



Understanding the Need for Interfaith/  
Intercultural Togetherness & Education

# Health Care & World Religions

A HANDBOOK FOR HEALTH CARE PROFESSIONALS

By: **Dr. Malcolm Nazareth**



Sponsored by:



Blue Cross and Blue Shield of Minnesota

Foundation

# Health Care & World Religions

## A HANDBOOK FOR HEALTH CARE PROFESSIONALS

(Insights on attaining Cultural Competence with respect to Hmong, Lao Buddhists, Latina/o Christians, Somali Muslims, and South Asian Hindus)

*Author:* Dr. Malcolm Nazareth

*Graphics designer:* Norhashimah Erpelding of Creative Artistic Nuance

*Sponsor:* Blue Cross and Blue Shield of Minnesota Foundation's three generous grants to UNIITE in 2006-07 enabled this booklet to see the light of day in 2008

*Presenters:* I owe much of the content, including phrases and sometimes sentences, to the respected presenters of UNIITE's "Health Care and World Religions" series (Phases A and C). For such authoritative "insider's information," and not for the idiosyncratic manner in which I put it all together, I am deeply obligated to Sunny Sinh Chanthanouvong, Casey Anonthisene R.N., Saphaonthong Komany, Drs. Kusum and Krishna Saxena, Dr. Surendra Chaudhary, Dr. H. Giovanni Antunez, Dr. Jesus H. Lopez Moreno, Dr. Saeed Fahia, Dr. Osman M. Ahmed (Harare), Dr. Kang Xiaaj, and Dr. Yang Lo (all of Phase A). I am similarly in the debt of Dr. Dia Cha, Dr. Mohamed Hassan, Dr. Napoleon (Lucho) Espejo, Dr. Sombath Senethong, and Dr. Shashikant Sane (all of Phase C).

*Co-sponsor:* CentraCare Health Foundation gave UNIITE a 2006 supporting grant

*Partners:* The Diversity Committee and the Educational and Professional Development Department at St. Cloud Hospital (SCH); Abbott Northwestern's Sartell Outpatient Center; Department of Nursing at the College of St. Benedict and St. John's University (CSBSJU); Department of Social Work at St. Cloud State University (SCSU); Central Minnesota Community Foundation

*Board of Directors of UNIITE:* April Lange, Dr. Lin Holder, Ric Studer, Dr. Mary T. Howard. *Advisory members:* Mariani Nazareth R.N., Fr. Dave Gallus

*Former Board members of UNIITE during HCWR series:* Dr. Jerry Wetterling, Jayme Wickman, Cristina Seaborn, Norhashimah Erpelding, Sharon Sponheim, Dan McKanan, Cindy Eskandary, Mark Thelen, Deborah Vander Eyk, and Bonita Zimmer

Published by Rengel Printing Company, St. Cloud, MN.

Date: July 26, 2008, St. Cloud, MN

July 20-26 is celebrated as National Hospitality House Week

© 2008 Malcolm Nazareth

The electronic version of this booklet, in pdf format, is downloadable at no charge for widest possible copying and distribution. After 9/30/08, the concluding day of UNIITE's existence as a nonprofit, and the closing of its website, please go to [www.communityview.org](http://www.communityview.org) to access the electronic version.

# Health Care & World Religions

## FOREWORD

### **What's the purpose of this booklet? What makes it special?**

This booklet is about honoring culture while “closing the gap.” It shows concretely “how to” eliminate racial and ethnic health disparities in one aspect of patient access to western medicine. **The booklet is for health care professionals of all stripes who strive for greater proficiency in their medical practice.**

The licensed and certified health care professional is already fully competent to practice medicine in her or his specific field of expertise. The goal of this booklet is to assist the *medically* competent professional to serve in ways that are *culturally* appropriate and acceptable to the patient, and thus attain a higher level of proficiency.

Health care professionals who are both medically *and* culturally competent undoubtedly please the patients whom they serve. Such professionals tend to attract people of diverse cultures and thus contribute significantly to the bottom line of the health care facilities which they serve.

The booklet is for every physician, nurse practitioner, nurse, midwife, social worker, chaplain, dietitian, hospital administrator, counselor, physiotherapist, occupational therapist, chiropractor, patient advocate, community health worker or any other person(s) who consider themselves to be health care professionals in North America today. Such professionals may be serving in family practice, mental health, critical care, maternity unit, hospice, emergency room, or operating room, for example. The booklet is addressed to a wider readership than can be listed here.

**The booklet is only a first step.** It is offered as a tool for ready use by health care professionals hurriedly preparing themselves to visit with patients of five groups, namely, Somali Muslims, Latina/o Christians, Lao Buddhists, South Asian Hindus, and Hmong. These groups are prominent among vulnerable, new immigrant groups in Central Minnesota and are each linked with a different world religion. They formed a perfect fit with the stipulations of the Blue Cross Foundation's “Healthy Together” grants in 2006-07. UNIITE (Understanding the Need for Interfaith / Intercultural Togetherness and Education), which has served St. Cloud, MN, since 2003, was a proud recipient of these grants.

Thanks to these Blue Cross Foundation grants for planning and implementation of a unique “Health Care and World Religions” (HCWR) series in 2006-07, along with a small grant from the CentraCare Health Foundation, plus generous offerings of auditorium space by SCH and Abbott Northwestern's Sartell Outpatient Center, UNIITE was able to bring outstanding medical practitioners, medical teachers, and others to the St. Cloud area. By way of follow up, this booklet is a modest attempt to distill the vast and detailed information which the HCWR series brought, and to transform it into a handy tool for health care professionals.

## FOREWORD (CONTINUED)

The booklet offers skimpy “laundry lists” of salient points of each group’s cultural history. It then points out significant ones that impact health care and, where possible, offers some ideas to respect these and yet give good health care.

**The profiles of the five target groups of the HCWR series are intended to serve as broad templates.** They are a mere gloss on the instructions and comments of diverse experts who spoke about a given ethnic group from the vantage point of their own discipline and experience.

A patient belonging to one of these five groups is likely to prove to be the exception rather than the rule. Despite the central importance given to immigrant groups’ religious beliefs, the author of this booklet is not ignorant of atheists, agnostics, and skeptics who are also to be found in significant numbers in any racial or ethnic group, however “new” its immigrant status.

**Consequently, it is proposed that the templates be used as maps and then set aside lest one miss the uniqueness of the reality that each patient brings.** One must especially guard against making generalizations about patients of a specific group. For one immigrant’s beliefs, values, and practices may differ significantly from those of another immigrant in that very same ethnic group. A wide spectrum ranges from those who are assimilated to western culture, on the one hand, to those who maintain traditional ways, on the other. As a Pakistani Muslim scholar puts it, **“A basic principle for best culturally sensitive care is to provide client-centered care.”**

Again, there is no monolithic “Islamic (or Buddhist, Hindu, Hmong, Christian) tradition.” The principles of Islamic religious practice may be similar, although there are variations there, too. However, the way of life of Muslims (or Buddhists and so on), in terms of traditional and cultural practices, are hugely different. **That is precisely why health care professionals should take care to find out from the patient or family what their preferences are.** It is the professionals’ responsibility to discern what is appropriate for *this* unique patient before jumping to conclusions merely on the basis of the five cultural and religious templates provided in this booklet or elsewhere.

### **Are there matters of cultural competence which are common to all five groups?**

This booklet offers insight into *all* new immigrants’ experience of the U.S. health care system. In addition, there are certain aspects of cultural competence which are fully applicable to the five groups presented in this booklet. To avoid repeating them under each group, I list them below:

- **Appropriate translation services are helpful.** Ideally, it is not advisable for a practitioner to use family members, especially children, for interpretation. The child may not understand medical terminology. Adult patients may not feel comfortable describing their health condition and symptoms to professionals via minors. Good

## FOREWORD (CONTINUED)

interpreter services are needed especially for seniors in new immigrant communities. The health care provider needs to assure the patient of her or his obligation of confidentiality, and impress upon the interpreter the importance of maintaining that same confidentiality.

- Given linguistic and other challenges, it is a wise practice to **allow new immigrant patients sufficient time to complete paperwork and get forms signed**. It is similarly important to **explain procedures and medicines carefully** to such patients.
- For effective communication outcomes, it pays to **use simple language and make the patient repeat key educational points**. It is also advisable to **pause often, speak slowly, and try not to communicate too much at one time**.
- Many **new immigrants are reluctant to seek medical attention**, or find it difficult to do so, **because of low-income jobs with long working hours and no health benefits**.
- Often enough, **scientific diagnosis does not have the same meaning for patient and provider**. Patients generally appreciate their provider's respect for their interpretation of their symptoms when the provider asks: "What does that mean to you?" "Why is that important?"
- Some people, especially **new immigrants, prefer to seek relief from symptoms first through traditional healing practices**. They may choose western medicine as a last resort. By this time their condition may have deteriorated. It might help to **find out from the patient if they are employing any traditional healing practices**, and what these might be. In any case, it wouldn't hurt to equip oneself with basic knowledge of such practices for better patient-provider rapport.
- It is recognized by increasingly more western healers today that **spirituality does have a critical role to play in health and healing**. For the past roughly one hundred sixty years, however, the practice of western medicine generally kept spiritual issues at a "safe" distance. For millennia prior to that, religious beliefs and practices went hand-in-glove with health and healing practices in the west as elsewhere. It is interesting that all five immigrant groups in this booklet generally regard health care in a more holistic way than their host country.
- **Cultural traditions of new immigrants have generally looked at humans as body-mind-and-spirit**. Consequently, if there is a single aspect of health care that strikes many new immigrants as alien in the United States, it's the dichotomized view of health and healing embedded in many a cubic foot of its "western" structure from health policy to insurance, from diagnosis to recovery processes. Openness, trust, and communication between the different cultural groups, traditional and western, would help build a bridge that is certain to stretch understandings of "medical science" on both sides of the divide, with improved health outcomes for all.

## Dedication

I dedicate this publication to my beloved wife Mariani. To a large extent, it was her nearly nine years of clandestine co-funding of CIE (Center for Interfaith Encounter, see [www.uniite.org/cie.html](http://www.uniite.org/cie.html)) and UNIITE in St. Cloud that made our close to five hundred interfaith and intercultural activities of over forty different types possible.

It has been one of the dreams of UNIITE, during its more than five years of existence, to enable St. Cloud, as a city, to be culturally competent and inter-religiously welcoming to all. To this day, working shoulder to shoulder with many others, we seek to place St. Cloud on the nation's map as an "international city welcoming to all nationalities" and "famous for quality of life for all." **We present this booklet as UNIITE'S swan song.**

During National Hospitality House Week, the booklet draws attention to the need for such hospitality to be offered in the "health care industry" to *all* of today's especially vulnerable populations, not merely the five highlighted in this booklet. In our "nation of immigrants," perfect hospitality will always consist of an ever receding horizon.

**UNIITE's mission is: "To foster mutual respect and understanding among people of diverse spiritual paths and cultures in the greater St. Cloud area through social and educational opportunities."**

UNIITE's HCWR project culminating in this booklet demonstrates the **hard work of many extraordinary people**, to make this mission succeed.

The health care system, as many experience it in the United States today, has become like a rudderless boat. The patient often feels secondary in importance to the very system that has been devised to care for her or him. UNIITE's unique HCWR project (2006-08) mirrors many movements in the land which are committed to effecting a 21st century "Copernican revolution" by making health care **once again people oriented.**

For, it is cost-effective **caring for people** through health and healing approaches from diverse cultures (Native American, African and African American, Latina/o, Asian, *and* Caucasian) that must take its rightful place at the center of the health care system. For their part, health care professionals have to once again become true **servants of the people's health and well being.**

I would appreciate receiving any comments, suggestions, and criticism you may have. Please call me at 320/230-6669. Or write to me at 819 North 14th Street, St. Cloud, MN 56303.

Email: [malnazareth@charter.net](mailto:malnazareth@charter.net) or [mjnazareth@stcloudstate.edu](mailto:mjnazareth@stcloudstate.edu).

Dr. Malcolm Nazareth, executive director  
UNIITE, [www.uniite.org](http://www.uniite.org)

# Hmong

## AND HEALTH CARE

### WHO THEY ARE

Hmong consist of a distinctive ethnic group from the uplands of Laos who first arrived in the United States as refugees in 1976. The CIA had recruited the Hmong to assist them during the Vietnam War (1963-75). After the war, the Pathet Lao (Communists) persecuted all US supporters in Laos, especially the Hmong. They were forced to flee from Laos to neighboring countries, such as Thailand, where they lived in refugee camps until they were brought here by the US government. Up until the present time, they continue to arrive in significant numbers. Despite the larger number of Hmong in California, **Minneapolis/St. Paul is the “Hmong capital” of the United States** probably because of density of location.

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES<sup>1</sup>

**Traditionally Hmong are strongly connected with each other.** They drop into each others' homes just to say hello and keep in touch. The common bonds they share are reinforced through Hmong language which has non-phonetic Roman script. The language was not written in Laos, so providing translated materials to first generation Hmong may be pointless.

**Hmong see pregnancy and childbirth as normal conditions and a matter of personal autonomy, not a pathology requiring medical care.** They are considered “women’s business.” As the only male in attendance, the husband is expected to assist in childbirth.

**Difficulties in childbirth** are traditionally **ascribed** to

- commission of wrong actions toward parents, elders, or husband,
- result of a curse,
- being struck by spirits of women in the husband’s clan who died of childbirth, or

<sup>1</sup>Please see Introduction for a caveat against stereotyping members of any group at all.

## HMONG AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

- capture by malignant outdoor spirits.

Some healing solutions in such a situation are magic, herbal medicines, shaman's ceremony, and request for assistance from spirits of ancestors.

Special care is given to the mother and her newborn for thirty days.

**Every person is believed to be born with a mandate of life.** Such a mandate is comparable to a visa which has an expiration date. **Death occurs when the mandate expires.**

**The most important social unit of Hmong society is the clan which influences the political, social, economic, and religious aspects of Hmong culture.** Currently Hmong Americans recognize eighteen clans. The clan is a group of families, of which all the individuals share the same last name and are linked by a common set of ancestors. Marriage is taboo within the same clan. **Clan culture fosters respect for elders and the family, and the keeping of traditional ways. These ways are hierarchical and emphasize interpersonal relationships and interdependence.** At the family level, **all decisions are made by the husband or the head of the clan, more so for first generation Hmong.**

It is considered polite to avoid direct eye contact with elders and to employ a soft and gentle voice.

**Traditional Hmong culture and religion are inextricably intertwined.** Approximately seventy percent of Hmong Americans practice traditional animist Hmong religion (see below). One-third of Hmong in the US today are Christian, many of whom belong to the Christian Missionary Alliance Church. Christianity, which some Hmong feel has shown intolerance of traditional Hmong beliefs, poses a threat to traditional communal harmony. But it is known that Hmong Christians may also engage in traditional Hmong practices when there is a health care crisis. Indeed, Christianity can assist in facilitating Hmong utilization of western health care.

## HMONG AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

**Reincarnation and fate are central to traditional Hmong belief.** Hmong also believe that

- there are good and evil spirits everywhere.
- each person has at least three souls, one soul occupying the head area, one the torso, and the third, the leg area.
- soul and body exist in unity. A soul may leave the body through fright, highly emotional circumstances, or extreme sadness. Spirits can kidnap the soul.
- a soul can change into other forms of life. When so transformed, it does not recognize its owner and cannot return. As a result, the owner becomes seriously ill and death can result.
- when a soul cannot find its way back home, ritual family practices symbolically serve to guide the soul back.

**Hmong shamans, both male and female, are traditional communicators with the spirit world. They deal with the prevention and/or treatment of illness. Their rituals and incantations,** which are handed down via oral tradition from shaman to pupil, **are the primary processes for traditionally curing spirit-related illness.**

**Hmong** pride themselves on their ability to understand a broad range of subjects, including complex diseases. They **maintain a holistic perception of health. Both physical and spiritual well-being is emphasized.**

**For Hmong, illness consists of disruption in nature, or disequilibrium.** It is a condition that renders an individual incapable of performing normal functions. Types of illness are natural, organic, magical, or supernatural.

**Involvement of the Hmong shaman, who plays a central role in the healing process, often includes animal sacrifice.** Payment is made if the sick person gets better.

**The Hmong experience illness and death as part of the normal cycle of life.** Both are believed to be caused by bad luck, bad deed(s) committed in a prior life, or inevitable fate. **An ideal stance toward illness and death is to be serene and stoic.**

## HMONG AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

**Hmong believe that planning in advance for death opens the door to evil spirits.** Use of the word “death” or any terminal condition is avoided.

Elderly Hmong prefer to die at home in comfort and privacy and in the presence of the house spirits and family members. **Not to die at home is considered a curse.**

**Hmong expressions of grief include touching and caressing the deceased, wailing and weeping loudly.**

## CHALLENGES TO HEALTH CARE<sup>2</sup>

**Some Hmong, especially seniors and recent arrivals from Thai refugee camps, do not understand or speak English.**

Herbal remedies given by Hmong herbalists may contain pharmacologically active substances that adversely interact with prescription drugs. **Western providers may not have herbal healing traditions on the one hand and sufficient knowledge of traditional Hmong health practices on the other.**

**Hmong may lack knowledge about the US health care system and how it functions.** Due to their experience of state assistance in refugee camps in Thailand, they **may harbor stereotypes about the medical industry.** These may discourage them from obtaining care.

Hmong may understate problems and seldom express feelings. A response of “OK” or “yes” may actually mean “no.” **It is difficult to obtain information from Hmong about emotional problems, hardships and suffering, family conflicts, sex life, and sexual problems.** They are not accustomed to detailed history taking.

**Recent Hmong immigrants may be married culturally but not legally.** In such cases they may experience **problems with obtaining spousal or family health insurance coverage.** For example, if one of the parties has health insurance through their place of employment, it may cover the “legal” but not the “cultural” spouse.

<sup>2</sup>Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

## HMONG AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

**Families often appear to be over-involved and make decisions for the patient.** Patient illness is seen as a family, or even a clan, problem.

Many Hmong believe that

- **surgery may interfere with reincarnation** after they die.
- **surgery may make the body accessible to evil spirits.**
- blood maintains balance in the body and is a non-renewable vital energy, hence **they are reluctant to have blood drawn.**
- **cancer cannot be treated successfully and they fear rejection by the community for having the disease.** This may pose a barrier to any type of cancer screening.

**Autopsy is not allowed because, according to Hmong belief, it will interfere with reincarnation.**

An outcome of the traumatic circumstances in which Hmong had to leave their country as refugees is the **high prevalence in their community of psychiatric disorders**, including Post Traumatic Stress Disorder. **Stigma of mental illness may invoke shame and inadequacy.** Patients may lack awareness of the availability of effective mental health treatment.

Some lab tests are difficult to explain in Hmong.

## BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

**It is advisable to learn a few basic words and phrases in Hmong to greet a Hmong patient appropriately and put her or him at ease.**

For example:

In greeting a patient, one might say: Nyob Zoo. This is in Hmong Roman script. It is pronounced: Nah Zhong.

In parting from the patient, a caregiver could say: Sib Ntsib Dua. It means Goodbye. It is pronounced: She Gee Duo.

## HMONG AND HEALTH CARE

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

Pronunciation of words in Hmong isn't as easy as it appears. Spoken and written Hmong use eight tones and tonal markers respectively. Words may sound very similar to the ears of non-Hmong, but the meaning of a word changes depending on the tone. Since there is a yawning gap between the written Hmong alphabet and spoken Hmong, **it would help to break the ice for the provider to get the patient or family to help with proper pronunciation.**

**It pays to take the time to patiently establish a trusting relationship with one's Hmong patient.** That would be one way for the provider to respect the patient's wish to become more open at her or his own pace. **Employing a soft and gentle voice and honoring individual expressions of Hmong culture are also recommended.** **An indirect and positive approach is generally more successful with Hmong.**

**The provider should not talk directly about death.** Euphemisms for death widely employed are "time to say goodbye," "last breathing," or "living a 120-year life."

**Family involvement greatly enhances Hmong patient adherence to treatment. It is useful to include the Hmong family at every step of the therapeutic process.**

**It helps to connect the Hmong patient with Hmong community organizations.** One way to achieve this would be to involve a social worker to increase the patient's awareness of available social services.

As circumstances permit, **Hmong spiritual healing could be used to supplement biomedical practices for more successful Hmong patient outcomes.** In cities where Hmong dwell in significant numbers, health care facilities might do well to regularly consult a knowledgeable Hmong elder or shaman on a professional basis.



# Lao Buddhists

## AND HEALTH CARE

### WHO THEY ARE

Laos (pron. Laa-os) is a landlocked country surrounded by Myanmar (formerly Burma), Thailand, China, Vietnam, and Cambodia. **People whose origins are in Laos are called “Lao” or “Lao people.” Lao Buddhists form the dominant majority.** They arrived as refugees in the United States from Laos, starting in 1976 after the fall of the Rightist government. **After the Vietnam War (1963-75), the Pathet Lao (Communists) took over Laos and formed the Lao People’s Democratic Republic. The Pathet Lao persecuted Lao Buddhists who had supported the United States. Forced to flee from Laos to neighboring countries, such as Thailand, these Lao lived in refugee camps until they were brought here by the US government.**

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES<sup>1</sup>

The **Lao Buddhists** constitute half the population of Laos. They **speak the Lao language**, live in the lowlands, and are not to be confused with the Hmong ethnic group who used to inhabit the uplands of Laos until the fall of Saigon. Lao Buddhists’ cultivation and consumption of sticky rice, for example, marks their culture from other ethnic groups in Laos. They generally **practice Theravada Buddhism** which has played an important role in shaping Lao life for nearly 600 years.

The **Lao Buddhist temple or wat is the vital center of village life.** The village, for its part, has sustained monastic communities. In return, the monks of the *wat* provide social services. The *wat* is at the same time a community and recreation center, school, hospital, dispensary, and refuge for people with psychiatric disabilities and older people. It is also the location where religious ceremonies and major religious festivals occur many times a year. The core Buddhist belief of *anatman* (literally, no-soul) denies that any eternal, unchanging self exists. Despite the strong presence of Buddhism in Lao culture, animist beliefs

<sup>1</sup>Please see Introduction for a caveat against stereotyping members of any group at all.

## LAO BUDDHISTS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

(see below) are widespread among all segments of the population.

Theravada Buddhist society consists of monks and lay people. The lay people supply food and shelter to the monks who, in return, provide teaching and merit-making ceremonies, and act as moral role models for the community. Buddhism is believed to command celestial power to dispel evil spirits from human bodies, homes or lands. Some monks are respected in part for special abilities, which some of them possess, to exorcise evil spirits from a sick person or to keep them out of the patient's home.

**Lao Buddhist culture sees suffering (*dukkha*) as the ultimate truth about life.** All living creatures fall ill, grow old, lose or depart from loved ones, and eventually die. Buddhist philosophy has taught Lao people to live and accept suffering as the fundamental truth of life. Indeed, the Four Noble Truths taught by the Buddha are all about suffering, its arising, its cessation, and following the eightfold path to overcome suffering. Meditation is proposed by Lao Buddhist culture as the one way to deal effectively with suffering. Freedom from suffering comes through non-attachment or not clinging to anything.

**Lao Buddhists believe in reincarnation or transmigration (*samsara*).** *Nirvana* is the ultimate goal to which the Buddhist way of life aspires. It is the definitive ending of *dukkha* which plagues human existence. Lao Buddhists also believe in *karma* which is the sum total of all actions that an individual has done, is currently doing, and will do. According to this belief, one is responsible for one's own life, including joys and sorrows.

Study of the Pali language, in which all Theravada Buddhist texts are written, is a fundamental component of Lao Buddhist monastic training. The Buddha's original words are believed to carry spiritual power. One popular healing technique is that of monks' pouring water over a sufferer while chanting Pali incantations. Holy water is prepared and poured at a funeral or at the blessing of a new house. Holy water is also used to ward off epidemic and disease.

**Monks are consulted** to help interpret bad dreams, bad feelings, or strange behaviors. Some monks are involved in magical practices and astrology.

## LAO BUDDHISTS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

Most significant in the life of a Lao Buddhist is the naming ceremony which is celebrated shortly after birth in the household in the presence of relatives.

#### **Lao people greet one another by saying “Sabaidee.”**

They “nop” each other instead of shaking hands. Nopping means raising both hands gracefully, palm to palm, fingers together and close to the body, and bringing them to the head while bowing slightly. They are honored when westerners return the polite gesture. They address others by their first name.

**All Lao Buddhists respect their elders.** They use the term “Ai” for big brother or “Eeuw” for big sister in front of the name of an elder to show respect. A prime responsibility among Lao Buddhists is **to take care of parents in their old age. It is a prominent feature of the Lao concept of family.** There is no concept of placing parents in nursing homes. Similarly, there are no psychiatric clinics in Laos. People with psychiatric disabilities are cared for at home for life when there are no other options, such as institutionalizing those so disabled.

The father is the leader of the family, but the mother also plays a prominent role, particularly in family finances.

Living with their parents is culturally acceptable for unmarried Lao Buddhist children even if they are old enough to leave their home.

Lao society is highly hierarchical. Thus, belonging to a wealthy or professional family brings respect.

**Lao people are described as gentle, easy going, and cultivating harmony.** Compromise and tolerance are essential to Lao communal lifestyle. The Lao concept of “saving face” indicates their refined sense of public image. They go to great lengths not to embarrass themselves or others. The “Lao smile” serves to ease even adverse situations.

**The Lao language has been called the “true language of love,”** thus challenging a similar western claim made about French and Italian. Lao Buddhists claim that their language brings a feeling of warmth and connection in the respectful and loving way it is used to create good will. For example, even when addressing total strangers, they use kinship words such as “Ai” (older brother), “E’euw” (older

## LAO BUDDHISTS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

sister), “Mae’pa” (aunt), and “Pu’Ing” (uncle).

**On visiting a Lao family, one should remove footwear outside the house despite being told otherwise.** If an older person is sitting on the floor, it is impolite for a visitor to sit in a chair.

**The head is the highest part of the body, hence one should not touch another’s head.** Similarly, one should not pat another’s shoulder. It is also impolite to point one’s feet at another or sit with one leg crossed over the other so that the bottom of the foot or toe is pointed toward another. Objects are passed and received with the right hand only.

**Lao people do not look directly at the eyes.** They tend to keep more physical distance from each other than westerners do.

A widespread **Lao belief in *Phi* (spirits) is blended with Lao Buddhist beliefs** especially at the village level. Such belief colors the relationships of many Lao with nature and the community. For example, they believe they are protected by *Khuan* (thirty-two spirits). Illness occurs when one or more of these spirits leaves the body. This condition may be reversed by the *Baci* or *Soukhuan* (invitation of the soul). In this ritual, all spirits are called back to bestow health, prosperity, and well being on the afflicted participant(s).

In general, sick persons will turn first to the family and/or Lao Buddhist community for understanding of an ailment and its treatment. **Traditional treatments are very likely to be tried first.** If loss of spirit is thought to be the problem, a ceremony is performed by a community healer, or if possible, an *acharn* (teacher or monk). The last resort is to seek treatment at a clinic or hospital. **Traditional practices are usually continued while utilizing western medicine.**

**Lao people have great respect for their Buddha images.** They never touch, point their feet, or turn their back on the images. It is acceptable to wear shoes in the compound of a Buddhist temple, but not inside the chapel where the principal Buddhas are kept.

**Women should not touch a monk or a monk’s robe.** If a woman wishes to give something to a monk, she gives it to

## LAO BUDDHISTS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

a layman and he presents it to the monk by placing it on a table or on the ground in front of him.

Generally Lao Buddhists cremate their dead. They collect the bones and place them in a *stupa* (a Buddhist monument commemorating the Buddha's achievement of enlightenment).

## CHALLENGES TO HEALTH CARE<sup>2</sup>

**Most Lao Buddhist seniors are not English speaking.**

**Physical suffering, illness, and death are viewed by Lao Buddhists in light of the Buddha's fundamental teaching about suffering as unavoidable.** Following the route of meditation, they seek to free themselves from pain and suffering through non-attachment.

In keeping faithful to this tradition, Lao Buddhists' first response to pain or illness may be to not access western medicine at all. **They may not seek medical care quickly. Or they may view medical care as an inappropriate response to physical pain.** Western medicine deals with pain as a symptom which needs to be relieved. Health professionals may therefore tend to view Lao Buddhist attitudes to illness and death as "fatalistic." The approach of Lao Buddhists thus seems to be contradictory to the approach of western medicine. **Of those few traditional Lao Buddhists who do seek western medical care, the vast majority do not return for follow-up health care.**

**First generation Lao Buddhists, who came to the US from rural Laos, generally distrust western medicine.** Many seek western health care only after trying traditional techniques in vain. Delay in receiving care might mean that Lao Buddhist seniors approach western medicine too late.

## BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

Health care facilities do well to make provision for a Lao interpreter, especially when treating first generation Lao Buddhists. **It certainly helps when a health care professional learns a few basic words and phrases in the Lao language to greet and put patients at ease.**

<sup>2</sup>Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

## LAO BUDDHISTS AND HEALTH CARE

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

Some common words and phrases follow:

<b>Hello</b>	= <i>sabaidee</i> . Pronounced: sir-bye-dee (lit. Do well/good/easy). Used to greet all persons at all times.
<b>Bye</b>	= <i>saukdee</i> (lit. good luck/karma).
<b>Thank you</b>	= <i>kop'chai</i>

If a Lao person says “Yes,” it doesn’t necessarily mean that they understand what is being said. **It is important to check with them what they have really understood.**

Lao Buddhists appreciate it when those who serve them are **respectful toward their beliefs, symbols, and practices, especially toward the Buddha and the monks.**

Importantly, health care professionals must **avoid touching or patting a Lao Buddhist patient on the head or shoulders.** During physical exam, if one has to touch those parts of the body, one does well to request the patient’s permission.

**Respect for their culture** includes allowing Lao Buddhist patients to wear amulets or wrist strings (called *katha* or *katout*). Some of these cotton strings have been tied around the wrists of patients to keep the thirty-two spirits in place.

In light of Lao Buddhist cultural practices, respectful medical professionals do not point their feet at anyone or anything. **Such professionals are also careful to avoid stepping over anyone. Instead, they walk around them.**

For successful outcomes with Lao Buddhists, **it is essential to be a “patient listener.”** Modesty is an important cultural value for Lao Buddhists.

**Raising one’s voice or losing one’s temper is not acceptable to Lao people.** It occasions embarrassment as it goes against the vital Lao concept of “saving face.”

It is advisable that Lao Buddhists’ **preference for same-gender physicians** be respected.

It is important to **explain procedures and medicines carefully to Lao Buddhist patients.**

For successful patient outcomes, it greatly helps to **provide educational materials preferably in the Lao language.**

# Latina/o Christians

(WITH A FOCUS ON MEXICANS)

## AND HEALTH CARE

### WHO THEY ARE

Latinas (masculine, Latinos) are an ethnic minority group in the United States who come from Mexico, Cuba, Puerto Rico, and diverse Central and Latin American countries. Other names used for Latinas/os are “Hispanics,” and “Latin Americans.” **The vast majority of Latinas/os are Christian, especially Catholic. Given the great predominance of Mexicans in the United States, following facts and guidelines focus on this majority group among Latina/o Christians.**

Mexicans (or Mexican Americans) hail from Mexico which is located between the United States and Central America. Similar to many other people in Latin America, Mexicans consist of many racial groups: Mestizo (Spanish and Native Mexican), Native Mexican (also known as Indian), White (Anglo) and Black. They are of Spanish ethnicity, with seventy-five percent speaking only Spanish at home.

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES<sup>1</sup>

**Religion plays an important role in most Mexicans’ lives.** Culturally they focus more on spiritual rather than material aspects of life. “La Virgen” of Guadalupe, the dark-skinned Virgin Mother of Christ, is a powerful symbol and model for Mexicans. They combine religious beliefs with social traditions. For example, Catholics celebrate their daughter’s fifteenth birthday (*quinceañera*), her coming of age, with Mass and a family party. This celebration is considered on a par with traditional wedding celebrations in the USA.

The following facts may apply to Mexicans depending on factors such as level of education, socio-economic status, extent of modernization, how traditionally they were raised, and whether they have a rural or urban life experience.

**Mexicans’ attitudes toward health and disease are closely linked to their perception of religion.**

<sup>1</sup>Please see Introduction for a caveat against stereotyping members of any group at all.

## LATINA/O CHRISTIANS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

They consider God as the giver of all, including health. Therefore, health is a consequence of being good, whereas disease represents punishment for evil deeds. One positive Mexican attitude toward health is *personalismo* (or self-worth) which indicates a patient expressing interest in overcoming a health problem against all odds.

**Personal devotion to the church** is important for Mexicans who maintain strong beliefs. General education includes formal education in schools, on one hand, and, on the other hand, learning proper manners, behavior, and religious beliefs from their extended family. Persons with higher degrees are respected for their knowledge.

**The family unit is traditionally important.** Family is not limited to one's nuclear family. It includes brothers, sisters, grandparents, uncles, aunts, nieces, nephews, and so on. **Respect (*respeto*) for parents and the rest of the family is required and expected.** Respect, especially of seniors, is highly valued. The mother of the family is especially cherished.

The extended Mexican family offers financial and emotional support and protection to one another, especially to children and seniors. This is seen in the premium which is placed by Mexicans on ***marianismo* which means taking responsibility for the health of all family members.** **Domestic violence is not necessarily seen as a serious issue** in some Mexican families due to the concept of *machismo* (male dominance). The woman may be conditioned to believe that she is subject to her husband, and the male to believe that he is head of the household.

**Mexicans tend to bring friends and/or relatives to the provider's office.** Within family culture it is assumed that family secrets will be kept confidential. **Punctuality is not a high priority for Mexicans,** so lateness for appointments is common. This is not because of rudeness but because Mexicans are culturally on a different time paradigm.

"Power distance" means the patient's acceptance of a knowledgeable clinician's recommendations. This applies to Mexicans, for they hold health care professionals in high regard. They are **accustomed to dealing with authoritarian health care providers who communicate directly.** When a provider is female, Mexicans stand up

## LATINA/O CHRISTIANS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

until asked to be seated. They appreciate their provider's eye contact during a visit and a handshake or pat on the arm when the patient is leaving the office.

**Communications, both verbal and non-verbal, are characterized by respect.** Older Mexicans seem to prefer formality in interactions. Over-familiarity is not appreciated early in relationships. When a patient or family disagrees with a decision, the usual response is silence and non-compliance.

**Mexicans prefer face-to-face human interaction.** To ignore somebody is rude. To respect another means to listen when she or he speaks and to follow her or his advice.

Mexicans generally have a sharp sense of justice. They tend not to complain. **They often perceive failure in communication to be due to prejudice.**

Mexicans give importance to relationships of trust and interpersonal comfort with their health care providers. To a large extent, **what encourages Mexicans to have recourse to folk healers is the relational aspect of care given by them.**

Back in Mexico, Mexicans have recourse to traditional health practitioners or folk healers. **Traditional health practices** are seen as both culturally compatible and financially more accessible than western medicine. Among such practices are herbal remedies such as teas, aroma therapy, and egg rub. These practices **continue among Mexican immigrants as a first response to illness.**

### CHALLENGES TO HEALTH CARE<sup>2</sup>

**Many Mexicans do not speak or understand English. Ideally the interpreter should be of the same gender as the patient.** Not all Spanish language interpreters are Mexican. The interpreter may not understand some Mexican expressions because Spanish language, with its dialects, idioms, and slang may be very different from one Latin American country to another. Often enough, apart from mere translation, the interpreter may need to amplify and paraphrase for the patient what the provider is trying

<sup>2</sup>Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

## LATINA/O CHRISTIANS AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

to say because of significant linguistic variation from one Latino/a group to another.

**Fatalistic attitude toward disease** may also prove a challenge to providers in treating Mexican patients who believe that they deserve their illness as a punishment for wrongdoing.

Many Mexicans live in poverty, experience lack of opportunity, low life expectancy, and poor nutrition. Their low income makes access to preventive health care, especially dental care of children, difficult. **Legal status may be a deterrent for some Mexicans to seek any medical attention at all.**

**Use of alcohol is culturally sanctioned among Mexicans.** Smoking is known to be a health hazard, but people tend not to listen to advice from their health care providers regarding this.

In Mexican culture, one does not tell a man what to do. Because of the cultural emphasis on the male's strength and position, some Mexican males refuse digital rectal examination.

Physical exercise, especially by women, is not emphasized. Meals tend to be large and high in fats and carbohydrates. **Obesity and diabetes pose significant problems.**

**Sometimes self-medicating behavior in Mexicans may mask symptoms so that they delay approaching a health care provider until the ailment reaches a critical point.** Among the uneducated and the poor, there is no concept of chronic disease.

**A Mexican patient may be simultaneously using medications prescribed by a health care provider along with folk and/or herbal medicine.**

As traditional Catholics, Mexicans may experience difficulty using birth control methods. In addition, sex before or outside marriage is culturally unacceptable. Mexicans generally hesitate to talk about sexual matters, even with their health care providers. Consequently some sexual problems, including **sexually transmitted diseases, are often hidden and go untreated.**

## LATINA/O CHRISTIANS AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

Since people suffering from psychiatric problems are viewed as being insane, **Mexicans are reluctant to seek psychiatric help or counseling due to fear of how family or neighbors will react.**

Mexicans tend not to reveal dysfunctional relations among family members out of a sense of family loyalty. **They prefer to be discreet about their own and their family's health history.**

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

**It is recommended that hospitals and clinics hire some Spanish speaking staff.** When a non-Spanish speaking provider attempts to speak a few catch phrases in Spanish, it goes a long way to put Mexican patients at ease. Some common phrases follow.

**Hi, how are you?** (when greeting an unfamiliar patient) = *Hola, como esta?*

Pron. Ola, ko-mo esta?

**Fine thanks, and you?** = *Muy bien gracias. Y usted?*

Pron. Moo-ee bee-en gra-see-aas. Ee us-ted?

**Good morning.** = *Buenos dias.* Pron. Boo-en-os dee-aas

**See you soon.** = *Hasta luego.* Pron. Aas-taa loo-ay-go

**What's going on?** = *Que pasa?* Pron. Kay paa-sa?

**It's not serious.** = *No es nada grave.* Pron. No es naa-daa graa-vay

One must be prepared to receive not only the Mexican patient but also the family for a visit to the doctor. It pays for the provider to **take some time to build a relationship with the patient** before getting down to examination, diagnosis, or treatment. One would do well to **shake hands with everyone, beginning with the oldest member of the family.** Mexican patients appreciate being touched. Standing close to the patient, and brief, non-intimate touch create a personal relationship and make adherence to treatment more likely.

Artificial birth control methods are forbidden by the Catholic Church. Yet, they are widely used by younger Mexican couples and among modern Mexican families. Nevertheless, **some sensitivity is called for in discussing family planning issues via interpreters** in the presence of extended family, some of whom may be traditional.

## LATINA/O CHRISTIANS AND HEALTH CARE

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

**Mexicans expect the provider to explain their diagnosis in layperson's terms and to come across as the expert.** Attempting to involve the patient in their treatment by asking her or him "What do you think?" generally translates in Mexican terms to mean "provider's incompetence." On the other hand, since endorsement of prescribed medical treatment by an authority figure in the family helps, it is advisable to **ask an elder, who is present, what he or she thinks of the treatment plan.**

For some Mexican patients, **an effective provider creates a compelling aura of "magic" when prescribing or giving advice about treatments.** Such an atmosphere is created by Mexican healers back in Mexico when they wave a branch over their patient or rub an egg on the patient's body to draw out the "susto" (fright sickness) caused by trauma or illness.

**If a patient brings food to show her or his appreciation, one does well to accept it graciously.**

Given the difficult financial situation in which many Mexican patients find themselves, it is wise to **prescribe inexpensive medications where possible.**

**Before the patient leaves the office, one does well to ask how he or she is going to implement the therapy.**

Education needs to be a top priority with chronically ill patients. Ideally the provider should **make culturally appropriate educational materials available** to patients in Spanish. But one may not rely on brochures being read, even if the patient is literate. While written instructions on medications and treatments are important, **personal instruction is more effective especially when direct, active, and visual.** One must remember to ask the patient if she or he has understood the treatment plan and the medicines which have been prescribed.

**By way of follow up, the provider should verify completion of treatment of acute illnesses** because when Mexican patients feel better they may discontinue the treatment.



# Somali Muslims AND HEALTH CARE

## WHO THEY ARE

Somalis are a group of new immigrants to the United States primarily from Somalia, which is in the northeastern corner of Africa. Somalia's neighbors are Djibouti, Ethiopia, and Kenya and its long coastline is on the Red Sea and the Indian Ocean. As a result of civil war which preceded the ousting of the Somali government in 1991, **Somali citizens fled to neighboring countries and to other parts of the world to escape the widespread consequences of the war, namely, hunger, rape, and death. Most Somali refugees have lived in camps in northern Kenya. Minneapolis/St. Paul is the "Somali capital" of the United States.**

## CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES<sup>1</sup>

**Almost all Somalis speak the same Somali language and share the same culture and Sunni Islamic religious tradition. Saudi Arabia, the heartland of Islam, being situated rather close to Somalia's northern border, Somali culture and the Islamic faith have blended together for the past fourteen hundred years.** Somalis were colonized by the Italians and the British and attained independence in 1960. Despite this fact, they generally have limited experience with multi-cultural and multi-ethnic situations.

The majority of Somali refugees come from rural Somalia and may not possess urban work experience. They have less formal education and literacy, hence less knowledge of English. Nonetheless, **many Somalis are multi-lingual given their historic links with neighboring and foreign countries.** Along with loss of extended family and community, they suffered from exposure to physical and emotional trauma having lived many years in refugee camps. **Many of these experiences are risk factors for poverty and illness.**

<sup>1</sup>Please see Introduction for a caveat against stereotyping members of any group at all.

## SOMALI MUSLIMS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

**Somali Muslim identity prescribes certain practices.** For example, Somalis **pray** five times a day after ritually washing and cleansing themselves. They fast during the sacred month of Ramadan from sunrise to sunset. **They are forbidden to eat pork and drink alcohol. Pre-marital sex is not acceptable.** Casual physical contact, such as touch, is forbidden between Somali men and women who are not family. Men shake hands with men only and women shake hands only with women. **Separation of genders is noticeable especially during prayers in a mosque. Since the last three generations or so in Somalia, women have generally been wearing *hijab* (headcover).**

Similar to Muslims worldwide, Somalis greet each other with “Salaamu alaykum” (pronounced “Sir-laa-moo aa-lie-koom”) which is Arabic for “Peace be with you” or “God bless you.”

**Somalis bury their dead the same day or within twenty-four hours. Autopsy is not acceptable,** except for criminal investigation. **Post-mortem organ donation is not generally known to the Somali community and hence not encouraged, but blood transfusion is not taboo in Somali culture.**

**Males are circumcised. Practices such as clitorodectomy, cutting, and infibulation are non-Islamic but common to most religions and cultures in northeastern Africa, especially Somalia.**

**Somalis tend to accept illness and death as coming from God.** Their attitude is “For every disease sent by Allah (Arabic for “God”), he also sends a cure, except the one that kills you.” **They vigorously try to find a cure for any illness that afflicts them.** They will seek out a cure sent by Allah. They routinely try to find a second opinion and sometimes resort to alternative healers. If they are cured, they take it as God’s will. If not, that is also seen as part of God’s plan. **Somalis are more accepting of death once it occurs.** This may be interpreted as fatalism.

**Somalis have strong family ties. Children are considered a gift from Allah.** Senior members stay with the family until death, usually with their daughters. **Elders remain active members of the family as long as**

## SOMALI MUSLIMS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

**they can and are treated with great respect.** They are addressed as “Aunt” or “Uncle” even if they are strangers.

**Somali society has a clan and family structure. The clan, with its multiple subdivisions, is an important traditional social unit in Somalia.** It is patrilineal and, until recently, mostly exogamous (marriage only outside one’s clan). **Clans continue to play a vital role in Somali culture and politics.** Clan conflict fragmented Somali society starting in the 20th century. This fragmentation may be continuing in some way among Somali Americans.

**Somalis are usually accompanied by many family members when they go to a health care facility.**

**Somalis have recourse to traditional healers** who may be using rituals, herbs, cauterization, and practicing medical procedures, including surgery and bone-setting. **A “Sheikh” or “Imam” (religious leader) reciting the Qur’an over a patient is generally believed to be far more effective than any herbal or medical procedures.**

**Somalis have an implicit belief in the healing power of Black Seed** which is called in Somali “Habad Sowda” or “Habad al-barakah.” This herbal remedy has been used for millennia to treat a variety of conditions related to respiratory health, including the common cold; skin, stomach, and intestinal disorders; kidney and liver dysfunction; circulatory and immune system support; and to maintain and improve overall health and a sense of well-being. Black Seed is said to be a remedy recommended by the Prophet Muhammad himself. **It is believed to heal every ailment but death.**

## CHALLENGES TO HEALTH CARE<sup>2</sup>

**Many Somalis do not speak English, so they need interpreter services. Gestures and body language of non-Somalis can at times be misinterpreted.** For example, when somebody uses the index finger to beckon a Somali to come nearer, he or she may feel put down. In Somali culture, such a gesture is never made to another human being, and certainly not to one’s social equal.

<sup>2</sup>Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

## SOMALI MUSLIMS AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

**Somalis may be embarrassed when sensitive or potentially offensive questions are asked during assessment.** Somali interpreters may not even translate such questions. **Concerns about confidentiality may often lead Somali patients to withhold information.**

**Somalis often lack basic literacy, health education, and prior experience with western medicine.** They experience difficulties with the following:

- routine procedures in clinics and hospitals, such as comprehensive and time-consuming admission procedures and paperwork,
- long waiting room times,
- staggered appointments,
- excessive, comprehensive, and invasive tests which are seemingly unrelated to patient symptoms, and
- the health insurance system, including confusing rules and restrictions.

**Punctuality is not a high priority for Somalis.**

**Somalis prefer same-gender health care providers.**

**Given the remarkably high percentage of women who have undergone clitorodectomy, cutting, and infibulation, pelvic exam and labor can pose challenges to health care providers.**

Based on their experience of health care in Somalia, Somalis are accustomed to seek medical help only when there are symptoms. **They are not accustomed to preventive care. Historically their health care priorities have been primarily related to survival.**

Somalis prefer short term treatments, maximum comfort (pain relief), and full discussion of risks and benefits of procedures with sufficient time to consult with influential family members.

**Trauma experienced by Somalis during the civil war and refugee camp periods may pose obstacles for**

## SOMALI MUSLIMS AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

them to reveal aspects of their medical history.

**Chronic pain and Post Traumatic Stress Disorder are common in the Somali population.** In most cases treatments are unsuccessful due in part to inaccuracy in diagnosis and interpretation of their symptoms by health care professionals. Anxiety lowers their threshold of pain endurance. **Somatization Disorder is common among Somali refugees.** It may be masked by poor communication and cultural barriers.

**For Somalis, health care is holistic. Mind, body, and spirituality are all interlinked.** Contrary to the western biomedical model of health, a holistic approach towards health care gives due consideration to economic, social, environmental, religious, and cultural factors impacting patients' lives.

**Lack of adherence to treatment is common among Somalis** and can pose a challenge when treating chronic conditions.

## BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

For effective delivery of health care with first generation Somalis, **face-to-face interpreter services are a must.** Many Somalis, particularly seniors, are unable to effectively use phone interpreter services.

In order to establish rapport, trust, and confidence, **it is desirable that providers equip themselves with some basic knowledge of phrases and words in Somali.** Using these can break the ice.

Hello.	= <i>Ma nabad baa?</i> (lit. Is it peace?)
Hello. (response)	= <i>Wa nabad.</i> (It is peace.)
How are you?	= <i>Iska waran?</i> Pronounced: Iska warran?
Good morning.	= <i>Subax wanaagsan.</i> Pronounced: Subah wanaksin.
Good afternoon.	= <i>Galab wanaagsan.</i>
Good evening.	= <i>Habeen wanaagsan.</i> Pronounced: Habayn wanaksin.
Goodbye.	= <i>Jaaw.</i> Pronounced: Chow.
What's your name?	= <i>Magacaa?</i> Pronounced: Maga-a?
Thank you.	= <i>Mahadsanid.</i> Pronounced: Mahatsenit.
Don't be afraid.	= <i>Ha cabsan.</i> Pronounced: Ha absan.

## SOMALI MUSLIMS AND HEALTH CARE

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

Health care providers need to **show respect and acceptance of differences** in Somali food habits and restrictions, dress codes, involvement of family members in patient care, and religious practices, such as prayer and fasting. **Health facilities would do well to include a prayer room which is culturally appropriate.** For example, a room for ritual washing of face, hands, and feet prior to prayer, copies of the Qur'an, and prayer rugs need to be available. In facilities where such provision is not made, Somalis try to make do with wash basins and the absence of a quiet place for daily prayer. This could lead to awkward situations such as water splashed around a wash basin in a public restroom.

Especially in communities where the Somali population is significantly large, a health care facility which makes such provision is showing hospitality to this immigrant group.

Since religious belief is central to Somali culture, it seems especially important to provide culturally and religiously appropriate spiritual care. **For example, a copy of the Qur'an** in Arabic should be made available when a Somali patient is terminal. A Muslim person reading the "Yassin," namely, Qur'anic verses which are especially comforting to the family, is believed to facilitate a peaceful death.

Time taken to **discuss diagnosis and treatment plans with the Somali patient** is time well spent. The same goes for efforts made to **involve family members in health care decisions** by asking the family, for example, about their preferences regarding end-of-life needs. Somalis can arrive at decisions more easily when offered convincing arguments based on sound evidence. One might ask the patient, "Are there any doctors in your family? Would you like me to talk with them?" There may well be physicians in the family who could help clarify situations for decision making. **The oldest blood relative, namely, father, brother, or son, may be the ultimate decision maker. Older Somali females also enjoy decision making status.**

When a Somali patient is terminally ill, it is appropriate to say, "There is nothing more that we can do for you. You are in the hands of Allah," rather than "You are going to die." It is similarly **preferable to employ the phrase "return to God" instead of "death."**

# South Asian Hindus

## AND HEALTH CARE

### WHO THEY ARE

South Asian Hindus are a group of new immigrants from South Asian countries, especially India, Nepal, and Sri Lanka, beginning in 1965. They subscribe to Hindu beliefs and practices. **Hindus worship one Supreme Reality.** They believe that everybody ultimately realizes Truth which may be approached under various names and forms. **Because of the numberless deities, male and female, human and non-human worshipped by Hindus, others mistakenly call them polytheists.** Given the great diversity of Indian languages and dialects, most South Asian Hindus are multi-lingual.

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES<sup>1</sup>

South Asian Hindu life is **strongly influenced by belief in astrology.** Noting the exact time of birth is important for a child's horoscope.

Usually the father is not present in the delivery room, but in the US the father may choose to be present. Hindu babies are breast fed. Boys are not circumcised.

**Birth control is widely practiced. Abortion is not approved.**

According to traditional Hindu medicine, there are three body humors—wind (*vata*), bile (*pitta*), and phlegm (*kapha*). Hot and cold theory applies to foods and equilibrium within the body. Illness is believed to be caused by imbalances.

**Hindus are often vegetarians.** They view this choice of diet as connected to spirituality. Many second generation South Asian Hindus may eat chicken and fish. Beef is prohibited because cows are considered sacred.

<sup>1</sup>Please see Introduction for a caveat against stereotyping members of any group at all.

## SOUTH ASIAN HINDUS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

**Personal food hygiene is important.** Food should not be touched by others. Hindus usually eat with their fingers, hence wash hands before eating. They prefer not to drink from the same cup.

A belief in the “**law of cause and effect**” (*karma*) is central to Hindu thought. Each individual creates his or her own destiny by thoughts, words, or actions. Illnesses, accidents, or injuries may be considered secondary to past actions and viewed as means of purification. Illness may thus be attributed to supernatural causes. *Karma* is believed to accrue over many lifetimes.

**Hindus believe in reincarnation.** The body is usually cremated within twenty-four hours following death. Death is considered the starting point for rebirth.

Making a living will or advanced directives is up to the individual. **Organ donation is acceptable.**

Prolonging life artificially is up to the individual. Letting nature take its course is a common Hindu tradition.

**Suicide and euthanasia are not acceptable. Autopsies are acceptable** only if legally necessary.

Physicians are treated with reverence. Their behavior or treatment is never openly questioned.

**Modesty is highly valued by Hindus. They generally feel more comfortable with same-sex health care providers.**

**Married Hindu women wear a sacred necklace (*mangalsutra*) which should not be removed during examination unless absolutely necessary.** The patient may be wearing protective jewelry or sacred strings. If it is necessary to remove these objects, one would do well to give reasons for doing so and hand over the objects to family for safekeeping.

## SOUTH ASIAN HINDUS AND HEALTH CARE

### CULTURAL AND RELIGIOUS BELIEFS AND PRACTICES (CONTINUED)

South Asian Hindus are a community and an extended family to one another. When one is admitted to a health care facility, **family and friends tend to visit in large numbers**. Non-acceptance by staff of such a show of support is resented.

**Hindus have close-knit family ties and respect seniors.**

Direct eye-contact between men and women is avoided and, with authority figures, may be considered a sign of disrespect.

Immediate family members help in making medical decisions, such as whether to operate. **Silence could indicate either acceptance or refusal**. It is all right to ask the patient or family to verbalize. The father or the oldest son are the decision-makers. At times the husband may tend to respond to questions addressed to the wife.

**It is common to remove footwear as one enters a house**, hence visitors may remove shoes at the door.

**Purity is a concept of central importance to the lives of South Asian Hindus** who tend to be meticulous about personal cleanliness. They prefer showers to baths. Bodily discharges are considered impure. Women are considered ritually impure when menstruating and temporarily following childbirth.

A Hindu patient may request a Hindu priest or guru to visit the hospital.

**Prayer, meditation, and scripture reading/chanting are common in a hospital setting.**

**Fasting is highly valued by South Asian Hindus.** The dying patient may choose to fast so that the body may be pure at the time of death.

A picture or statue of a deity may be used in prayer in the hospital room. Facing east or north is preferred. Feet facing south is forbidden.

### CHALLENGES TO HEALTH CARE<sup>2</sup>

**Self-medicating** behavior may mask symptoms until the ailment reaches an advanced stage.

**Hindus tend to be stoic and consider illness a result of their past *karma*.** They tend to have a fatalistic attitude about illness causation.

Hindu beliefs about pain and suffering may impact what the patient reports about pain levels. He or she may use meditation as an intervention to manage pain instead of pain medication.

**The patient may be fasting.** The health care provider may need to adjust administering insulin and other medications accordingly. Food intake on days of fast may vary from complete abstinence to one meal per day. Education about disease processes, such as diabetes, that may be affected by fasting, will need to address the impact of fasting on disease management.

**Adults frequently avoid regular checkups.**

**There is social stigma attached to seeking psychiatric help,** hence the tendency among Hindus to turn to friends and family rather than access the health care system.

**Potential conflict between medical ethics and a Hindu patient's values** may pose a challenge. From a Hindu end-of-life perspective, given beliefs about karma and rebirth, quality of life and natural timing of death are of great value. These are likely to conflict with law in many parts of the United States concerning the terminally ill patient who may not have a living will, is incapable of taking end-of-life decisions, and has no immediate family to do on her or his behalf. A hospital usually does all it can to keep such a patient alive as long as possible, no matter what her or his state of consciousness or quality of life. For Hindus, the natural timing of death is to be respected by neither hastening nor delaying it unduly. Quality of life,

<sup>2</sup>Please see Introduction for elements which are of common concern to all five new immigrant groups of the HCWR series.

## SOUTH ASIAN HINDUS AND HEALTH CARE

### CHALLENGES TO HEALTH CARE (CONTINUED)

too, is important because it is conducive to one's ongoing spiritual progress from one lifetime to the next. When one's soul moves on to assume a new body in the next birth, it matters greatly to die in the right frame of mind and in the right state of consciousness, namely, contentment, harmony, and peace.

**South Asian Hindus may not accept food prepared in a medical facility because it may have come in contact with a prohibited food.** Since cows and pigs are sources for manufacturing some capsules, patients may refuse medication by capsule.

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS

Some South Asian Hindus may not understand English. Ideally, the health care professional will speak the patient's language. If not, interpreters should be linguistically competent in the patient's language or one of the very many South Asian languages, such as Hindi or Tamil.

**Instead of shaking hands, it is preferable to greet by saying "Namaste." The same word is used in parting.** The word is pronounced num-us-tay, and works for all times, seasons, and people of Indian origin.

Other words and phrases in Hindi:

**How are you?** = *Aap kaise hain?*

Pronounced: Aap kay-say hai?

**We'll meet again** = *Phir milenge*

Pronounced: Phir mil-ayn-gay

**Please be seated** = *Baithiye*

Pronounced: Bye-thee-ay

**Female doctors and nurses are preferred by Hindu female patients.** They may prefer a family member or friend present during professional examination.

## SOUTH ASIAN HINDUS AND HEALTH CARE

### BEST PRACTICES FOR HEALTH CARE PROFESSIONALS (CONTINUED)

Given South Asian Hindu cultural understandings about discreet exposure of the body, health care professionals demonstrate cultural sensitivity when they **dress the patient modestly in a hospital gown.**

While planning patient care for South Asian Hindus, **flexibility is advised to accommodate for prayer and meditation** which are generally done after bathing in the early morning and early evening.

Given South Asian Hindu patriarchal traditions, it would seem wise to **consult the husband and obtain his advice on medical decisions concerning the wife.**

**Provide factual information about disease or illness, preferably in writing,** and in the patient's own language, if possible.

Dieticians need to **find out from accompanying family members what is "vegetarian food" for a given South Asian Hindu patient.** In the case of strict vegetarians, for example, egg-related food and items such as Jell-O, which are made from animal products, should never be served.

**South Asian Hindus may insist on having family members bring food cooked at home.** Hospital administrators and physicians would do well to show flexibility and sensitivity to patient food habits as well as cultural and religious customs as far as possible.

Given Hindu taboos concerning death, it is wise to **consult the family of the deceased regarding non-family members touching the body.**

# Health Care & World Religions

## A HANDBOOK FOR HEALTH CARE PROFESSIONALS

(Insights on attaining Cultural Competence with respect to Hmong, Lao Buddhists, Latina/o Christians, Somali Muslims, and South Asian Hindus)

*Credentialing and contact hours:* Vickie Ruegemer of SCH and Kathy Twohy of CSBSJU for Phases A and C respectively

*Evaluation matters:* Mary Kruger; Vickie Ruegemer of SCH; Elizabeth Badillo-Moorman of Touchstone

*Photography:* Cristina Seaborn of UNIITE; *Videography:* Tom Allen of SCH. DVDs of Phase A sessions and copies of handouts are available for check out at SCH Library.

*Among countless other supporters:* Jocelyn Ancheta, Program Officer, Blue Cross MN Foundation; CiteScape; Dr. David Zander of the Council on Asian-Pacific Minnesotans; Bret Reuter, Vickie Ruegemer, Tom Allen, and David Waage of SCH; Paul Knutson of Mid-Minnesota Family Medicine Center; Sally Griffin; Shivanthi Sathanandan; Dr. Sandra Robin of the Department of Social Work, SCSU; Jean Gunderson of Primary Care, Mayo Clinic; Dr. Cathleen Urbain of Pediatric Home Service; Sister Adela Gross of the Office of Multicultural Ministry, St. Cloud Diocese; Sister Carol Virnig of Centro Hispano; Administration at Abbott Northwestern's Sartell Outpatient Center; Dr. Kathy Twohy and Dr. Lu Ann Reif of the Nursing Department, CSBSJU; Peggy LaDue of Central Minnesota Sexual Assault Center; Sanh Chareunrath; Willa Pearls (aka Helen Gaebe); MaoHeu Thao of St. Paul-Ramsey County Public Health; Dr. Bounlieng Phommasouvanh of Minnesota Department of Education; Dr. Mark Pfeiffer of Hmong Cultural Center; Staff of Lao Assistance Center of Minnesota; Mohamoud Mohamed of St. Cloud Area Somali Salvation Organization; Christ Church Newman Center team; Diane Tuff of Upfront Consulting; Dr. Saeed Fahia of Confederation of Somali Community in Minnesota; Dr. Don Ottenhoff of Collegeville Ecumenical Institute; Hedy Tripp of Create CommUNITY; Dr. Ana Maria Studer; Dr. Joan Wilcox of the Department of Nursing, SCSU; Nepalese Student Association, SCSU; Raj Chaudhary of SEWA-AIWF; Rupesh Modi, international student at SCSU; and Michelle Bergh of Infinite Light

*Advisors on content of booklet:* Mariani Nazareth R.N.; Mary Kruger, former Community Mentor of UNIITE; Julie Collins of Lutheran Social Services; Fartun Hussein, a Community Health Worker at Create CommUNITY; Marlyss Keller R.N.; Dr. Yang Lo of St. Cloud Medical Group; Dr. Giovanni Antunez of the Department of Health, Physical Education, Recreation, and Sport Science, and Dr. Linda Gensheimer of the Department of Social Work, SCSU; Dr. Laila Gulzar; Dr. Cathleen Urbain; Dr. Bounlieng Phommasouvanh; Carolyn and Dr. Jesus H. Lopez Moreno of Bridge World Languages Services; Dr. Mohamed Hassan of the University of Minnesota Medical Center, Fairview

*Final proof reader:* Willa Pearls, author, artist, community educator

*Logistics:* Cheryl Schaefer

*Among*  
**Lao Buddhists**  
*Latina/o Christians*  
**Somali Muslims**  
*South Asian Hindus*



Understanding the Need for Interfaith/  
Intercultural Togetherness & Education

[www.uniite.org](http://www.uniite.org)

Sponsored by:



Blue Cross and Blue Shield of Minnesota

Foundation

