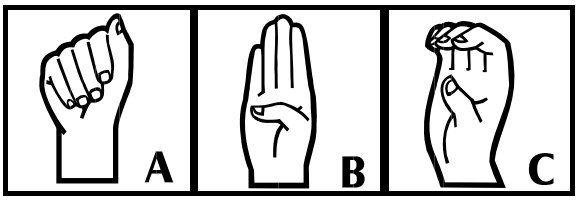
- Deaf and hard-of-hearing are 120-240 times more likely to have retinitis pigmentosa.

- Prolonged QT Syndrome is 15 times higher than non-deaf or hard-of-hearing patients.
- More than 70% of surveyed deaf and hard-of-hearing said deaf people could NOT get HIV. More than 50% did not know the meaning of "HIV Positive."
- 40% could not identify signs of a heart attack.
- More than 60% did not know signs of a stroke.

Further studies are in great need to determine health disparities of the deaf and hard-of-hearing. Identification of these disparities will make it possible for those in health care to address specific issues, reduce associated risks, and improve treatment and understanding. In addition to preparing for communication barriers and common health issues, it will be helpful to read some background information on deaf culture, a fascinating culture which prides itself on being deaf.

Communication Tips

- Ask the patient which communication technique they prefer.
- If the patient is most comfortable with lip reading, sit where the patient can read lips most clearly and articulate slowly and deliberately. Do not shout or speak loudly.



- Ensure that the exam room or office is quiet and free of distraction. Also refrain from paging the patient overhead when it is time to see them. Instead, walk directly to the patient and let them know it is time for their appointment.
- Know how to contact ASL interpreters and be prepared ahead of time for patients preferring to sign.
- Confirm that the patient understands by asking them to repeat information back, whether by writing, interpretation, or other devices.

Elderly

The life expectancy in the United States has steadily risen year by year and because health care is becoming more specialized, it is clear that people in the U.S. are living longer. In fact, the 2005 U.S. Census estimates that over 42 million people in the U.S. are over the age of 62. By 2050, more than 80 million people are expected to be over 62. The census specifies that in Vermont, 1/6 or more than 100,000 people are age 62 and older. As the number of elderly increases throughout the country, there is an obvious need for more attention to the field of geriatrics. In addition, care for chronic conditions and for end-of-life care (including palliative care and hospice) will also increase in necessity.

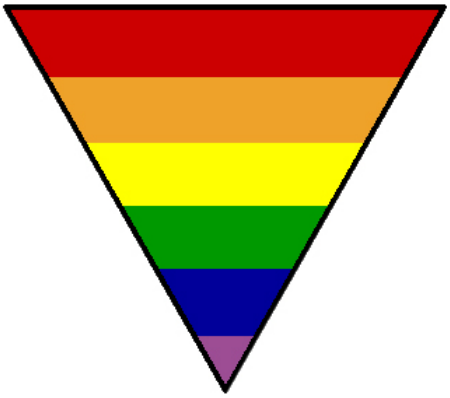
Caring for elderly people can be complicated, as many ailments are common to the elderly population. Older individuals are at higher risk for diseases affecting virtually every system in the body. According to the research at the National Institutes of Health (NIH), the following health issues are of concern for the elderly population:

- **Bone, muscle, and joint disease**: Over time, there is natural loss of bone size, density, flexibility of joints, and strength of muscles and tendons.
- **Cardiovascular disease**: Aging brings with it years of narrowing arteries (atherosclerosis), less elastic blood vessels, and resulting hypertension. Hypertension is extremely common in the elderly population.
- **Dental health**: Tooth decay, gum disease, and infection are all more common in older adults. Also, oral cancer is more prevalent.
- **Digestive problems**: The digestive tract generally moves more slowly as the body gets older. This leads to common problems like difficulty swallowing and constipation.
- **Eyes and ears**: Hearing and vision are often affected in the elderly population. In addition to an increased need for glasses and hearing aids, there is increased incidence of cataracts, glaucoma, and macular degeneration. Also, it is estimated that one in three people older than 60 and half of all people older than 85 have significant hearing loss.
- **Nervous system and brain**: It is more common for elderly to have memory problems, less coordination, and slower reflexes. This is due to the loss of neurons as the aging process occurs. Mental health is also of concern as the elderly may be experiencing loneliness or transitioning to nursing homes or long term care.

- **Renal diseases and bladder**: Elderly people are at higher risk for complications from diabetes and hypertension. As the kidneys are less efficient in old age, kidney damage can result. In addition to the kidney, the bladder and urinary tract are often weakened in older people, especially in women. Urinary incontinence is a common result of this.
- **Skin, nails, and hair**: It is more common for elderly people to have dry, thin skin, bruising, age spots, and skin tags. Decreased ability to sweat can lead to an increased risk of heat exhaustion and heat stroke. Also, sun exposure and smoking can affect skin. Smoking causes skin damage and the risk of having skin cancer is 40 to 50 percent by the age of 65.

It is important to be sensitive to the life changes that the elderly are experiencing. Transition periods such as retirement, moving to long term care, or losing friends and spouses are all very profound experiences that should be acknowledged. Educating the patient about healthy living and aiding them as they cope with life changes is important to the patient-provider relationship.

GLBTI (Gay, Lesbian, Bisexual, Transgender, and Intersex)



Accurate census information is difficult to obtain for GLBTI populations for many reasons. Although the U.S. Census does have statistics on same-sex couples, it does not have information on bisexual, transgender, or intersex people. In addition, statistical error is quite high in same-sex estimates. Nationwide statistics from 2004 estimate that 1.16% of all couples are same-sex couples. The most recent figures from the U.S. Census estimates that 1.54% of the couples in Vermont are same-sex couples. In fact, Vermont ranks fifth out of all fifty U.S. states in this percentage, demonstrating the importance of sensitivity to and understanding of this population.

The history of the GLBTI community in the United States is one of great struggle. Only recently has the country moved toward a more accepting attitude, recognizing the population and their rights. This is a topic of highly sensitive political, ethical, and religious debate, however, and much work needs to be done in the future to eradicate discrimination against GLBTI individuals.

As advocacy increases in the U.S., several organizations have vested interest in educating and providing information for the GLBTI population with respect to health care. In addition, many health care facilities include GLBTI-specific questions on intake sheets and ask specific questions during the patient interview, which is a progressive method that should be incorporated in all facilities to accommodate the GLBTI population.

Although many of the health disparities of GLBTI patients are similar to the general population, there are additional issues related to sexual identity, gender identity, and sexual health and behavior that providers should be aware of when treating GLBTI patients. The Gay & Lesbian Medical Association suggests several things that health care facilities can do help GLBTI patients feel comfortable enough to share information with their providers.

- Display ethnically and racially diverse posters showing same-sex couples.
- Implement rainbow flags, pink triangles, unisex bathroom signs, or other GLBTI-friendly symbols and stickers.
- Have brochures (possibly multilingual) about GLBTI health concerns, such as breast cancer, safe sex, hormone therapy, mental health, substance abuse, and STIs.
- Visibly post a non-discrimination statement stating that equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability, religion, sexual orientation, or gender identity expression.

- Display GLBTI-specific media, which might include magazines or newsletters about GLBTI and HIV-positive individuals.
- Alter intake or health history forms to include GLBTI-specific questions. For example, adding a "transgender" option for the male/female checkbox.

Top Ten Health Issues – Gay Men

(Gay and Lesbian Medical Association)

1. HIV/AIDS, safe sex
2. Substance abuse
3. Depression and anxiety
4. Hepatitis immunizations
5. STDs
6. Prostate, testicular, and colon cancer
7. Alcohol
8. Tobacco
9. Fitness
10. Anal papilloma

Top Ten Health Issues - Lesbians

(Gay and Lesbian Medical Association)

1. Breast cancer
2. Depression and anxiety
3. Heart health
4. Gynecological cancer
5. Fitness
6. Tobacco
7. Alcohol
8. Substance abuse
9. Domestic violence
10. Osteoporosis

Top Ten Health Issues – Transgender Individuals

(Gay and Lesbian Medical Association)

1. Health care access
2. Health history
3. Hormones
4. Cardiovascular health
5. Cancer
6. STDs and safe sex
7. Alcohol and tobacco
8. Depression and anxiety
9. Injectable silicone
10. Fitness

Homeless

The Department of Health and Human Services estimates that over a five-year period, 2-3 percent of the U.S. population, or 5-8 million people will experience at least one night of homelessness. The Vermont Housing Awareness Campaign estimates that, in Vermont, the average number of people who have utilized homeless shelters in the past four years has been about 4,000. Furthermore, those who are able to stay in shelters are staying longer. In 2000, the average stay in a shelter was 12 days. In 2004, the average stay increased to 26 days.

There are many different reasons why people become homeless. It is estimated by the U.S. Department of Housing and Urban Development (HUD) that more than 5 million households in the U.S. with incomes less than 50 percent of the median pay more than half of their income for rent and/or live in substandard housing. The combination of insufficient incomes, lack of affordable housing, unforeseeable circumstances, and inadequate aid leads to homelessness for many individuals and families. Health issues may also contribute to homelessness, such as mental illnesses, chronic disability and disease, and substance abuse. Also, social concerns such as domestic violence and neglect can lead to homelessness.

The homeless population faces many day-to-day challenges ranging from finding their next meal to caring for a chronic condition with no health insurance. Many communities have shelters, free clinics, food banks, job placement organizations, and other services in place for the homeless. Unfortunately, it is common for these organizations to be inadequately funded and understaffed. This can lead to limits on the number of homeless families and individuals being assisted and can hinder possible progress.

The complications of health and homelessness are perhaps best described by the National Health Care for the Homeless Council (NHCHC), which explains that health problems can cause homelessness, but homelessness can also cause health problems. The NHCHC states that people without homes are three to six times as likely to suffer from illness. In addition, because of poor health care and living conditions, the life expectancy for homeless individuals is roughly 40-50 years, compared to 77 years for an average person. Malnutrition, vulnerability to parasitic infection, frostbite, communicable diseases, violence including rape and beatings, circulation and musculoskeletal problems, STIs, and mental illness are very common issues amongst the homeless population. Lack of health insurance is a

significant barrier to adequate health care in the U.S. and is of particular concern for the homeless population. If homeless individuals are able to obtain transportation to a health care facility, they are often unable to be seen because of inadequate insurance or inability to pay. Also, many homeless people suffer from mental illness and substance abuse, services which are not always offered at free clinics.

Even when homeless individuals are able to see providers for their ailments, treatment is not always realistic. For example, it is more difficult for homeless patients to refrigerate medications such as insulin, take medications with food, obtain clean bandages, adhere to diet and exercise regimens, and comply with orders for bed rest. Treating a homeless person involves much more than a physical exam and a prescription. Providers should familiarize themselves with local resources that can help assist homeless patients with necessities of everyday life. Understanding common issues faced by the homeless population will help providers prepare with necessary information, contact numbers, and develop an effective technique for treating homeless patients.

According to the National Coalition for the Homeless:

- More than 44 percent of homeless are single men.
- Over 65 percent of homeless people are of a minority group. Fifty percent are African American.
- Families with children are the fastest growing population of homeless, accounting for roughly 39% of this population.
- One fourth of Vermonters in homeless shelters are children.
- Homeless people are 3 to 6 times more likely than non-homeless people to develop illnesses.
- The life expectancy of homeless individuals in major cities such as Boston and San Francisco has been decreased by an average of thirty years.
- More than 23% of the homeless are mentally ill. Common illnesses include schizophrenia and affective disorders.

Migrant and Farm Workers

A migrant worker is considered a person who travels from job to job, usually seasonally, and usually for very low wages. While migrant workers hold a variety of jobs, agricultural employment is the most common, especially amongst migrant workers in Vermont.

Current information from the Office of Minority Health (OMH) estimates that over 3 million migrant and seasonal farm workers are working in the United States. The U.S. Department of Labor shows that more than 80% of the nation's migrant farm workers are men and over 84% speak Spanish, in accord with the fact that the majority of the workers are of Hispanic or Latino background. In Vermont, a 2007 report released by the Department of Health states that about 2,500 migrant farm workers work throughout the state, with greater concentrations in Franklin, Grand Isle, and Addison Counties.

The health of these workers has been a large area of interest and concern as the population expands throughout the U.S. and especially in Vermont. There are many significant barriers to adequate health care for the workers. For instance, the National Center for Farm Worker Health (NCFH) states that more than 52% of farm workers are not legal citizens or legal residents of the United States. In addition, only 12% speak English, the median level of education is the 6th grade, more than 75% of farm workers earn less than $10,000 a year, and employment benefits such as health insurance are virtually non-existent. Even when the workers are able to obtain federal aid such as Medicaid, benefits are often lost as they migrate from state to state. These conditions create financial barriers, language barriers, unfamiliarity with health care protocols and inability to understand many health care risks, and distrust of providers for fear of deportation.

The health care concerns for farm workers are similar to those for citizens of developing nations. Poverty, inadequate housing, low literacy, reluctance to seek health care, and difficult working conditions put farm workers at risk for many illness that are not often seen in the general population.

A large part of providing health care to migrant and farm workers is ensuring access. Communities can develop services that travel to farms to provide preventative screening, education, assurance, and other assistance in attempt to prevent health care from becoming treatment focused.

For helpful information:
Migrant Clinicians Network
www.migrantclinician.org

Dictionary of Occupational Safety and Health Terms – English to Spanish
www.cbs.state.or.us/osha/pdf/dictionary/english-spanish.pdf

Health Conditions of Greatest Concern for Migrant and Farm Workers are:

(Information summarized from the *Journal of Health Care for the Poor and Underserved*, *Texas Medicine*, and National Center for Farm Worker Health)

- **Musculoskeletal disorders**: Causes of these disorders include heavy lifting, prolonged kneeling, uncomfortable postures, and unnatural body positions for extended periods of time.
- **Pesticide poisoning**: A 2003 estimate from the Environmental Protection Agency (EPA) states that more than 300,000 farm workers suffer acute pesticide poisoning each year. Farm workers experience the highest rates of pesticide and chemical poisoning out of any other working group in the United States.
- **Traumatic injuries**: Agricultural work is one of the three most dangerous jobs in the country. Falling, accidents with heavy machinery, exposure to toxic chemicals, and many more hazards are involved in farm work.
- **Respiratory conditions**: Farm workers are at great risk for allergies, asthma, pulmonary fibrosis, chronic bronchitis, emphysema, and many more respiratory conditions due to exposure to hazardous agents.
- **Dermatitis**: Contact with pesticides, chemicals, fertilizers, allergenic plants and crops, long hours in the sun, excessive sweating, and chapped skin all contribute to dermatological complications in the farm worker population.
- **Infectious diseases**: Migrant farm workers are at significantly increased risk for parasitic infections, tuberculosis, HIV and other STIs, and urinary tract infections.
- **Cancer**: Working with carcinogens, pesticides, oils, fuels, fumes, solvents, biological agents, and long exposure to sun puts migrant workers at increased risk for cancer. In addition, the workers have a higher mortality rate for cancers of the lip, stomach, skin, prostate, testes, and hematopoetic and lymphatic systems.
- **Eye conditions**: Exposure to toxic substances and inadequate hand hygiene can lead to eye problems, such as irritation, tearing, blurred vision, and more serious conditions like blindness.
- **Mental illness**: Poverty, isolation, stress, exhaustion, lack of recreation, cultural barriers, fear of deportation, poor living conditions, and many other aspects of migrant life have contribted to increased rates of mental illness, especially depression, substance abuse, and domestic violence.
- **Poor personal hygiene**: Unsanitary conditions on farms, crowded housing, and poverty all contribute to a decrease in personal hygiene.

Native American

Native Americans, also called American Indians, and Alaska Natives, have a deep-rooted history in North, South, and Central America. The first to inhabit much of the land on these continents, Native Americans were subject to a long history of persecution, misunderstanding, and violence as settlers came to America from European countries. In addition, many Native Americans, especially in New England, died of European diseases in the 1500's and 1600's.The U.S. Census estimates that more than 2.3 million American Indians and Alaska Natives are currently in the U.S., accounting for more than 0.8% of the total population. There are more than 500 federally recognized tribes and many more tribes that have not been federally recognized. The Vermont Department of Health estimates that 0.4% of the population, or more than 2,500 Native Americans live in the state. Nativelanguages.org states that Vermont is home to inhabitants of four main tribes, including the Abnaki, Mahican, Pennacook, and Pocmtuc.

Many of the barriers to health care for Native Americans come from conflicted history with the federal government, cultural beliefs, poverty, and inadequate education. While federally-recognized tribes are eligible for federal health care benefits, those tribes which are not federally-recognized exist as their own entities and are often unable to obtain these benefits. In fact, the U.S. Department of Health and Human Services states that more than 44% of American Indian and Alaska Native individuals do not have access to Indian Health Services. In addition to health insurance barriers, much of Western medicine is not understood or followed by Native Americans. Traditional health beliefs still permeate Native American culture. Although beliefs differ based on tribal affiliation, some shared beliefs have been identified by Diversity Resources, Inc., which may include:

- All healing begins with the Great Spirit (the Supreme Creator). Illness is an opportunity to purify one's soul.
- Humanity is made up of body, mind, and spirit, and health is maintained by preserving harmony among the body, heart, mind, and soul. Illness affects the mind and spirit as well as the body. Spirituality and emotions are just as important as the body and the mind.
- Plants, animals, and humans are part of the spirit world that exists alongside and is intermingled with the physical world.
- Death is not an enemy, not a natural phenomenon of life. The spirit existed before it came into a physical body and will exist after the body dies.
- One's relationships with others and with the earth are essential to health; disease is felt by both the individual and the family.

Income, environment and education also play a large role in poor access to health care for Native Americans. Census statistics estimate that unemployment is 2.5 times higher among American Indians and Alaska Natives than for the remaining U.S. population. The poverty rate for the American Indian population is higher than African Americans, Hispanics, and Caucasians. Smoking and obesity rates are extremely high in American Indian populations, contributing to the high percentages of cardiovascular disease and diabetes.

Providers should be aware that although health disparities have been identified for the American Indian and Alaska Native population, not all patients will have similar illnesses, concerns, or understanding. Different tribes follow different ways of life and being sensitive to individual needs will provide the best health care for the patient.

The OMH Lists the Top Ten Causes of Death for Native Americans as:

1. Heart disease
2. Cancer
3. Unintentional injuries
4. Diabetes
5. Stroke
6. Chronic liver disease and cirrhosis
7. Chronic lower respiratory disease
8. Suicide
9. Influenza and pneumonia
10. Nephritis, nephrotic syndrome, and nephrosis

Women

The 2005 U.S. Census estimates the female population to be 50.7% both nationwide and in Vermont. Women's health has had great publicity over the last few decades, and has become a specialized field. Historically, women have overcome much adversity and with more women as equals today, women are seen less and less in traditional homemaker roles and more and more in the workforce. It is now more common than ever for women and their partners to be working and juggling a family.

Women's health is multifaceted and often encompasses aspects unique to the bodies of women. For example, health concerns may include things like breast or cervical cancers which are not focuses of men's health. Also, pregnancy and prenatal care are issues of women's health. The U.S. DHHS states that women are also more likely than men to suffer from domestic violence and abuse and certain mental illnesses. For example, caregivers, who are often women, are much more likely to suffer from depression.

Heart disease, cancer, and stroke are the top three leading causes of death for women. Although many people are under the impression that heart disease is more common in men, the CDC states that it was the cause of death for more than 25% of women who passed away in 2003. Educating female patients on their risk for heart disease, stroke, or any other health concerns is important to prevention and treatment. Sometimes asking the patient about their understanding of a certain illness can help the provider know which areas should be addressed.

Top Ten Causes of Death for Females of All Races:

(Released by the CDC in 2004).

1. Heart disease
2. Cancer
3. Stroke
4. Chronic lower respiratory diseases
5. Alzheimer's Disease
6. Unintentional injuries
7. Diabetes
8. Influenza and pneumonia
9. Kidney disease
10. Septicemia

When caring for female patients, it is important not to make assumptions about lifestyle, beliefs, education, and background. Females of different ethnicities and cultures will want to address certain aspects of health and some might not be comfortable sharing personal information with their provider. Keeping an open-mind and non-judgmental attitude with each patient will allow for a more trusting relationship.

Strategies for Addressing Health Disparities

Patient education

Helping the patient understand their illness in the simplest terms will be beneficial to their comprehension and will likely improve their motivation to change. Ask the patient to demonstrate their understanding by repeating information back. This will allow providers to address pertinent information and clarify as needed. Also, educational materials such as brochures (in multiple languages when available), can enhance patient understanding and can also be brought home for future reference.

Provider education

Part of becoming culturally competent is educating oneself about health care issues common to different cultures and ethnicities. Having background information and resources ensures better preparedness. When an encounter with a patient is difficult due to cultural barriers or misunderstandings, try to prepare for future visits by researching, attending workshops, and asking the patient's input.

Do not discriminate or stereotype

Although there is a wealth of information available to providers about ethnic groups, not all patients from a particular ethnic group will be the same. Each patient is an individual person with their own beliefs, goals, backgrounds, and health concerns. Asking the patient about their preferences will not only make them more comfortable, it will show flexibility and acceptance.

Recognize health literacy

The ability to understand health issues, make appropriate health decisions, and follow treatment instructions are all components of health literacy. Reading brochures, prescription instructions, consent forms, and other written materials does not necessarily demonstrate health literacy. The ability to process information and make appropriate decisions based on the information are also integral to being competent in health literacy. Health literacy is a significant problem in the United

States and it is estimated that more than 90 million adults have limited literacy skills. This estimate, however, is significantly affected by the fact that many people with health literacy problems are too embarrassed to admit their difficulties to their providers.

Health literacy is not a problem specific to certain ethnicities or backgrounds. Studies have shown that health literacy problems exist across all economic and educational backgrounds, ages, cultures, and races. Rates of disparities in health literacy, however, are higher amongst minority patients, elderly patients, those who speak English as a second language and patients with low income.

Improving Health Literacy

(Tips from the Society of General Internal Medicine)

- **Slow down.** Take time to recognize warning signs. Patients may claim to forget their reading glasses, bring family members with them to visits, or struggle with filling out health forms.
- **Do not use medical jargon.** Using words that the average person is familiar with can help patients understand the issues at hand.
- **Use visual aids.** Pictures and diagrams can help with comprehension and recall.
- **Limit the amount of information given and repeat instructions.**
- **Confirm understanding.** Have patients repeat instructions to demonstrate their understanding. Never simply ask, "Do you understand?" as patients can easily reply, "yes" even if they do not.

For More Information on Health Literacy:

National Institute for Literacy
www.nifl.gov/nifl/facts/health.html

National Network of Libraries of Medicine Health Literacy Resources
http://nnlm.gov/outreach/consumer/hlthlit.html

U.S. Department of Health and Human Services: Health Literacy Improvement
www.health.gov/communication/literacy/

Adult Literacy Estimates by City, County or State
www.casas.org/lit/litcode/search.cfm

Clear Language and Design Plain Language Thesaurus
www.eastendliteracy.on.ca/clearlanguageanddesign/thesaurus/

Specialized Health Issues

As Vermont becomes a more diverse state, providers will treat patients from many different ethnicities, cultures, belief systems, countries, and backgrounds. Due to health care barriers resulting from educational level, language, economic status, health insurance, cultural beliefs, and more, many health issues are not addressed as often as they should be. Often, providers focus on their specialty care and may miss warning signs of other problems they are less familiar with. Two areas of health care that are relatively common disparities of refugee and minority health include oral health and mental health.

Mental Health

While physical health is often the main focus of health care, providers should be aware that disparities also exist in mental health, especially among minority populations. Consider the following facts from the Office of Minority Health.

- 1 in 2 Americans has a diagnosable mental disorder each year. This includes 44 million adults and 13.7 million children.
- Fewer than half of adults and only one-third of children with diagnosable mental disorders seek help.
- 80 to 90 percent of mental disorders are treatable using medication and behavioral therapies.
- The World Health Organization states that four of the ten leading causes of disability in the U.S. and other developed countries are mental disorders. They predict that, by 2020, major depressive illness with be the leading cause of disability in the world for women and children.
- Roughly 877,000 people die from suicide every year, making suicide the 8th most common cause of death in the U.S.
- African Americans are more likely to experience a mental disorder than Caucasians. They are also *less* likely to seek treatment.
- American Indians and Alaskan Natives suffer disproportionately from depression and substance abuse.
- Homeless people have one of the highest rates of mental illness.
- Asian American and Pacific Islanders are more likely to be misdiagnosed when it comes to mental illness.

Mental health is of particular concern in refugee populations. High levels of stress, feelings of despair and isolation, histories of violence and persecution, and many other contributing factors can lead to severe emotional problems. Post traumatic stress disorder (PTSD) and depression are among the two most common mental illnesses seen in the refugee populations. Approaching a refugee patient about mental illness can be complicated. Providers who suspect mental illness should speak with the patient about their cultural beliefs regarding mental illness, as the

stigma is greater in some populations than in others. Working with the patient to find the right care for their illness and to understand treatment options can also be challenging. Being prepared with the right resources, knowing about specific cultures, and being sensitive to the wishes of the patient will help in communicating concern.

In addition to refugees, minority populations in the United States are at great risk for mental illness. Being familiar with common health disparities for given populations can help remind providers that mental health is an area worth exploring with their patients. Ultimately, providers should work toward aiding patients in achieving both a healthy body and a healthy mind.

Oral Health

There are many reasons why dental health has become a significant problem in health care, particularly for minority populations. Access to dental care is perhaps the largest contributing factor to poor oral health. Dental services are rarely covered under medical insurance and with more than 40 million uninsured in the United States, it is easy to see why dental health is not a priority for many. Dental work and maintenance can be expensive and many people are more concerned with day-to-day living than with cavities and tooth decay.

Poor oral health is extremely common among refugee populations. Many did not have access to clean water, toothpaste, toothbrushes, floss, fluoride, or any other necessary components for healthy teeth and gums. Many refugees have never been to a dentist or are not aware of the benefits of oral health.

Dental health is extremely beneficial to those who can access it as it can prevent serious health complications. Poor oral health can lead to gum disease, which can result in lost teeth and an increased risk for heart disease and stroke. When plaque builds up and hardens on teeth and gums, it can travel from the mouth to the bloodstream where it can clog arteries, damage heart valves, and cause lung conditions. Research at the National Institutes of Health (NIH) has shown a link between gum disease and diabetes as well. Complications of diabetes can become more severe with gum disease and conversely, diabetes can cause gum disease, making good oral hygiene particularly important to diabetic patients. Finally, oral health is extremely important for pregnant women. The CDC states that gum disease in pregnant women may put women at higher risk of delivering premature, low birth weight babies than women without gum disease.

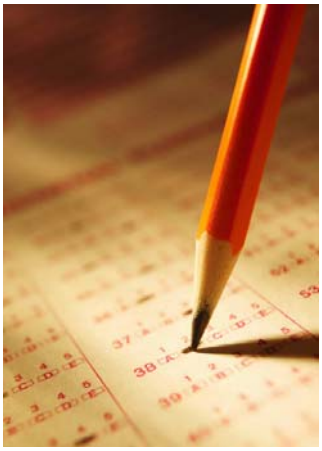
Oral health is best addressed early, when children are first beginning to care for teeth and gums. According to the Vermont Department of Health, dental decay is the single most common chronic disease of childhood and is 5 to 8 times as prevalent as asthma. Nationally, more than half of all children have cavities by 2nd grade and 80% of children have had cavities by the time they graduate high school.

Providers should participate in oral health education as much as possible, and refer patients to dental organizations that can help.

Take Home Points of this Manual

- To be culturally competent, the health care professional needs to understand *their own* world view and those of the patient, while avoiding stereotyping.
- Cultural competency involves an understanding and acceptance of cultural practices and is more than simply being able to speak the same language.
- Communicating effectively across cultures is a critical factor in providing quality health care to diverse populations.
- Becoming culturally competent is an ongoing process. Providers will see patients from all different backgrounds throughout their practicing years making it a lifelong commitment to be culturally competent.

Self-assessment Tools



Cultural competency self-assessment tools have been developed by several institutions for employees of all trades, particularly those working in health care that have close contact with patients. Below are select online assessment tools that providers might find helpful.

The American Academy of Family Physicians Cultural Competence Self-Assessment.
www.aafp.org/fpm/20001000/58cult.pdf

Georgetown University Center for Child and Human Development
www11.georgetown.edu/research/gucchd/nccc/documents/ChecklistBehavioralHealth.pdf

An assessment produced by the Planned Parenthood Federation of America, Inc.
www.plannedparenthood.org/files/PPFA/diversity-self-assess.pdf

Continuing Education Opportunities

It is clear that becoming culturally competent involves time, understanding, patience, and experience. In addition to these requirements, education is critical not only to becoming culturally competent, but to maintain the competence as populations become more diverse. There are many online opportunities available for continuing the educational process on this topic. A selection of some of these websites, as well as a local workshop opportunity and over fifteen pages of references are listed to aid providers in expanding their knowledge in their quest to becoming culturally competent.

Cross-Cultural Health Care Literature Workshop

This workshop can aid professionals, health care providers, and students become sensitive to cultural competency and understand how to improve the quality of care for those from different backgrounds. Workshops can be arranged for interested groups. Contact Laura Haines of the Dana Medical Library at the University of Vermont School of Medicine for more information.

(802) 656-4143
Laura.haines@uvm.edu

Critical Measures Online Learning Course

Critical Measures has developed an online e-learning course called, *A Patient-Based Approach to Cross Cultural Care*. The module offers Continuing Education Units (CEUs) for health care providers.
www.criticalmeasures.net/cross_cultural/elearning.htm

Culture Vision Seminars

Culture Vision provides free cultural competency seminars online. Some seminars offer Continuing Education Units (CEUs).
www.crculturevision.com/index.htm

National Center for Cultural Competence

The NCCC has developed training modules addressing four main topics: cultural awareness, cultural self-assessment, process of inquiry, and public health in a multicultural environment. To access the modules, just follow the registration instructions.
www.nccccurricula.info/

Physician's Practical Guide to Culturally Competent Care

The U.S. Department of Health and Human Service's Office of Minority Health (OMH) offers this website, which includes cultural facts, clinical vignettes, and a structured online course.
https://cccm.thinkculturalhealth.org/default.asp

Select References & Resources

Africa

http://allafrica.com/
All Africa

www.sul.stanford.edu/depts/ssrg/africa/health.html
Stanford University: African Health and Medicine Resources

www.afro.who.int/
World Health Organization: Regional Office for Africa

www.culturalorientation.net

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Center for Cross Cultural Health

www.xculture.org
Cross Cultural Health Care Program

www.culturalcompetence2.com/
Cultural Competence Online

www11.georgetown.edu/research/gucchd/nccc/
National Center for Cultural Competency

www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3
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www.deaflinx.com/Services/health.html
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National Institute on Deafness and Other Communication Disorders

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Appendix A: Population by County with Race and Minority (Vermont Department of Health 2005 Population Estimates)

	Total	Hispanic	White Total	White Hispanic	White Non-Hispanic	Black	American Indian, Eskimo & Aleut	Asian & Pacific Islander
July 1, 2005								
VERMONT	623,050	6,769	608,703	6,333	602,370	5,023	2,581	6,743
Addison County	36,965	450	36,280	401	35,879	293	75	317
Bennington County	36,999	478	36,317	451	35,866	299	78	305
Caledonia County	30,440	242	29,973	228	29,745	171	156	140
Chittenden County	149,613	1,849	143,479	1,729	141,750	2,041	459	3,634
Essex County	6,602	40	6,501	35	6,466	29	36	36
Franklin County	47,914	346	46,742	331	46,411	255	763	154
Grand Isle County	7,703	36	7,589	34	7,555	16	70	28
Lamoille County	24,495	251	24,030	240	23,790	209	134	122
Orange County	29,287	255	28,972	243	28,729	105	78	132
Orleans County	27,640	267	27,205	250	26,955	153	165	117
Rutland County	63,743	520	62,961	488	62,473	320	115	347
Washington County	59,478	856	58,300	807	57,493	408	254	516
Windham County	44,143	567	43,226	519	42,707	394	83	440
Windsor County	58,028	612	57,128	577	56,551	330	115	455