



THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health



Arizona State Office of Rural Health Webinar Series



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AZ State Office of Rural Health Monthly Webinar Series

Focused on providing technical assistance to rural stakeholders to disseminate research findings, policy updates, best-practices and other rural health issues to statewide rural partners and stakeholders throughout the state.



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PROGRAM



THE UNIVERSITY OF ARIZONA
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Center for Rural Health



**Az CRH Navigator
Consortium**

Connecting Arizonans with Affordable Health Insurance Coverage

Today's presenters



Hong Chartrand, MPA

Program Manager for the Arizona Health Disparities Center, Arizona Department of Health Services



Emily Oake, MHSM

Special Populations Coordinator for the Arizona Alliance for Community Health Centers

Stella Kiarie, MPH

State Refugee Health Coordinator for the Arizona Department of Health Services



RJ Shannon

Program Manager for Native Health's Integrated HIV Care Program



Health Disparities and Cultural Competence: A Local Approach



THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH

Center for Rural Health



Health Disparities and Cultural Competence: A Local Response

Emily Oake, RJ Shannon
Stella Kiarie, Hong Chartrand

Objectives

- * To learn about the Arizona Health Alliance for Language Access Rights (AHALAR)
- * To provide an overview of the CLAS Standards
- * To share resources and materials available that can assist with improving cultural and linguistic services within organizations
- * To seek participants input on community profiles

AHALAR

- * Long-term goal: Create and sustain a welcoming environment that embraces Language Access Services (LAS) in Arizona
- * Three goals
 - Improve cultural and linguistic competency and diversity of the community health center workforce
 - Enhance consumers' health service experience through awareness and availability of LAS.
 - Enhance public and private entities' capacity to effectively address LAS needs.

AHALAR (cont.)

* Partners

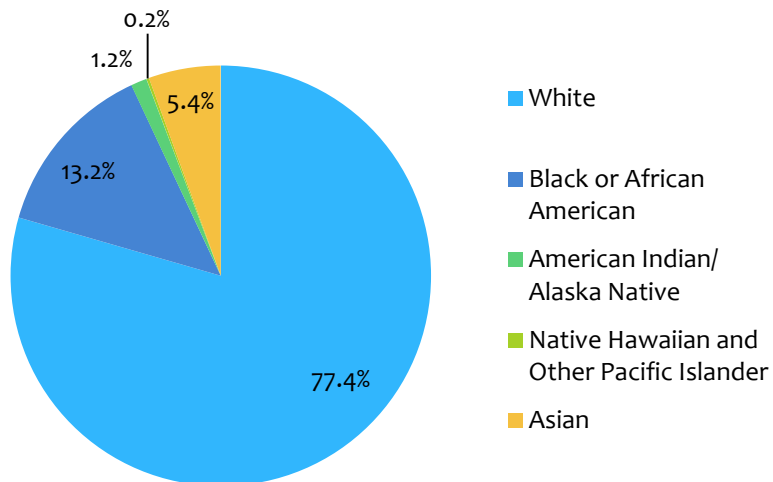
Area Agency on Aging
Arizona Alliance for Community Health Centers
Arizona Department of Economic Security
ADHS Refugee Health Program
ADHS Bureau of Nutrition and Physical Activity
ADHS Bureau of Women's and Children's Health
ADHS Division of Behavioral Health Services
Asian Pacific Community in Action
Cancer Treatment Centers of America
Gateway Community College
Hamro America
International Rescue Committee
Maricopa Integrated Health System
Mayo Clinic
Mountain Park Health Center
NATIVE HEALTH
Phoenix Children's Hospital
Tucson Medical Center
University of Arizona

Health Disparities

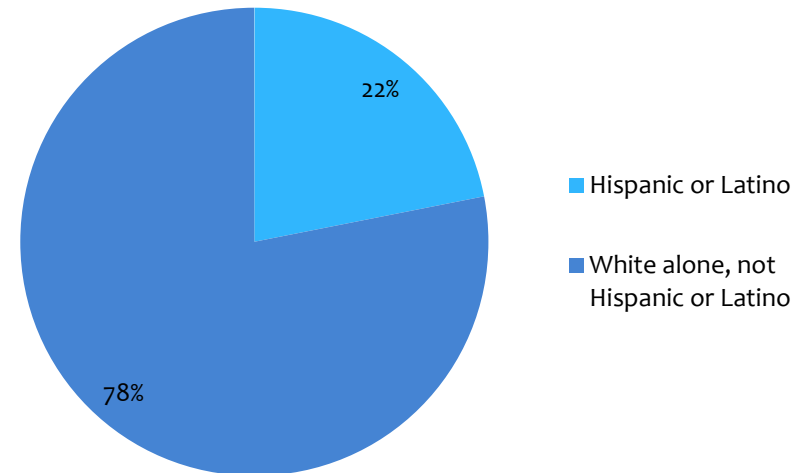
- * Health disparities: differences in the incidence, prevalence, mortality and burden of disease and other adverse health outcomes that exist among specific population groups.

Demographics

United States Population By Race

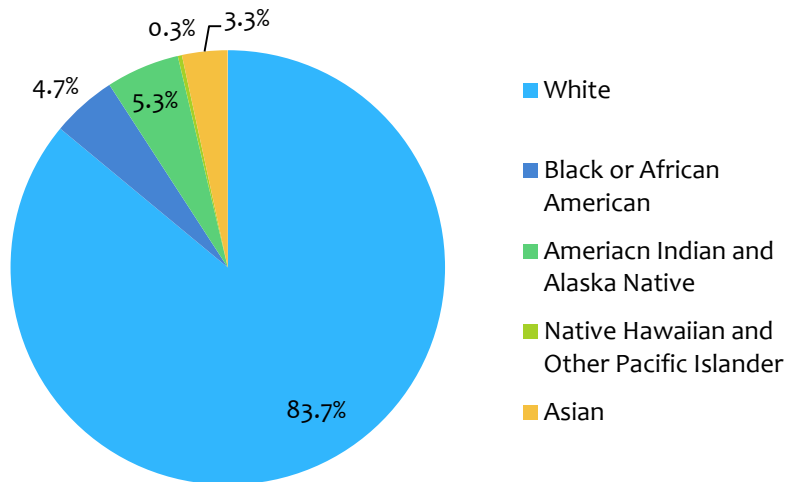


United States Population By Hispanic Origin

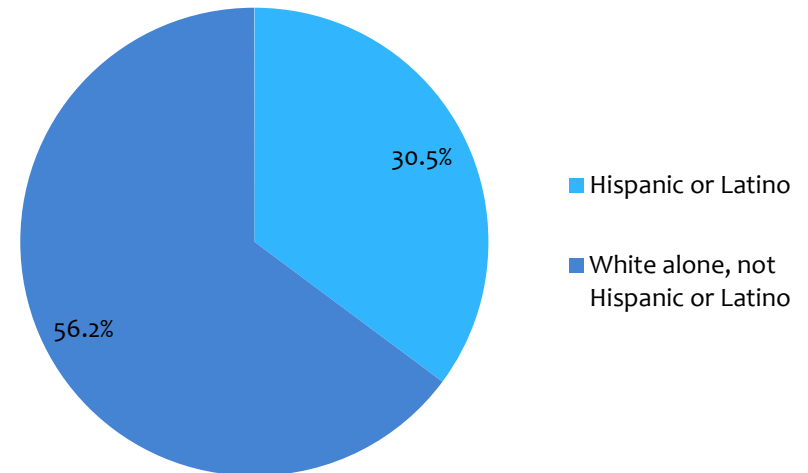


Demographics (Cont.)

Arizona Population By Race



Arizona Population By Hispanic Origin



Leading Causes of Death by Age Group, Race/Ethnicity Males, United States, 2010*

Rank	All Races	Hispanic	Black	White	American Indian/Alaska Native	Asian/Pacific Islander
1	Heart disease 24.9%	Cancer 20.7%	Heart disease 24.1%	Heart disease 25.1%	Heart disease 18.9%	Cancer 27.1%
2	Cancer 24.4%	Heart disease 20.6%	Cancer 23.3%	Cancer 24.6%	Cancer 18.6%	Heart disease 23.5%
3	Unintentional injuries 6.2%	Unintentional injuries 9.5%	Unintentional injuries 5.5%	Unintentional injuries 6.2%	Unintentional injuries 13.5%	Stroke 6.6%
4	Chronic lower respiratory diseases 5.3%	Stroke 4.2%	Stroke 4.8%	Chronic lower respiratory diseases 5.7%	Diabetes 5.1%	Unintentional injuries 5.0%
5	Stroke 4.2%	Diabetes 4.2%	Homicide 4.6%	Stroke 4.1%	Chronic liver disease 5.0%	Diabetes 3.5%
6	Diabetes 2.9%	Chronic liver disease 3.9%	Diabetes 3.9%	Diabetes 2.7%	Chronic lower respiratory diseases 4.1%	Chronic lower respiratory diseases 3.4%
7	Suicide 2.5%	Homicide 3.1%	Chronic lower respiratory diseases 3.1%	Suicide 2.6%	Suicide 4.0%	Influenza & pneumonia 3.1%
8	Alzheimer's disease 2.1%	Chronic lower respiratory diseases 2.7%	Kidney disease 2.8%	Alzheimer's disease 2.2%	Stroke 3.0%	Suicide 2.8%
9	Kidney disease 2.0%	Suicide 2.7%	HIV disease 2.1%	Influenza & pneumonia 1.9%	Homicide 2.4%	Kidney disease 2.0%
10	Influenza & pneumonia 1.9%	Kidney disease 2.1%	Septicemia 1.8%	Kidney disease 1.9%	Influenza & pneumonia 2.0%	Alzheimer's disease 1.3%

*Percentages represent total deaths in the age group due to the cause indicated. Numbers in parentheses indicate tied rankings. The white, black, American Indian/Alaska Native, and Asian/Pacific Islander race groups include persons of Hispanic and non-Hispanic origin may be of any race. Some terms have been shortened from those used in the National Vital Statistics Report. See the next page for a listing of the shortened terms in the table and their full unabridged equivalents used in the report. To learn more, visit *Mortality Tables* at http://www.cdc.gov/nchs/nvss/mortality_tables.htm or <http://www.cdc.gov/nchs/deaths.htm> HHS, CDC, NCHS).

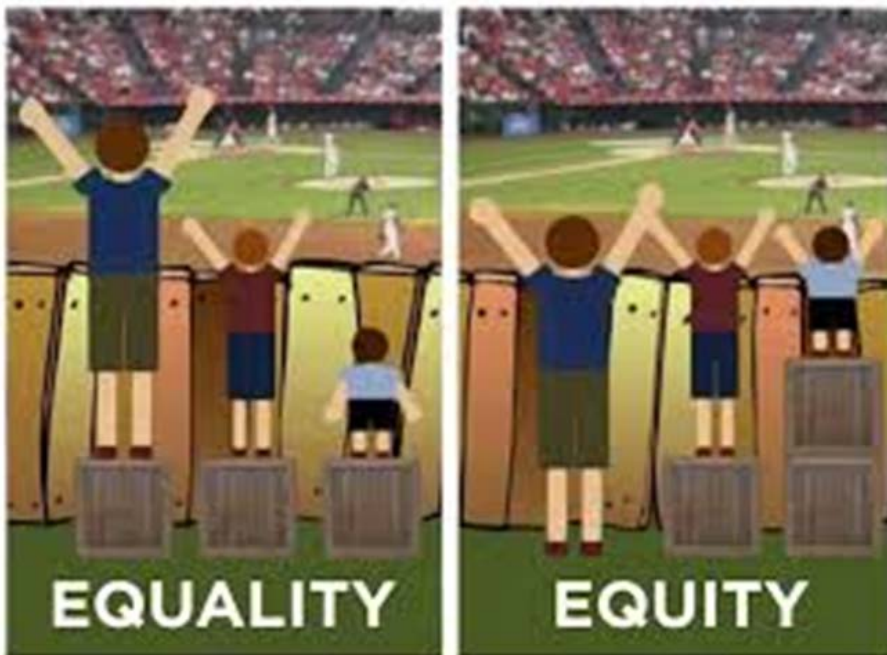
Comparative Age-Adjusted Mortality Rates for the Five Leading Causes of Death by Race/Ethnicity in Arizona in 2011

Rank	Asian or Pacific Islander	American Indian or Alaska Native	Black or African American	Hispanic or Latino	White non- Hispanic
1	Cancer 116.6	Diseases of heart 111.1	Diseases of heart 174.0	Diseases of heart 137.4	Cancer 170.3
2	Diseases of heart 77.0	Cancer 100.8	Cancer 167.1	Cancer 136.3	Diseases of heart 164.3
3	Stroke 29.1	Unintentional injury 100.6	Diabetes 57.8	Diabetes 41.7	Chronic lower respiratory diseases 55.3
4	Diabetes 23.3	Diabetes 61.3	Stroke 56.5	Unintentional injury 38.9	Unintentional injury 46.9
5	Alzheimer's disease 21.0	Chronic liver disease and cirrhosis 43.6	Alzheimer's disease 54.7	Stroke 34.9	Alzheimer's disease 36.3

Social Determinants of Health

- * Social determinants of health: are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

Health Equity



- Health Equity, refers to the concept of fairness in health distribution, information, access to care, etc., such that all individuals have the opportunity to achieve their full potential through healthcare and disease prevention

Cultural Competence

- * “...a concept that has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients” (National Institute of Health, 2014)
- * Alternative terms: cultural empathy, cultural humility, cultural capacities, cultural sensitivity, cultural awareness, cultural responsiveness...

Overview of CLAS Standards

- * The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
- * The Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:
- * Principle Standard: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. (Standard 1)

Overview of CLAS Standards (cont.)

- * Theme 1: Governance, Leadership, and Workforce (2-4)
- * Theme 2: Communication and Language Assistance (5-8)
- * Theme 3: Engagement, Continuous Improvement, and Accountability (9-15)
- * 15 CLAS Standards:
<https://www.thinkculturalhealth.hhs.gov/pdfs/enhanced-nationalclasstandards.pdf>
- * **Providing Language Assistance Services is Federal mandate for all recipients of Federal funds**

Resources and Materials

- * AHALAR as a resource: <http://azdhs.gov/hsd/health-disparities/campaign-initiatives/language-access/index.php?pg=alliance>
- * CLAS Standards Training – online and in-person <http://azdhs.gov/prevention/health-systems-development/health-disparities/index.php#clas-standards>

Resources and Materials (cont.)

* List of resources and materials:

- Implementing CLAS Standards and Improving Cultural Competency and Language Access - A Practical Toolkit
- Arizona Cultural & Linguistic Competency Technical Assistance Resource Kit
- Manual for Non-English Written Materials and Translations
<http://azdhs.gov/hsd/health-disparities/clas-standards.htm>
- Language Access Plan Template
- I Speak Cards
- Know Your Language Access Rights Fact Sheets
- Required documents for AHCCCS and/or Sliding Fee Scale
- Language Identification List (26 languages)
- Know Your Patient's Language Access Rights Fact Sheet
<http://azdhs.gov/hsd/health-disparities/campaign-initiatives/language-access/index.php?pg=resources>

**I speak Arabic.
Please provide me with an interpreter.**

Under Title VI of the 1964 Civil Rights Act, agencies that receive federal funds must provide the services of a professionally trained interpreter to clients who are not fluent in English. This law is meant to provide all people with equal access to public services. The interpreter's services must be provided at no cost to the client.

For more information on Title VI, call the U.S. Department of Justice, Civil Rights Division at 1-888-848-5306 or U.S. Department of Health and Human Services, Region IX Office for Civil Rights: 1-415-437-8310.

We recommend that you note this person's spoken language is his/her file.

أنا أتحدث باللغة العربية.
يرجى توفير مترجم شفوي.

إذا لم تحصل على المساعدة بلغتك، فإن لك الحق في تقديم شكوى. يرجى زيارة:
<http://www.justice.gov/crt/about/cor/complaint.php> للحصول على
المساعدة، يرجى الاتصال بهاتف رقم 1-888-848-5306.

LANGUAGE IDENTIFICATION LIST

	Amharic አማርኛ ጽንፈኛን ያመልክቱ		Korean 한국어 사용하는 언어를 가리키십시오
	Arabic العربية يرجى اختيار لغتك		Mandarin 普通话 / 国语 请指出您讲的语言
	Bosnian Bosanski Pokaži na svoj jezik		Nepali नेपाली आफ्नो भाषासाईं संकेत गर्नुहोस्
	Burmese မြန်မာဘာသာ သင့်၏ ဘာသာစကားကို ဖော်ပြပါ		Russian Русский Показать ваш язык
	Cantonese 廣東話 唔該點出您講嘅語言		Somali Soomaali Luqaddaada farta ku fiq
	Croatian Hrvatski Pokaži svoj jezik		Spanish Español Seleccione su idioma
	Dinka Thuonjān Wēt tēnōn thuonjūn		Swahili Kiswahili Elekeza kwa lugha yako
	Farsi فارسی به زبان خود اشاره کنید		Tagalog Tagalog Pakituro ang iyong wika
	French Français Indiquez votre langue		Thai ภาษาไทย ชี้บัตรภาษาของคุณ
	Haitian Creole Kreyòl Ayisyen Mete dwèt ou sou lang ou pale a		Tigrinya ትግርኛ ፍብ ጽንፈኛን አመልክቱ
	Hindi हिंदी कृपया अपनी भाषा को चुनें		Turkish Türkçe Dilinizi işaret edin
	Karen ကရင် နဲၣ်ဖျါၣ်နဲၣ်တၢ်တၢ်		Uzbek O'zbekcha Sizning tilingizni tanlash
	Kirundi Ikirundi Erekana imvugo yawe		Vietnamese Tiếng Việt Chọn ngôn ngữ của quý vị

Please point to your language. We will arrange a qualified interpreter at no cost to you.

Title VI of the Civil Rights Act of 1964 is a national law that protects persons from discrimination based on their race, color, or national origin in programs and activities that receive Federal financial assistance. Furthermore, the Federal civil rights law and other laws also prohibit discrimination in such programs and activities based on disability, age, sex and religion. Under this law, agencies that receive Federal funds must provide the services of a professionally trained interpreter to clients who are not fluent in English. This law is meant to provide all people with equal access to public services. The interpreter's services must be provided at no cost to the client.

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Content is adopted from the Maricopa Integrated Health System.
This is a project of the Arizona Health Alliance for Language Access Rights (AHALAR), a group of professionals devoted to creating and sustaining a welcoming environment that embraces Language Access Services (LAS) in Arizona.

Required documents for AHCCCS and/or Sliding Fee Scale

Photo Identification



Social Security Card (if applicable)



AHCCCS Denial Letter (if applying for Sliding Fee Scale)



Lease Agreement or Utility Bill



City of Phoenix



Birth Certificate



Proof of Income (from last 30 days income)



Documentos necesarios para AHCCCS y/o Escala de Pagos

Identificación Con Foto

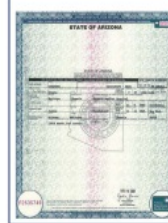


Tarjeta de Seguro Social (si es aplicable)



AHCC-015-SPANISH

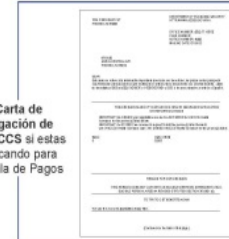
Certificado de Nacimiento



RMAP



Carta de
negación de
AHCCCS si estas
aplicando para
Escala de Pagos



Prueba de
Ingresos
(de los últimos
30 días)



Contrato de arrendamiento
o actual factura de servicios
públicos



Community Profile: Bhutanese

Language: Nepali, Dzongkha, English

Country of Origin: Bhutan

Places of Transition: Nepal, India

*This guide is meant to provide a general cultural orientation and does not describe every person from this community

Dos and Don'ts

- Recognize that most Bhutanese refugees are Lhotsampas, people originally from Nepal whose families settled in southern Bhutan several generations ago.
- Patients may have high expectations for healthcare providers. It is important to take some time to build rapport, treat the patient kindly, and be receptive to the patient's concerns.
- Many Bhutanese have been exposed to English, but may still find it difficult to understand. Speak slowly and recognize that most refugees will require an interpreter.
- Elders are highly respected in Lhotsampa culture. Decision-making is often first discussed with elders in the family, so be sure to keep them informed.
- For OB/GYN and reproductive health issues, try to match the patient with a female provider. The patient will feel more comfortable discussing these issues with a female provider.
- Emphasize the importance of preventive health measures, routine check-ups, and screening procedures.
- Encourage patients to communicate openly about their use of traditional medicine.
- Many Bhutanese are malnourished due to the limited nutritional diversity of food rations in the refugee camps. Give patients appropriate nutrition advice and supplements. Vitamin B12 supplements are particularly important for this population.

Health attitudes, beliefs and stigmas

Most Bhutanese refugees are Hindu (60%). Other religions include Buddhism (27%), Kirat (10%), and Christianity.

Hindus and Buddhists believe in reincarnation and often attribute illnesses to karma, actions performed in past lives.

Some Hindus and Kirat are vegetarian. Cows are considered sacred, and eating beef is prohibited among Hindus and Kirat.

Home remedies, traditional healers and shamans, spices and herbs, and astrological readings are often used as first-line treatment for illnesses.

Lhotsampas tend to be reluctant about seeking medical care. Many prefer going to the ER for immediate care of serious health problems, rather than scheduling appointments for preventive care.

Physical and mental disabilities are considered shameful and are often kept hidden.

Pregnancy, birth, and death are viewed as spiritually impure periods that require the performance of rituals. In some families, women are expected to rest and not prepare food during their menstrual period.



Contraception and family planning are widely accepted and used, except by some more traditional individuals.

Many women have never encountered health screening procedures such as mammograms and pap smears.

Patients from the pre-literate class are often uncomfortable discussing sexual relationships and reproductive health.

The rate of exclusively breastfeeding infants for the first 6 months is low. Other liquids are often introduced early on.

The Bhutanese tend to depend on herbal remedies and prefer to only take low doses of pharmaceutical drugs.

Traditional gender roles may influence utilization of health services. A woman will voice concern about the health of her spouse and children, but may be reluctant to discuss her own health.



What you may see

The education system in Bhutan started in 1960. Most refugees over age 40 are either pre-literate in both Nepali and English or have a low level of formal education.

Most Bhutanese refugees have lived in refugee camps ever since their families were forced to leave their country more than 20 years ago.

Many Bhutanese refugees speak a low form of Nepali and may not understand the formal language interpretation over the phone.

The caste system in Bhutan divides the population into a social hierarchy, influencing choice of spouse and social interactions. For many Lhotsampas, caste is no longer a consideration. For others, particularly traditional individuals of the upper castes, caste remains an important issue but is not openly discussed.

Family is a high priority and the community tends to be tight-knit. The Bhutanese are accustomed to visiting neighbors and welcoming others into their homes.

Lhotsampas usually live in large households with extended family. The younger generation is responsible for taking care of the elders.

Arranged marriages and polygamy occur, but tend to be uncommon.

Did You Know?

The Bhutanese view pregnancy, birth, and death as spiritually impure periods that require the performance of rituals.

Households are generally patriarchal. Women are expected to do almost all of the housework and have less authority in decision-making.

Hindus have important rituals and traditions at birth, marriage and at death. Families may prefer to forgo autopsy and organ donation.

Common health concerns

Bhutanese refugees have very high rates of anemia, chronic malnutrition, and micronutrient deficiency. Low meat consumption and long periods on refugee camp food rations may contribute to these high rates. Common micronutrient deficiencies include Vitamin B12, Vitamin A, and Vitamin B2.

Other health concerns include diarrhea, acute respiratory illness, malaria, intestinal parasites, and tuberculosis.

Mental health is a major concern for Bhutanese refugees. Many have spent long periods of time living in refugee camps and have experienced trauma due to detention, imprisonment, torture, sexual assault, rape, and domestic violence.

Bhutanese refugees exhibit high rates of depression, anxiety, and PTSD. There have also been a high number of suicides among Bhutanese refugees who have resettled in the US. This prompted a formal investigation and report by the CDC entitled "An Investigation into Suicides among Bhutanese Refugees in the US 2009 – 2012".

Potential barriers to care

- Inability to obtain health insurance
- Inadequate interpreter services
- Unfamiliarity with modern amenities
- Poor understanding of health care system
- Traditional gender roles affecting health care utilization
- Transportation difficulty
- Limited health literacy
- Stresses of resettlement
- High cost of care

For additional resources, please visit AZrefugeehealth.org

Arizona Department of Health Services • Community Profile

Community Profile: Iraqi

Language: Arabic, Kurdish, Chaldean

Country of Origin: Iraq

Places of Transition: Syria, Jordan, Lebanon, Turkey

*This guide is meant to provide a general cultural orientation and does not describe every person from this community

Dos and Don'ts

- Respect the patient's religious beliefs and practices.
- Whenever possible, match patients with caregivers of the same gender.
- Address the patient formally with Mr., Mrs., or Miss, rather than using first names.
- A handshake with eye contact and a smile is a common greeting, however men should wait for a woman to extend her hand first.
- If the husband is present in the room of a female patient, be sure to acknowledge his presence when speaking.
- Always explain your reason for initiating contact before touching the patient.
- Prioritize urgent concerns and if there are concerns that have not been addressed yet, be sure to schedule a follow-up visit.
- Smile, listen attentively, and express genuine concern.
- Compliment good health behavior to encourage and reinforce healthy habits.
- Inform the patient of proper medication usage, and describe the consequences of inappropriate use.
- Be sure to stress disclosure of all medications.

Health attitudes, beliefs and stigmas

The majority of Iraqis practice Islam (2/3 Shi'a, 1/3 Sunni¹). A small minority practice Christianity and other religions.

It is common for conservative Muslims to accept a health condition as God's Will and reject treatment.

Iraqis may use natural remedies such as cumin, tea, butter, and henna to treat minor ailments.

Muslims follow halal dietary laws. Meat must come from animals slaughtered by another Muslim according to ritual. Pork and alcohol are forbidden.

During Ramadan², Muslims fast from sunrise to sunset for a month. Medication regimens may need to be adjusted.

Children, pregnant women, and the ill may be exempt from the fast. Still, conservative Muslims may refuse to take medication during the daytime. Speak with an elder in the family, or an Imam³, to discuss if the patient's state of fasting is inappropriate.



In Iraqi culture, there is a strong stigma associated with mental health and counseling services. Discuss mental health issues in terms of the symptoms, rather than using jargon that may elicit immediate negative reactions.

Many Iraqis have come from a modern city and an educated background, shaping their health beliefs. Take time to learn about the patient's family situation and life in Iraq.

1. Shi'a and Sunni are two major denominations within the religion of Islam.

2. Ramadan is a month of religious observance for Muslims. Based on a lunar calendar, the dates for Ramadan change from year to year.

3. In Islam, an Imam is a religious leader or scholar.

Exercise is not emphasized in Iraqi culture as important for health. Being overweight is often associated with health and strength.

Iraqis are reluctant to discuss sexual relationships, and premarital sex is rare in youth. Avoid asking questions that may be seen as shameful or emotionally disturbing.

An Iraqi may voice a specific concern repeatedly. Repetition is used to show emphasis and the priority of a concern.

Iraqis often expect to receive medication for each visit to a provider. If no medication is necessary, be sure to explain why.



What you may see

Iraqis are generally proactive about seeking medical care. However, it is common that only a vague description of symptoms is offered to the provider.

Iraqis may not be comfortable disclosing detailed health information to strangers, including interpreters.

Iraqis place strong emphasis on the values of family, honor, modesty, and privacy.

Families play a significant role in decision making and may expect to be informed and included in discussions with the patient. The oldest male often serves as the family spokesperson.

Muslim women may wear a hijab (head covering) or jilbab (full body covering) for modesty.

Displaying emotions may be viewed negatively and expression of pain is often kept to oneself.

Muslims have important religious rituals at birth and death.

Did You Know?

1 in 5 Iraqi refugees has experienced torture or violence, and many more have witnessed such cruelty.

Unrelated community members may visit the patient or newborn as part of religious tradition.

Death is commonly accepted as having been predetermined by God. Families may wish to decrease sedation, discontinue life support, or forgo autopsy and organ donation for the patient.

Some people, accustomed to the Iraqi healthcare system, may be forceful and demanding in expressing their needs. Be patient and help them understand the US healthcare system.

Understand that there is diversity among Iraqis and there may be resistance to interact with others across socioeconomic, religious, gender or political lines.

Common health concerns

One in five Iraqi refugees has experienced torture or violence, and many more have witnessed such cruelty. Victims of torture and violence may have physical wounds, amputations, or traumatic brain injury (TBI).

Iraqi refugees exhibit very high rates of depression, anxiety, and PTSD. Many have experienced trauma associated with war, killings, kidnapping, rape, imprisonment, torture, blackmail, and threats from militias.

Iraqis experience high rates of chronic health conditions including obesity, hypertension, diabetes, arthritis and high cholesterol.

Other health concerns include low vaccination rates in children, high rates of latent tuberculosis, and high rates of congenital diseases and cancer linked to the effects of war.

Potential barriers to care

- Inadequate interpreter services
- Previous unfavorable healthcare experience
- Desire to maintain modesty and gender preferences in seeking and accepting care
- Values of family privacy and honor
- Transportation difficulty
- Stresses of resettlement
- Domestic violence
- Lack of follow-up care
- Limited health literacy
- High cost of care

For additional resources, please visit AZrefugeehealth.org

Arizona Department of Health Services • Community Profile

Community Profile: Somali

Language: Somali, Arabic

Country of Origin: Somalia

Places of Transition: Djibouti, Kenya, Ethiopia, Burundi, Yemen

*This guide is meant to provide a general cultural orientation and does not describe every person from this community

Dos and Don'ts

- Recognize that the clan is an important social unit, and much of the conflict in Somalia is due to inter-clan disputes. However, avoid referring to clans because it is considered disrespectful.
- Respect the patient's religious beliefs and practices.
- Whenever possible, match patients with caregivers of the same gender.
- A handshake is a common greeting, but only between people of the same sex.
- Be aware that Somalis may avoid eye contact as a sign of respect.
- Use the right hand to greet or give medication and food to the patient. The right hand is considered the clean and polite hand to use for daily tasks.
- Always explain your reason for initiating contact before touching the patient.
- Somalis may not express gratitude or appreciation verbally. Do not assume patients are ungrateful.
- Avoid excessive complimenting of patients that could be interpreted as casting the 'evil eye' upon them.
- Emphasize adherence to medication regimens and preventive medicine.

Health attitudes, beliefs and stigmas

Most Somalis practice Islam and the majority are Sunni¹ Muslims.

Somalis may attribute health conditions to God's Will, spirit possession, or the 'evil eye'—the belief that directing comments of praise at a person will cause misfortune or harm to befall the person.

Many Somalis believe illness is prevented through prayer and adherence to Islam, and are unfamiliar with the US model of preventive medicine.

A common traditional belief is that there is no need to continue taking medication if feeling healthy.

Common alternative medicine practices include herbal remedies, wearing amulets, and 'fire-burning', in which a special stick is burned and applied to the skin.

Muslims follow halal dietary laws. Meat must come from animals slaughtered by another Muslim according to ritual. Pork and alcohol are forbidden.

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3. In Islam, an Imam is a religious leader or scholar.



Children, pregnant women, and the ill may be exempt from the fast. Still, conservative Muslims may refuse to take medication during the daytime. Speak with an elder in the family, or an Imam³, to discuss if the patient's state of fasting is inappropriate.

In Somali culture, there is a strong stigma associated with mental health and counseling services.

Somalis often expect to receive medication for each visit to a provider. If no medication is necessary, be sure to explain why.

Circumcision for both males and females is considered an important rite of passage, necessary for marriage, and a source of pride, as the uncircumcised are considered unclean. Due to the practice being illegal in the US for females under 18, Somali families are often reluctant to discuss this issue or may wish to transport the child to another country to perform the procedure.

What you may see

Family and honor are very important in Somali culture. The health of one family member is of concern to the entire family.

If a patient is found to be terminally ill, the family may wish for the health care provider to tell the family members first, so they can comfort and protect the patient.



Somali society and households tend to be male-centered. A male family member usually serves as the family spokesperson and decision-maker. Rural women may be shy and reluctant to speak up in the presence of men.

Somalis tend to have large families. One-fifth of the population is polygamous.

Women marry and have children early. It is not uncommon for a woman to have 7 or 8 children. Children are highly valued and elders are highly respected.

Before coming into the US, about 80% of Somalis lived a nomadic or semi-nomadic lifestyle as herders.

Somalis have three names: given name, followed by father's and grandfather's given names. Somalis usually identify with their first and second names or a nickname. Women do not change their names at marriage.

Muslim women may wear a hijab (head covering) or jilbab (full body covering) for modesty.

Did You Know?

By age 10, about 98% of Somali girls undergo some form of circumcision.

The literacy rate among Somalis is low since the written form was only created in 1972, and ongoing civil war has disrupted the education system.

Many males chew qat, a leafy narcotic. Qat is an illegal drug in the US and may have health implications.

Somalis greatly appreciate oral communication and have a tradition of using proverbs in everyday speech.

Common health concerns

An estimated 30% of Somali refugees have been tortured, and many have experienced trauma associated with war, rape, mass violence, severe poverty, famine, and living in refugee camps for a long period.

Somali refugees have high mental health needs, exhibiting high rates of depression, anxiety, PTSD, psychosomatic symptoms, flashbacks, misplaced anger, and feelings of disconnection.

Malnutrition is common among Somalis. Common concerns include iron deficiency, anemia, Vitamin A deficiency, and scurvy.

Common infectious diseases include diarrheal disease, measles, malaria, and acute respiratory illness. Intestinal parasites affect 47% of arriving Somali refugees.

Female circumcision causes many health complications including urinary tract infections, menstrual problems, chronic pain, and increased risks during pregnancy.

Potential barriers to care

- Inadequate interpreter services
- Previous unfavorable healthcare experience
- Desire to maintain modesty and gender preferences in seeking and accepting care
- Male-centered household and health decisions
- Traditional beliefs may interfere with treatment
- Low adherence to preventive medicine
- Values of family privacy and honor
- Transportation difficulty
- Stresses of resettlement
- Limited health literacy
- High cost of care

For additional resources, please visit AZrefugeehealth.org

Arizona Department of Health Services • Community Profile

Poll

- * Please rate usefulness of community profiles

Not useful

Less useful

Neutral

Useful

Most useful

- * Please type your answer in the Q&A box

Community Profiles

- * List of existing Community Profiles:

Afghan, Bhutanese, Burundian, Congolese,
Eritrean, Iraqi, Karen, Somali, Somali Bantu,
Sudanese

<http://azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/refugee-health/index.php#providers-profiles>

- * What other groups would benefit from having community profiles? Please type your answers in the Q&A box.

Questions?

- * Thank you!

- * Contact information:

Hong Chartrand:

hong.chartrand@azdhs.gov

602-542-2911

Upcoming Webinar Schedule

January 26, 2016 – 11am	Health Disparities and Cultural Competence: A Local Approach
January 26, 2016 – 1pm	Rural Women's Health Network- Brain Injury
February 23, 2016 – 12pm	Heart Health in Rural Arizona- College of Nursing
March 29, 2016 – 12pm	Farmworker Health Month
April 26, 2016 – 12pm	Sexual Assault
May 31, 2016 – 12pm	Update on Rural Men's Health- May Native Men's Health

Next webinar is scheduled for January 26th at 11:00am MDT

Go to <http://telemedicine.Arizona.edu/distant-education/upcoming-workshops>

**Your opinion is valuable to us
Please participate in this brief survey:**

<https://www.surveymonkey.com/r/AzSORH>

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