CROSS-CULTURAL ***RESOURCE***

FOR HEALTH PRACTITIONERS

WORKING WITH CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) CLIENTS

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Te Wai Awhina
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Cross-cultural Resource for Health Practitioners working with Culturally and Linguistically Diverse Clients (CALD)

Resource contains CD-Rom with summary booklet and folder

Written and compiled by Victoria Camplin-Welch

This iCare™
Cross Cultural Resource Kit is
designed and produced by Sue Lim of Asian Health Support Services, Waitemata District Health Board

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FOREWORD

WDHB and RAS NZ are proud to present jointly an innovative cross-cultural resource kit for health practitioners working with culturally and linguistically diverse clients, in the form of a booklet and a CD-Rom. It is the first of its kind in New Zealand.

One of the key drivers for the resource development is because of requests for resources and references from health practitioners who attended cultural workshops ran by WDHB Asian health support services.

Secondly, Ministry of Health's District Health Board (DHB) Operations Policy Framework 2006/07 and the Health Practitioners Competence Assurance Act 203 also requires cultural competence of medical practitioners.

Thirdly, WDHB and RAS NZ have a strategic focus on developing workforce capacity and capability to work with culturally and linguistically diverse clients. WDHB has a strong focus on Asian migrant and refugee needs, and RAS NZ has a focus on the refugee population which includes Asian refugees.

We are pleased to have combined efforts, strengths, knowledge and expertise in developing an essential cross-cultural resource to enhance current workforce development initiatives of both organizations.

We would like to convey our sincere acknowledgements and thanks to the researcher, the communities for participating in this research process and everyone involved with the project (as listed overleaf).

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THE PROJECT TEAM

This cultural resource was developed by the following project team:

- Victoria Camplin-Welch – Researcher, Cultural Competence Specialist responsible for writing and compiling the resource booklet and CD-Rom
- Sue Lim – Manager Asian Health Support Services WDHB and Project Manager for this resource development for WDHB, responsible for providing some materials, designing and coordinating the production of the resource kit which includes the booklet and a CD ROM
- Charles Cui – Asian Health Project Coordinator, responsible for formatting the CD ROM

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- *Dr*. *Kathy Jackson* for her consistent support and highly valued expertise in cross-cultural work
- People who offered themselves as consultants for the different cultures: *Dr. Nyuant Naing Thein* for the Burmese, *Judy He, Charles Cui*, *Sue Lim, Mo Yee Poon* and *Ching Sy* for the Chinese, *Sally Han* and *Grace Ryu* for the Koreans, *Hien Mack* for the Vietnamese, *Supreet Cheema* and *Pratima Nand* for the Indians, and *Kuy Be Mathin* for the Cambodians and *Dr. Arif Saeid* for the Afghani, *Elizabeth Alkass* for the Christian Iraqi, *Zoreh Karimi* for the Iranian, *Monica Jok* for the Sudanese, *Dahaba Hagi* for the Somali, *Dawit Arshak* for the Ethiopian and a number of community members for the Burundians and Arabic Iraqi who would like to remain anonymous. Their input provided invaluable current and real perspectives from resettled immigrants on theoretical material. Many spent considerable time in consulting additional community members and leaders, and others gave generously of their time in proofing the information once it had been written up
- The work of *Kemp and Rasbridge* (2004) and Jackson (2006) all of whom have provided the basis for much of the material. Thanks to other researchers and publications and also to *Queensland Health*, Australia whose extensive resources and information for clinicians has been extremely helpful

INTRODUCTION

This resource is in honour of the Great Movement of Cultures across our planet, of people bravely migrating, and some being displaced with much anguish from their homelands to settle in New Zealand. With them they bring new perspectives, traditions and experiences to enrich our rapidly growing multi-cultural society.

This booklet is also produced with respect for those health professionals who serve in our health system within this dynamic and demanding context, constantly having to update, integrate and re-frame their world views, traditions and practice to meet the needs of this changing society.

Lastly it is in recognition of the New Zealand Spirit, a vessel able to hold a myriad of possibilities. Rich in its own heritage it is constantly challenged to embrace and support the New.

This aim of this resource is threefold:

1. The first is to enhance awareness around cultural competence issues, what cultural competence means and what it constitutes.
2. The second is to provide information to assist practitioners in developing a relevant set of skills for culturally competent practice. For this purpose we have included a self-assessment for cultural competency development, pre-interview checklists and interview guidelines, communication tips and greetings for each culture, tables comparing various aspects of Asian and Western cultures, and how to work effectively with interpreters (Section I).
3. The third aim is to provide some brief background information on seven Asian cultures that will assist practitioners in their attempts to develop rapport, build relationship and provide an effective and appropriate service (Section II).
4. The fourth aim is to provide general information about the Eastern Mediterranean and African cultures and some brief background information on seven Eastern Mediterranean and African cultures that will assist practitioners in their attempts to develop rapport, build relationship and provide an effective and appropriate service (Section III).

The CD-Rom is an updatable resource. The initial focus is on Asian cultures (included are Chinese, Korean, Indian, Vietnamese, Cambodian, Laotian and Burmese) and Eastern Mediterranean and African cultures (included are Afghani, Burundian, Ethiopian, Iranian, Iraqi, Somalian, and Sudanese), as these are the considered as the major migrant and refugee population groups outside the dominant New Zealand host cultures. The CD-Rom will be revised from time to time with information on additional cultures as the needs arise, mental health issues, and other refugee and migrant issues.

For ease of reading, references and resources are included at the end of each chapter, rather than inserted into the text.

HOW TO USE THIS RESOURCE

1. Booklet
The booklet is a Desk-top-guide as requested by many practitioners and contains summary points from the CD-Rom. It needs to be used **in conjunction with the CD-Rom** and is compiled with the expectation that the CD-Rom will have been consulted prior to using the booklet.

2. CD-Rom
The CD-Rom is a more comprehensive guide and includes explanation, examples and background information on the points in the booklet. It also includes additional issues, comparative tables, generalized sections on Asian, Eastern Mediterranean and African Cultures and video and audio clips of the greetings in each language. It is not intended as a definitive guide on each culture, but contains information we considered useful to practitioners in a health setting who will work with CALD clients.

It is divided into four sections:

- Section I contains general information about cultural competency, effective communication and working with interpreters.
- Section II contains generalised information about Asian cultures and then specific individual cultures which includes brief background information, greetings and communication tips, health beliefs and practices, family values, tips for practitioners working with culture-specific clients, health risks, women's and youth health, and spiritual practices.
- Section III contains generalised information about Eastern Mediterranean and African cultures and then specific individual cultures which includes brief background information, greetings and communication tips, health beliefs and practices, family values, tips for practitioners working with culture-specific clients, health risks, women's and youth health, and spiritual practices.
- Section IV contains additional resources.

How to navigate the document

1. The CD-Rom can be navigated by clicking on the **WHITE** text on the cover page of each culture. These are **hyper-links** to the relevant sections.
2. In addition, the '**bookmarks**' tab, (located on the upper left of the page) contains a more detailed list of headings and sub-headings within each section. These contents are **hyper-links** and can take the reader to the desired section.
3. After using a hyper-link, the reader can return to the section being read beforehand by simply clicking on the relevant heading in the bookmark column.
4. Details on common treatment practices and on the different religions is contained in the general section on Asians. The reader can be connected with these through hyperlinks within each of the individual culture sections.

PLEASE NOTE This booklet outlines *traditional* practices from each of the cultures. These are more likely to apply to recent migrants. However many CALD clients who have migrated from other countries of resettlement, as well as those of 2nd and 3rd generations in New Zealand may have acculturated to the extent that there are few, if any, noticeable differences between theirs and the New Zealand culture. **It is imperative, to avoid stereotyping, that the tools in Section I of this Resource are used to assess the degree of acculturation of each individual client.**

SECTION I

CULTURALLY COMPETENT PRACTICE

1. CULTURE

Culture is defined by the *shared history, values, beliefs and practices of a group,* and not just by ethnicity. Culture affects all aspects of living including behaviour, family structure, child rearing, dress, body image, diet, food, caregivers' roles and spiritual practices. In the context of health care, culture is integral to ideas of what constitute illness and wellness, and what acceptable and effective treatment is.

In addition 'culture' provides people with a way to identify themselves, to make sense of their world, and gives some structure to understanding their thoughts, behaviours and events. For people immigrating to a different country, being able to retain aspects of their culture is vital, particularly if the host culture of the new country is markedly different. When people move from one cultural context to another, one of four processes tend to occur: assimilation, integration, separation or marginalisation (Berry 1997). People may move through the spectrum, experiencing different degrees of each process at different times. Some may stay within a particular process. It is important to ascertain how much your client may have integrated or assimilated before initiating treatment decisions.

Processes occurring when people move from one cultural context to another	
Integration	retaining the beliefs, values and behaviour of their own cultural group as well as adopting many of those of the new cultural group/s
Assimilation	loses own cultural identity by assimilating the values, beliefs and behaviours through constant interaction with the new culture/s
Separation	maintains own culture by avoiding interaction with the new culture/s
Marginalization	loses contact with own cultural group and avoids interaction with the new cultural group

(Berry, 1997)

2. CULTURAL COMPETENCY

2.1 Defining Cultural competency

In most countries the *host cultures* (i.e. in New Zealand the Maori, Pacific and Anglo-European based cultures) dominate health care services. However, since New Zealand is an exceptionally fast growing multi-cultural society, services need to be accessible, equitable and appropriate for a markedly diverse population.

To provide such service we need a workforce who is competent to work with culturally and linguistically diverse clients, and who can tailor service delivery to meet health, social, cultural and linguistic needs of these clients.

Cultural competence involves different levels of awareness, knowledge, skills and respect. Terms such as *'cultural awareness'*, *'cultural safety'* and *'cultural clinical competence'* have been used to describe these different levels. Whilst in the past it has been considered sufficient to be sensitive in cultural interactions, expectations and requirements are now that all health care providers practice cultural safety and possess the skills to be considered culturally competent, particularly *within a clinical context*.

1. *Cultural awareness* involves being sensitive in interactions with other cultures. This requires awareness of one's own beliefs, values, expectations and cultural practices before being able to recognize and evaluate how these impact on people from other cultures, and on how they influence one's attitude towards healthcare interventions. Culture-sensitivity also requires some knowledge of the other culture and the ability to develop mutual respect between the client and practitioner, as well as the preparedness to negotiate the process of treatment. The tendency towards *ethnocentrism* (the conviction that ones' own culture is 'normal' or superior) is particularly important in this regard as it prevents us from meeting people on their own cultural ground. Instead there is often an implicit goal to try to get people to conform to mainstream. This has direct implications for healthcare safety and influences the relationship between provider and client and therefore, of course, compliance.
2. *Cultural safety* refers to the outcome of professional education that enables safe service to be defined by those who receive the service.
3. *Clinical Cultural Competence* involves cross-cultural skills in clinical assessment, effective communication and rapport building, knowledge of cross-cultural ethics, and working with interpreters.

It is well known that the therapeutic relationship plays a central role in client compliance and the successful outcomes of treatment. Given the cultural challenges and barriers to access for CALD (culturally and linguistically diverse) clients, it is recommended that practitioners give priority to developing rapport and understanding between the parties. There are guidelines in the individual culture sections that will assist this process, but in general, being respectful, interested in the client's perspectives and being willing to negotiate treatment to accommodate as much of the client's needs as possible, will facilitate this process considerably. An increased awareness and understanding of the different health beliefs and expectations about treatments that clients may hold is essential. This includes:

- **Tolerance** for diversity
- **Sensitivity** to the role of traditional medicine and practices
- Considering whether, and how, **prescribed interventions may conflict** with client's beliefs or traditional practices
- Enquiring about **client's own perspectives and explanations** of their illness
- Willingness and ability to negotiate treatment by accommodating client's framework and expectations to some degree
- The possible need to **involve family** in interventions and feedback
- Ensuring that a good rapport between parties is facilitated when engaging an interpreter

Best Practice	Not culturally competent practice
Cultural Relativism The attitude that other ways of doing things are *different* but equally valid Attempt to understand the behavior in its cultural context	**Ethnocentrism** The view that one's culture's way of doing things is the right and natural way, and that all other ways are inferior, unnatural, perhaps even barbaric
Generalization Indicates common trends, but further information needed to ascertain appropriateness of a statement to a particular individual May be inaccurate when applied to specific individuals	**Stereotyping** Belief that a statement is true of all individuals from a particular group

2.2 Self-assessment for Cultural Competency Development

It is inevitable that all of us will hold some predjudices, stereotypes, or have beliefs that remain within the shadows of our awareness. It is the consistent attempts to identify and manage these that nurture development in cultural competency and acceptance of diversity. Below are some questions for reflection:

Checklist for ongoing Cultural Competency Development

1. How self-reflective are you about your interactions with clients from other cultures or minority ethnic groups?

2. Do you recognize prejudices you may hold about certain ethnic groups, or their practices and beliefs?

3. Can you identify how *ethnocentric* you might be in your interactions with clients from different cultures?
    - Can you greet people from any other culture in their own language (verbal or non-verbal)?
    - Do you assume that they need to understand how your system works?
    - Do you know anything about where they come from and the circumstances under which they might have migrated?
    - Do you know anything about their traditional health practices and expectations?
    - Are you able to accommodate any of the diversity in your interventions?

4. How does your ethnic identity affect your decisions with clients and others?

5. How often do you attend functions or take part in any activities involving people from minority ethnic groups?

6. Have you read any books/articles or seen any films recently about people from other cultures, particularly minority ethnic cultures?

7. Do you respect client's religious or spiritual beliefs that are different from your own? Are you able to encorporate these comfortably in interventions when appropriate?

8. Have you discussed any cross-cultural issues that might have arisen in your work, with a colleague or supervisor?

9. Have you attended any training or sought education on cross-cultural issues?

10. Have you ever challenged a racist attitude by someone, or realized you might have made/thought one?

11. How much do you value the metaskills of 'compassion', 'neutrality', 'non-judgement', 'acceptance' and 'listening' in your practice?

See Jackson (2006) p. 195, for *Charactersitics of cross-culturally competent mental health practitioners*, and Pack-Brown Williams (2003) p. 136 for a checklist on *Professional development in multicultural mental health* (some of both included in above questions).

3. COMMUNICATING EFFECTIVELY

"It is much more important to know what sort of patient has a disease, than what sort of disease a patient has" (William Osler, quoted in Carrillo *et a*l)

When conducting a clinical assessment with someone from another culture practitioners are faced with not only the challenge of different levels of host language proficiency, acculturation and socioeconomic status, but more importantly within the health context **different expectations, traditions and experience of health care**. Since client satisfaction and compliance is closely related to the effectiveness of the communication between practitioner and client, not only cultural sensitivity, but particular cross-cultural skills are needed in assessment to ensure adequate understanding between the two.

Core issues that are likely to create misunderstandings across cultures relate to **physical contact, authority, communication styles, gender, sexuality, family, spiritual beliefs,** and **explanatory models of illness and health.**

A 'Pre-interview Checklist' and 'Essentials for communicating' during the interview will assist both rapport building and assessment.

3.1 Pre-interview checklist:

- Do you know what *culture* your client is from?
- Do you know what *language and/or dialect* they speak?
- Can you *greet* your client in their language?
- Do you need an *interpreter*? (see Working with Interpreters below)

3.2 Essentials for Communicating Clearly during the interview:

- *Explain your role* to your client (different professional roles are not always understood by someone who has come from a different health system)
- *Do not assume* English proficiency
- *Speak clearly* and *slowly*
- *Avoid jargon*
- *Simplify* the form of the sentence or question (e.g. use active not passive statements)
- *Pause* and take time to explore any issues that need clarifying to ensure you are understood before continuing (the assumption that everything is understood could lead to non-compliance)
- *Periodically summarize* and encourage feedback to check understanding
- *Note differences in meanings* of words (e.g. Anglo Europeans use "Yes" as affirmative, whilst in other cultures it can be a form of acknowledgement without indicating consent. Saying "that is correct" or "I understand" may be clearer. Check what your client means)
- Be aware of *client's level of understanding* (need to find the balance

between being patronizing or assuming they understand how the health system and treatments work)
- *Respect* others' beliefs and attitudes (don't be afraid to ask how things are done/seen/understood in the client's culture. People often open up if they feel the listener is genuinely interested)
- *Take note of non-verbal language* (people express emotions in different ways, a dissonance between verbal and non-verbal language may also indicate a lack of understanding)
- *Engage interpreters* where there is low English proficiency and utilize their role as cultural advisors to assist the communication process
- Be sure to *address the client appropriately* (not all cultures regard first names as acceptable in a formal setting)
- Find out whether *eye contact* is acceptable or not
- Find out what kind of *physical touch* and *examination* is expected and acceptable

3.3 CROSS-CULTURAL ASSESSMENT

Guidelines for culturally competent assessment:

3.3.1 Important cultural background information:

1. Where was the client born?
2. How long has the client been in this country?
3. What is the client's ethnic affiliation?
4. Who are the client's major support people?
5. What are the client's primary and secondary languages, their reading and writing ability in these?
6. What is the client's religion, its importance in daily life, and current practices?
7. What are their food preferences and prohibitions?
8. Is the client's income adequate to meet their own and their family's needs?
9. What are their health and illness beliefs and practices?
10. What are their customs and beliefs around life events such as births, illness and death?

Adapted from Allotey et al., (1998) listed in

www.health.qld.gov.au/multicultural/checklists/questions

Guidelines for eliciting the client's own explanatory model so that this can be encorporated into the diagnosis and treatment plan.

3.3.2 A BRIEF set of questions to elicit client's own perspective and beliefs about their health: (The CAT, Cultural Awareness Tool)

1. What does your sickness do to you; how does it work?
2. What do you think caused your problem?
3. How bad is your sickness? How long do you expect it to last?
4. Do you have a name for this problem in your language?
5. What is your biggest worry about your sickness?
6. What have you been doing or taking for this problem so far?
7. Who advises you about your health in your culture?
8. What kind of treatment do you think you should receive?
9. What are the most important results you hope to receive from this treatment?
10. Is there anything you would like me (your doctor) to know about your problem?

Adapted from The Cultural Awareness Tool, Multicultural Health Australia, 2002.

3.3.3 Treatment/care and Discharge Considerations:

1. Does client understand your perception of their illness?
2. In the case of serious/terminal illness is it appropriate to speak with a relative first?
3. Does the client understand how the treatment works/ how to take the medicines/can they read the instructions?
4. Does the client understand how the treatment will help him/her? (NB for compliance)
5. Does the client understand how to incorporate the treatment with (possibly) their own existing practices? (Consider dietary and food preferences)
6. Is there place for self-determination of client and family in the treatment/care process?
7. Does the client understand the whole plan?
8. Is follow-up procedure clear?
9. Consider using an interpreter for treatment instruction/discharge if English proficiency is not high or if there is difficulty about compliance

4. WORKING WITH INTERPRETERS

Working with interpreters is a further challenging factor to the CALD treatment sessions. The presence of a third party has significant influence on rapport potential, and depending on the client-interpreter relationship, can also affect outcome. It is essential to engage trained interpreters when necessary (see below) and to facilitate the process according to guidelines. In New Zealand considerable steps are being taken to ensure that interpreters are professionally trained and practice according to standard guidelines and ethics. There is currently a specialist, Regional Interpreter Training Package for interpreters working in mental health which also includes a component for practitioners. It is a requirement that all interpreters working in the area of mental health attend this training in order to continue working in the field. It is also recommended that practitioners attend the 2 day training component in order to develop the most effective means of working together with interpreters.

4.1 Engaging an interpreter

A client may request an interpreter in advance, or you may need to assess whether one is required. If you feel that your client's English ability could restrict either their *understanding of information* provided or *your ability to understand their needs*, then an interpreter is required. (Note that English ability as a second language can deteriorate in situations involving illness, shock, pain or stroke).

To assess the need:

- Ask your client open ended questions that require more than a Yes / No answer
- Ask your client to repeat what you have just said in their own words

4.2 Using trained or untrained interpreters

Trained interpreters are available from professional Interpreters services in South, West and Central Auckland **(Resources)**. The term 'untrained' interpreter refers to family members, friends, support persons, volunteers or staff, or anyone who has not had professional training as an interpreter.

4.2.1 Use a *trained interpreter* when:

- Client is not accompanied by family / support person / friend, or when one cannot be readily contacted
- Dealing with children
- Client does not wish to use family / friends / support persons or staff
- Client and/or family request an interpreter
- Staff need to determine client's medical history, injury or ailment
- Explanations of confidential / sensitive issues are delivered
- Client and/or family are distressed / emotional

- Client is to undergo invasive procedure / treatment
- Pre-op or post-op instructions are to be given to the client
- Discharge or referral information is to be given to the client
- Managing an entire episode of care
- Client is undergoing therapy / counselling and crisis intervention

4.2.2 An *untrained Interpreter* can be engaged:

- When a client requests or agrees to use family/support person/staff **and there is no conflict of interest**
- When the client and/or family are not in an emotional / traumatised state
- When staff are confident that the use of an untrained interpreter is appropriate
- For communicating simple / non-medical related information
- In emergency situations where insufficient time to obtain a trained interpreter
- In conjunction with a trained telephone interpreter

4.2.3 Identified Risks when using untrained interpreters (especially

- children under 20 years old):
- It can be unsafe from a clinical safety perspective
- It can be culturally inappropriate
- Equity of treatment is not ensured
- Inaccurate interpretation / lower standard (lower English proficiency)
- Bias and distortion (e.g. may censor information obtained)
- No confidentiality or ethical code
- No explanation of cultural differences
- Possible misunderstanding of roles

4.3 Interpreters' Roles

Policy and guidelines have been developed for interpreters and it is important to note that their roles are threefold ONLY. Their roles are:

1. To act as a ***Conduit*** – to process the spoken language, with meaning, so that an accurate equivalent is provided in the target language, with no omissions, additions or editing. (When language is perceived to be nonsensical, interpreting needs to be literal).
2. To act as ***Clarifier*** – to interpret underlying and metaphorical meanings within the cultural context.
3. To act as ***Cultural Clarifier*** – to provide a necessary framework for the message being interpreted. The interpreter would inform either party about relevant cultural practices and expectations, ethics and etiquette when there is either apparent or potential misunderstanding, and assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding.

4.4 Clinical Safety

In the interests of clinical safety it is advisable that interpreters are not left alone with the client/family either before or after the session. (They may require a private place to wait before the session begins).

Since clients often identify strongly with the interpreter for cultural reasons, they may divulge information to the interpreter before or after the session which they do not share with the practitioner. This leaves the client vulnerable and the interpreter holding information they may not be equipped to deal with. For this reason interpreters are not to transport clients. Interpreters are expected to engage with the client/family in a professional capacity only, for the purposes of the health intervention. It is understood that interpreters may know clients from a social context, or may have had contact with them previously, given the small communities to which many CALD clients belong. If there are concerns this can be addressed in the pre-briefing session if necessary. Interpreters are expected to let practitioners know if there is a conflict of interest (see 'Code of Ethics' below).

4.5 Pre-and Post briefing and structuring sessions

When working with an interpreter it is necessary to make time for a short *pre-briefing session*, and also for a *de-briefing session* after the appointment time. This is important for both the quality of service to the client, and for the benefit of the practitioner and interpreter relationship.

4.5.1 Pre-session briefing when using an interpreter

- Introduce yourself and check ID and confirm Job Number of interpreter
- Identify a leader for the session (if more than one health professional)
- Arrange seating appropriately to facilitate communication (trained interpreters can guide you on this)
- Brief interpreter on purpose and objectives of the session
- Obtain cultural background information from the interpreter if necessary, and any cultural etiquette required
- Establish mode of interpreting - consecutive or simultaneous
- Brief on confidentiality protocol (this also includes not discussing client in the session)

4.5.2 Session structure

- Introduce interpreter and explain your and their role to client (include fact that <u>everything said in the session will be interpreted</u> i.e. no private discussions between parties)
- Ensure client of confidentiality with all parties (interpreter also bound by a Code of Ethics)
- Establish ground rules of speaking ***through*** the interpreter, not ***to*** (i.e. use 1st person singular)
- Expect the interpreter to use the 1st person singular when interpreting
- Maintain eye contact with your client (if appropriate) not the interpreter
- Direct questions / statements to the client or family, not directly to the interpreter
- Do not enter into direct conversation with the interpreter

- Do not ask the interpreter for their opinion (only for cultural clarification)
- Pause at regular intervals for the interpreter to assimilate and interpret
- Allow interpreter to interpret after every 3-5 sentences
- Allow enough time for the interpreter to convey information (it may only take you 3 words to explain but it may take more time for the interpreter to convey the information in their language)
- Use short sentences
- Check with interpreter about any cultural contexts for information provided by patient (if necessary)

4.5.3 De-briefing after the session

- Summarize session and discuss whether objectives were met (there may be language or cultural reasons if objective were not met)
- Clarify diagnostic/treatment issues where necessary
- Clarify any cultural issues, interpretation of words or concepts
- If the session involved traumatic material, check whether the interpreter has had personal material triggered (considering that many interpreters may have come through similar experiences/cultural context as the client for whom they are interpreting). If so offer some de-briefing
- Confirm follow-up procedure/appointments as appropriate
- Complete interpreter Job Information Forms as required

4.6 Perspectives from different parties:

4.6.1 A client who requires an interpreter, might experience some of the following difficulties:

- 'loss of voice' that occurs through not speaking host language
- restricted access to services because of not having enough information about the services or how to find them
- be confronted with myths, taboos and stigmas about health services, and sometimes with what feels like a hostile and unfamiliar health care system
- institutionalized racism
- racism within the practitioner-client relationship
- disempowerment within the intimacy of the practitioner-client relationship
- a loss of their own traditional interventions and illness models

4.6.2 Interpreters can experience the following difficulties:

- lack of recognized professional status
- de-valued by working with professionals who do not understand the role of the interpreter or who do not have experience working with interpreters
- double role – both professional and community member/friend
- neutrality can be difficult when a client is misrepresenting or distorting the ideology and practice of the interpreter's own culture or political affiliation
- responsibility – the interpreter often has to make important judgments when a client is communicating through them, some of which may require the astute combination of clinical insight and experience that comes with psychological and psychiatric training

- vicarious traumatization and indirect therapy – experiences can be re-activated during interpreting in therapeutic contexts. De-briefing is essential and the interpreter needs to ask for this if it is not offered by the clinician.

4.7 Accuracy in health care interpreting

Accuracy in interpreting is vital since inaccurate interpreting and information can result in misdiagnoses, and unsafe and ineffective health care. It is useful to be aware of the **7 most commonly committed errors in interpreting:**

- **Omission** (e.g. leaving out part of the sentence/explanation)
- **Addition** (adding their own words to those of the client's)
- **Substitution** (e.g. because the interpreter cannot think what is meant; or does not know an exact synonym, or concept does not exist in Target language or culture
- **Role exchange** (interpreter takes over the session)
- **Condensation** (interpreter summarizes what is said)
- **Closed/open Statements** (interpreter changes closed into open statements and vice versa)
- **Normalization** (strange statements 'normalized' for benefit of practitioner which increases possibility of misdiagnoses)

If you think one of the above errors have occurred, address this directly with the interpreter.

4.8 Expected competencies for Interpreters

- To understand and adhere to the prescribed roles (see 'Roles' above)
- To be able to do sight translation (i.e. translate documents in sessions such as consent forms, Mental Health Act etc. Written translations are not part of the role)
- To be able to do *simultaneous interpreting* (when interpreter and 2nd party speak simultaneously with the interpreter one or two sentences behind)
- To be able to do *consecutive interpreting* (when interpreter interprets after other party has finished speaking)
- To have some knowledge of mental health within their own culture/community
- To have some knowledge of the mental health system in NZ and basic terminology
- To have knowledge of, and to adhere to the Interpreters' Code of Ethics. These include the following clauses:
  - Accuracy
  - Confidentiality
  - Impartiality
  - No conflict of Interest
  - Professional courtesy
  - Declining work
  - Contractual obligations
  - Self education
  - Standard of Conduct
  - Regular peer supervision (if available)
  - Membership of a professional body (not yet available in New Zealand)

5. PROVIDING A CULTURALLY RESPONSIVE SERVICE

Responsiveness is about working with clients to provide an effective service that can meet their needs, appropriately and timeously.

Does your practice/team:

- Have *flexibility* in service delivery
- Employ *culturally competent staff*
- Have *clinical cultural staff* in the team
- Have access to *clinical cultural advice* if there is no appropriate staff member on your team
- Include *cultural education* as part of professional development
- Provide staff with *resources* about other culture's beliefs and practices
- *Look at gaps* in service provision
- *Provide information* to your clients in a form that they can understand
- *Have access to translations* in various languages on common illnesses and treatments (see Additional Resources at the end of each culture section)
- *Get feedback* from clients about your service
- *Reflect on practice* after feedback/evaluations
- Use *interpreters*

How can you achieve effectiveness?

- Collect client satisfaction data
- Record data on client outcomes
- Have staff with culturally and linguistically diverse skills to assist clients
- Use interpreter services when necessary (**Resources**)

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SECTION II
Asian Cultures




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ASIAN CULTURES


Background Information

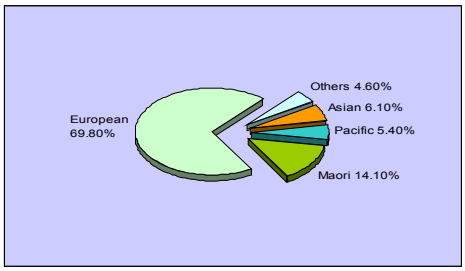
Asians are culturally an extremely diverse group and differently defined in different countries. In New Zealand the term implies an ethnic group and is increasingly used to refer to persons with origins in East and Central Asia (sometimes including Russia) with the line drawn at either Pakistan or Afghanistan. It does not include Middle Eastern peoples (Rasanathan et al, 2004).

The Asian population constitutes about 6% of the New Zealand population. About two thirds of the NZ Asian population reside within Auckland region representing the second largest group in this region at 12.5%. The largest ethnic populations are Chinese (45%), Indians (27%) and Koreans (9%).

The individual countries that the ethnic group we call 'Asians' originate from, have extreme differences in their cultures. Customs can also vary greatly even within a country and there is a danger amongst Anglo Europeans to assume that all people with Asian physical features belong to a homogenous group. Ethnicity (as defined by Ministry of Health, 2001) is more a psycho-cultural identity rather than a genetic one and involves a shared sense of common origins, distinctive history and identity, and a sense of unique collective solidarity. Therefore, seeing 'Asians' as an ethnic group can be problematic and sometimes has little meaning to the people themselves.

NB The information in this section is *generalized* and is intended to highlight some of the differences between the Asian and Western practices and norms. Please refer to sections on specific cultures for more details on each, and for issues particularly pertinent to health care.

Interesting facts about population profile



Source: Asian Public Health project Report February 2003

- > 30 Asian ethnic groups living in NZ
- It is the fastest-growing ethnic population in NZ
- Between 1991 and 2001 - the group more than doubled
- It forms 6.4% of the total population - almost 240,000
- Other Asians (apart from Chinese, Indian and Korean) in NZ include Thai, Filipino, Japanese, Sri Lankan, Malay, Cambodian, Burmese, Laotian and Vietnamese
- The 'Asian' population profile includes: NZ Born Asians, Settled Migrants (15 years or more), New Migrants, Refugees and Asylum seekers (it does not include international students and visitors/tourists)

1. COMMUNICATION TIPS

Many Asian **gestures and greetings** differ significantly from Western ones. Below is a table highlighting essentials for greetings and communication to develop good rapport and show respect. When in doubt, a smile and a slight bow of the head will always be appreciated.

In general for all the Asian cultures in this booklet:

- avoid prolonged or direct eye contact
- deem it acceptable to shake hands with men
- preferably use customary greeting with women
- assume that passivity/shyness will prohibit people asking questions of the health practitioner, or answering in the negative
- 'yes' may be ambiguous
- respect, especially to elderly is appreciated
- use formal address
- over-familiar touch is not appreciated

Culture	'hello'	Form of address	Customary gesture	Specific to culture
Chinese	*nî hâo* (mandarin) Mandarin Video Clip *néi hóu* (cantonese) Cantonese Video Clip	**title** and **second name**	nod or slight bow	silence over interruption
Korean	*an nyung haa se yo* Korean Video Clip	**title** and **second name**	bend the upper body slightly	
Indian	*namaste* (hindu) *salaam aleikum* (muslim) Indian Video Clip	**title** and **second name**	hands held in the prayer position (Hindus and Sikhs) Muslim women do **not shake hands**	
Vietnamese	*xin chao* (pronounced 'sin chow') Vietnamese Video Clip	**title** and **first names**	bow head slightly	avoid premature **familiarity** a smile not necessarily indicative of happiness
Cambodian	*choum reap sur* Cambodian Video Clip	use **title** and **first name**, or both names (***not*** second only)	place hands palms together at chest level and bow slightly (called a *Som Pas*).	very impolite not to return customary greeting **bow slightly** when walking in front of adult

				avoid praising babies/child-ren too much (bad luck)
Laotian	*sawadee* Laotian Video Clip	Use **title** and **first or second name**	place hands together as if praying and incline the head (called a *wai*) women do **not shake hands**	**respect and politeness** is critical **confiden-tiality** NB NB that **children** NOT be used as interpreters
Burmese	*mingalaba* Burmese Video Clip	• *'U'* is for addressing a male (as in Mr) • *'Daw'* to address women (as in Mrs) • *'Saya'* to address a teacher, master or traditional healer	incline head slightly	

2. TRADITIONAL FAMILY VALUES and PRACTICES

Asian	Western
○ Family is the unit of society ○ Extended family ○ Dependence and infirmity is more natural ○ Decisions made by family, tribe or community as serves the collective interest best	○ Individual is the unit ○ Nuclear family ○ Independence valued with illness needing to be eradicated ○ Decisions more often made by the individual or nuclear family

○ Shame at 'failures' ○ Honour, duty and filial love towards family ○ Rearing is oriented towards accommodation, conformity, dependence, affection ○ Religion plays an important role in symptom formation, attributions (God's will/karma) and management ○ Marriage partners often need approval from family, or are arranged by families ○ Health practitioner seen as the authority and highly respected ○ Informed consent a family decision ○ Seniors/elders respected ○ Honouring of ancestors	○ Guilt at 'failures' ○ Individual rights ○ Rearing oriented towards individuation, intellectualisation, independence, compartmentalization ○ Attribution of illness and recovery is seen to be self-determined, and psychological symptoms are attributed to weakness of personality, thinking patterns etc. ○ Marriage partners more often self chosen ○ Doubt in doctor-patient relationship ○ Informed consent an individual decision ○ Elderly viewed much as any other age group ○ Ancestors not usually a factor

3. HEALTH CARE BELIEFS AND PRACTICES

In general, health care providers should be aware that traditional practices and beliefs of most Asian migrants and refugees are **dynamic** and that they **change** considerably after resettlement. In some cases, there may be little or no reliance on traditional practices. In others, illness will result in a reverting back to more traditional practices, especially as it becomes apparent that Western medicine does not have all the answers. Younger people will often seek more modern medical treatment, but may also follow practices passed on to them by their families at the same time. There may be many 2nd and 3rd generation Asians living in New Zealand who do not hold any traditional health beliefs and practices. It is vital to make assessments on an individual basis.

In general Asians tend to be 'holistic' in their view of health where 'Life Force' balance or 'Body Balance', spiritual and supernatural factors, as well as physical / environmental, social, economic, mental, and hereditary factors are seen to be interrelated and interdependent in influencing health. People from rural areas may follow more traditional lifestyles and health treatments than people from urban areas (due to lack of knowledge about modern medicine). Economic status and education (which can vary greatly among people from the same country) are also significant factors. Cultural variations may also be marked between generations. Each of the cultural sections details the health beliefs and practices specific to that culture.

3.1 Some needs and beliefs around Illness and Health

- Asians have specific food requirements when sick (due to Body Balance beliefs, and to cultural dietary norms differing from western ones). It is best to consult families who are usually happy to advise and/or supplement hospital food when necessary

- Any surgery can be considered a big trauma and is believed to have side effects for health in general. Practitioners need to explain procedures, options and consequences to help clients make their own decisions

- Asians avoid bathing or showering when recuperating as they are afraid of getting cold. Hospital staff can offer them a self-wash if they prefer not to bath or shower

- Generally Asians have a smaller body build and believe that they have a longer recovery time. They traditionally take rest when ill and are careful not to over exert when in recovery. Concepts of rehabilitation and exercise may be new to some clients

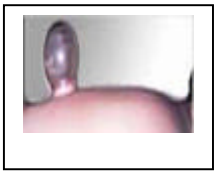
- Many Asians expect something tangible, like a prescription or an injection, as part of western treatment – this is often a standard practice in their countries of origin, and just talking can be seen as a waste of time. Interventions not meeting this expectation will need explanation in order to keep the client engaged and compliant with treatment

- There tends to be a strong resistance to continuous medication

- Western medicine is seen as useful in acute situations, and traditional treatments are used to address underlying causes and longer term health

- There is often supplementary use of alternative medicines or treatments to Western treatment

- Public image is important and visitors play a significant role in this, so patience is requested for the often large gatherings of visitors at hospital beds

3.2 Traditional treatments/practices Many of the Asian cultures presented in this manual use some or all of the practices below. Please refer to specific cultures for applicability.	
Coining or Scraping (also referred to as ***'dermabrasion'***) 	A popular treatment around 3,000 years ago in rural areas of China (still used today) where the use of an instrument such as ceramic spoons, coins, bone, etc. is used to scrape the skin. The instrument is vigorously rubbed across the skin in a prescribed manner, causing a mild dermabrasion. This practice is believed to release the excess force or "wind" from the body and hence restore balance. It is believed to re-activate the body's healing mechanism to clear any blockages from dead blood cells and debris from accident areas, and to allow proper circulation. It is used for physical discomforts such as headaches, back pain, joint pain, muscle aches, etc. (It may leave marks on the body, not to be assumed a result of physical abuse)
Cupping 	A series of small, heated 'cups' are placed on the skin, forming a vacuum that draws on the underlying soft-tissue. Different cultures have slight variations in the technique, e.g. Laotians fix a piece of cotton in the bottom of the glass, light the string and place the open mouth of the glass on the client's back. The process can be repeated a number of times in one session and used to treat backache, sprains, and soft-tissue injuries. It can leave a red circular mark
Moxibustion 	A soft combustible material (a herb or *artemesia vulgaris*) is heated and burned indirectly at specified spots on the skin (acupuncture points or energy channels). (This may also leave marks on the body)
Pinching	Similar to coining and cupping, by pinching and pulling up the skin, the unwanted 'force' is allowed to leave the body (may also leave marks)
Steaming	A mixture of medicinal herbs is boiled, the steam is inhaled, and the body bathed
Balming	Various medicated oils or balms are rubbed over the skin
Acupuncture	Specialized practitioners insert thin steel needles into specific locations known as vital-energy points. Each of these points has specific therapeutic effects on the corresponding organs
Acupressure or Massage	Fingers (or a blunt tool) are pressed at the same points as with acupuncture, and together with massage, stimulate these points to maximize their therapeutic effects. It is used to relieve a

	variety of symptoms and pain
Herbs	Various medicinal herbs are boiled in water in specific proportions or mixed with "wine" (often vodka) and consumed, for example, in the postpartum, to restore balance
Patent Medicines	These powdered medicines come packaged usually from Thailand or China and are mixed or boiled with water and taken for prescribed ailments
Qi Qong *(Chi Kung)* 	The name means 'to cultivate energy'. It is an integration of physical postures, breathing techniques and mental focus and can be classified as marital arts, medical or spiritual practice. It includes 'soft' styles such as *Tai Chi*, or energetic styles such as *Kung Fu*
Ayurvedic Medicine 	Restores and maintains the balance of the 3 elements in the body (aspects of the Life Force) referred to as *doshas: pitta, vatta,* and *kapha*. The rhythms of the pulse as well as clinical history and observation are used in diagnosis. Herbs, oils, dietary management, detoxification, and some massage regimes are included in treatment. See Indian Culture section

3.3. Practices and Beliefs relevant for managing those who are unwell, disabled or dying	
Asian	Western
Diet/nutrition when unwell For all of the Asian cultures (included in this manual) food plays an important part of health care. Food values revolve largely around the principle of maintaining the balance of various elements in the body (referred to differently by different cultures), and hold different qualities which are believed to influence this delicate balance.	
○ Preference for hot meals and drinks when ill ○ Warm water preferred to take medicine ○ Rice and noodle cultures ○ May not like cold dairy products ○ "Hot" foods are avoided, e.g. oil, butter, cheese, protein rich foods, potatoes, etc. when ill ○ Foods with 'hot'/'cold' qualities preferred for certain health conditions ○ Families may prepare special foods – traditional recipes/ foods for particular ailments, e.g. ginger for new mothers ○ Preference for home made food for babies ○ Preference for food by mouth, suspicious of the drip ○ Some meats or all meats are excluded from diets for practising Buddhists, Hindus and Muslims	○ Can tolerate both hot and cold with cold drinks and water preferred ○ Tap water usually used to take medicine ○ Bread culture ○ Accept dairy products, hot or cold ○ Less restrictions on food groups ○ Not a factor ○ Uncommon for families to supplement or replace hospital diet ○ Hospital food usually meets western requirements ○ Drip acceptable ○ Less restrictions on meat, although more people eating meat-free diets than previously
Disabilities	
○ There is shame and guilt around physical and mental disability ○ Due to the shame, families may often not want to reveal the difficulties to a health professional. It may take some consistent encouragement to help them open up and make use of facilities and rehabilitation plans ○ There is a strong sense of duty towards those with disabilities in the family	○ More openness and acceptance ○ Seek professional help ○ Community care more accepted

(particularly caring and loving) ○ Some cultures see disabilities as a curse and may hide themselves or their family member away from friends / community to avoid ostracization ○ Some families may refuse to send the child away from home ○ New Language and culture can add to the confusion for the disabled child/ person	for mental and physical disabilities ○ More openness and acceptance ○ Will more often accept community care and assistance ○ Not a factor
Death and Dying	
○ People may choose to refrain from telling the family member that they are dying especially if they are very young or old. The belief is that the client may lose hope / will to live. End-of-life issues need to be discussed with the family first	○ Usually the family is informed
○ Those who are aware of their prognosis may hide it from their families so that they do not become distressed, particularly if a relative is pregnant or ill themselves	○ Will usually want help and support from family, with expectation that individual family members can manage own grief and anxiety
○ Some have an almost mystical faith in western medicine and believe that hospital care will rescue even at the last moment	○ Some doubt and mistrust of mainstream medicine and many will seek their own information or alternative interventions
○ Pain is generally endured with stoicism and with the degree of expression of pain varying considerably within cultures. Most of the Buddhist based cultures value dying with mindfulness and equanimity over being in a drug altered state	○ Preference for pain control
○ It is important in most of the cultures for the family to be with a dying member, even when in an unconscious state. The eldest son or closest family member should be notified to accompany the person at the last moment	○ Presence at death often determined by convenience/possibility rather than seen as a requirement
○ Some prefer the person to die at home (e.g. Laotians) and will want to take the body back if they had been previously hospitalised, whilst others believe that it a misfortune to bring the person's body back home	○ Varies with condition

4. HEALTH RISKS
There are a number of health risks reported for people who arrive as refugees from specific Asian countries. These are listed under the relevant cultural sections. In addition, awareness of the general risks below will be helpful when providing healthcare to migrated Asians.

- After migration Asian people may have an increased risk for cardiovascular disease and diabetes due to lifestyle changes, physical activity and changes in diet
- Asian immigrants have higher than average rates of communicable/infectious diseases, in particular TB
- Asian people have statistically higher rates of traffic injuries
- The top 6 potentially avoidable deaths in the Auckland region are heart disease, motor vehicle crashes, stroke, lung cancer, diabetes and suicide
- The 6 leading causes of preventable hospitalisations are angina, respiratory infections, cellulitis, gastroenteritis, road injuries and asthma

5. WOMEN'S HEALTH (see cultural sections)
- Pregnancy is a highly valued and expected stage in a woman's life
- A good mental state during pregnancy is considered important as the state will be transferred to the baby and affect its future health and wellbeing
- There are a number of taboos during pregnancy to ensure a healthy baby (these include foods and activities)
- There are also specific taboos after delivery to ensure that the mother has no future health problems, e.g. no showering or washing hair for up to 30 days, need to keep mother and the baby warm
- Post-partum practices are very different to Westerners with new mothers taking plenty of rest in the first month, traditionally staying in bed for 1 week up to 100 days (where possible) and keeping themselves and the baby warm
- Traditional Birth Attendants are available in some Asian cultures and play the role of midwife and will often deliver the baby
- Food plays an important part of healthcare during pregnancy and post-partum period

6. YOUTH HEALTH
Newborn & Child Health
In some Asian populations breastfeeding is lacking due to:
- the belief that bottle-feeding is modern and superior
- misinformation about breastfeeding and infant feeding practices
- concerns about privacy and modesty
- communication difficulties with health professionals
- lack of family support
- newborns tend to be kept warm at all times, even in summer
- babies are kept close to stop excessive crying, and may share a room with parents until at least a year old
- children are usually highly valued and seen as an asset to the family, so childhood illness causes immediate anxiety

Adolescent Health
- Limited or no sexual education amongst new immigrants (particularly the foreign student) is a risk factor for unwanted pregnancy and high abortion rates. 36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)

- Low levels of physical activity are reported for adolescent Asian New Zealanders, especially amongst females
- High levels of depression, anxiety and eating disorders are reported for Asian adolescents in New Zealand
- Many of the young Asians residing in New Zealand are students with families abroad. Difficulties they commonly face include:
  - loneliness
  - homesickness
  - communication
  - prejudice from others
  - financial difficulties
  - academic performance pressures from family back home
  - cultural shock

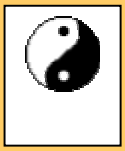
- Others face:
  - status challenges in the family with role-reversals
  - family conflict over values as the younger ones acculturate
  - health risks due to changes in diet and lifestyle
  - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana and other substance abuse) as they become more acculturated

7. SPIRITUALITY

For most Asian cultures, religion plays a central role in life and provides a framework for understanding all aspects of living, including illness and health. It is important to acknowledge this role with clients and to have some understanding of the implications of the belief systems.

For some cultures the beliefs and practices are a composite of a number of traditions. Such diversity in spiritual beliefs requires that assessment precede implementation of any type of spiritual care during illness. The most common of the faiths are:

FAITH	**DESCRIPTION**	**COUNTRY** (where significant numbers practice)
Confucianism 	Confucianism originated in China in the 6th century BC as the major religion or philosophical system. Teachings emphasize devotion and obedience to parents, family and ancestors, honesty, righteousness and benevolence. Also central to Confucianism is ethicality, loyalty to the state and the maintenance of justice and peace. There are 6 different schools **Implications:** given the authoritative and hierarchical structures, compliance may be affected by the head-of-the-family's acceptance of diagnosis and treatment plans	*China* *Korea* *Vietnam*

Taoism 	Taoism originated in China in the 6th century BC as a philosophical/religious system based on the doctrines of Lao-tse. Taoism advocates harmony, simplicity, and selflessness. The *Tao* (Life Force or *path*) is seen as the first-cause of the universe and the goal of the individual is to harmonize with this force. The concept of *Yin-Yang* has origins in this system **Implications:** the Life Force (Tao) will be restored to balance (and thereby the illness resolved) if the relative principles are employed/adhered to. Western medicine **can** be seen to interfere with this system	*China* *Korea* *Vietnam*
Buddhism 	Buddhism was also founded in the 6th century BC, and has become a transcultural religious and philosophical system based on the teachings of Gautama Siddhartha, the Buddha. There are a number of branches of Buddhism – namely Theravada (practiced in Burma, Cambodia and also Vietnam), Mahayana which embraces the various traditions within China, Korea, and Japan, and Vajrayana, which is associated primarily with Tibet. Common to all forms of Buddhism is the belief that life involves suffering, that desire and attachment create the suffering, and that this can cease if specific principles are followed. These principles describe ethical, humanitarian and disciplined practices. Central to Buddhist world view is the concept of *Karma* (the total sum of good and bad deeds over lifetimes) which holds that all actions have consequences and these are seen to influence current circumstances **Implications:** ill health may be attributed by many Buddhists to *Karma*. Some may passively accept this as their fate and seek little treatment, others may actively seek to address the illness by praying, performing rituals or meditating in an attempt to alleviate the problem. The belief that life involves suffering might also cause some practitioners to delay or avoid seeking treatment.	*China* *Korea* *India* *Cambodia* *Vietnam* *Laos* *Burma*

Shamanism /animism 	is the belief in positive and negative entities/spirits which affect humans. A Shaman, i.e. religious/spiritual practitioner, can traverse at will, between the worlds of the spirits and the consensus-reality world and influence the entities and the effects they have on humans. It is believed that the Shaman can not only avert bad luck, but also be instrumental in resolving tensions and conflicts between the living and the dead. Integral to this belief is that all aspects of nature have spirit, (referred to as animism). The influence of ancestors is also central to this practice. The correct burial rituals following the death of a relative are thought to ensure a good fortune for the family. Some Asians may maintain shrines or alters in their homes where they are able to honour their ancestors in the traditional ways. Maintaining a good relationship with the environment and its inhabitants is believed to be advisable **Implications:** the belief that external forces are responsible for ill health and that appeasing the forces either through their own actions, or with the help of a shaman, will resolve the problem. Some practitioners may use this method before seeking medical intervention	*China* *Korea* *Cambodia (animism)* *Laos (Phram-animism)* *Burma (Nat-animism)* *Vietnam*
Christianity 	was introduced into the Asian countries presented in this resource at different times, and has varying degrees of influence over those cultures and their spiritual practices. Today many Asians practice Christianity, and with some of the other noted faiths influencing their world views	*China, Korea* *India,* *Vietnam (Catholicism)* *Cambodia (Evangelist and Mormon)* *Burma (Catholic, Baptist, Protestant)*
Hinduism 	is practiced by 80% of people in India. The basis of Hinduism is the belief in the unity of everything (the totality is called *Brahman*), and the goal is freedom from endless reincarnation (*samsara)*, with *karma* as central to the cycle. The caste system is another principle concept of Hinduism and divides society into four social classes. The highest class is called the priest class, or the Brahmans. The lowest class is referred to as the laborer class, or Sudras. One inherits class at birth, based on one's karma, or tally of good and bad deeds from previous lives.	*India*

	Implications: for some Hindus there is a fateful attitude to health based on beliefs about karma, and treatment may be delayed or avoided. Others will accept that whilst the illness has karmic origins, treatment can be sought to resolve the problem	
Islam 	is practiced by a small percentage of Asians in the different countries covered in this manual with the highest numbers in India. The cornerstone of Islamic faith, the 'Five Pillars' are the obligations which are required of every Muslim. They are: *shahadah* (statement of faith), *salat* (prayers), *zakat* (alms), *sawm* (fasting), and *hajj* (pilgrimage). The prophet and teacher within Islam is Muhammed and the holy book, the Qur'an lays out all the religious lore. Muslims believe that paradise is available to all who believe in God, 'Allah' and who do good. Unlike Buddhists and Hindus they believe that this world is their one and only chance to earn the gift of paradise. Practising Muslims with ill health may be challenged to meet the obligations of the 5 daily prayers and fasting and may need assistance to meet these **Implications:** that ill health may be God's will. Some Muslims will passively accept this whilst others will seek treatment	*India (and small numbers in other Asian countries)*
Sikhism 	is a 500 year old religion and practiced by 20 million Sikhs living in India. *Guru Granth Sahib* is the holy book. The religion combines the Hindu concept of *karma* (righteous deeds) with the Muslim concept of monotheism and stresses loving devotion to God, universal principles of morality, truth and honest living, and full equality of mankind irrespective of race, caste, creed or sex. Many devout *Sikh* men wear the *kirpan* (a traditional small sword) which has sacred religious symbolism of power and freedom of spirit, and is a reminder to Sikhs to fight injustice and oppression, but is not to be used as an instrument of violence. The *kirpan* is one of five highly emotive articles of faith (the 5 K's) all of which need sensitive handling when they are affected by medical treatments and care. The 5 K's are: *kes* (unshorn hair, as a sign of a saint), *kangha* (a small comb to keep the hair tidy), *kachhehara* (knee-length underpants symbolic of propriety), *kara* (literally a link, a steel bangle worn on the right wrist, as a reminder of the bond between a Sikh and the	*India*

	Guru, and for the need for restraint) and the *kirpan*. Hospitals and clinics may need to provide guidelines to ensure that Sikh clients are allowed to wear the *kirpan* without compromising health and safety standards, and ensure that the healthcare staff are informed so that the issue can be sensitively and appropriately dealt with **Implications:** although the belief in God's Will or *Karma* may play a part in perspectives on health, most Sikhs will readily seek treatment, whether it be allopathic or an alternative. Some may use prayer and practice to find strength during ill health.	

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CHINESE CULTURE

Chinese longevity symbol

Background Information

The Chinese are guardians of a magnificent tapestry of legacies resulting in an extensively diverse and dynamic culture. They are one of the most heterogeneous groups of people and describing their culture is complex and a challenging task necessarily full of generalizations. Their extensive origins, varying countries of residence (even within Southeast Asia), numerous dialects (more than a dozen in mainland China) and variety of traditions and beliefs make categorization very difficult. People with the same dialects may have different practices and beliefs depending on where they reside, and upon the local influences; some ethnicities classified as Chinese do not consider themselves Chinese (e.g. some Tibetans). Many Chinese whose families migrated some generations before may not have beliefs or practices much different to the host nations of their resettlement countries.

The *Han* Chinese constitute 95% of China's population (and are also the largest ethnic group in the world). They are in themselves a diversely heterogeneous group. The remaining 5% of China's population are made up of 55 other ethnic groups.

Chinese settlement has taken place in Australia and New Zealand from the mid 19th century, with most people coming from southeast China (Guandong). Wars, floods, famine and poverty were initial reasons for migrating, with more recent immigrants fleeing for political freedom after incidents such as the Tiananmen Square event. Others are well-educated people and are seeking business, lifestyle and educational opportunities. Over the past 20 years, Cantonese speaking Chinese have arrived from Malaysia, Singapore, Hong Kong, Vietnam and elsewhere in Indochina. More recent arrivals originating from the People's Republic of China (PRC) have often spent time in other countries before coming to New Zealand and bring with them their own culture, a new culture, and have to merge with yet a third culture.

The following information is to be regarded as extremely general.

1. COMMUNICATION

Greetings video clip

	Mandarin	**Cantonese**
Welcome	HUĀN YÍNG	FOON YING
Hello	NÎ HÂO	NÉI HÓU

Main language

The two main languages are **Mandarin** (*Kwoh Yue/Poo Toon Hwa*) and **Cantonese** (*Kongtongwah*). Most people from the PRC (People's Republic of China) and Taiwan would speak or understand Mandarin while most Chinese people from South East Asia and Hong Kong, and also older migrants from Grungdong are likely to speak Cantonese. There are 7 major groups of dialects with Mandarin the largest. The non-Mandarin is also referred to as the Southern dialects. Other major dialects include the *Hakka, Hokkien, or Techeow, Shanghainese.*

Gestures and interaction

- Address clients using a **title and surname** (premature familiarity is considered disrespectful)
- **Shaking hands** with men is an acceptable greeting
- Greet women with a **smile** and a 'hello' or traditional greeting to avoid any offense as not all women are comfortable with hand shaking
- A **nod or slight bow** is also customary
- **Avoiding eye contact**, shyness and passivity are cultural norms
- Many Chinese will avoid **saying 'no'** as it is considered impolite
- **Silence** (listening) is a sign of politeness; interrupting is considered rude
- To **summon** someone using your fingers is considered extremely rude (hands palm facing downwards and moving fingers together in a scratching motion is acceptable)
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

Special concepts

- **'Saving Face'** is a strong principle and will be used over confrontation or questioning of those in authority. It is also important not to put a person in a position where they will be seen to 'lose face'.

2. TRADITIONAL FAMILY VALUES

- Traditional families are extended with more recent trends tending towards nuclear and 'astronaut' families (where the father of the migrant family spends periods of time in the country of origin for business and returns to the family when time permits)
- Traditionally (and currently still common) sons are valued over daughters
- There is a strong sense of filial duty
- Fathers and sons are heads of household and decision makers

- Eldest sons inherit family leadership and wealth and will look after the parents when they are older
- Younger sons are expected to leave the home and live close to the parents
- Traditionaly women were expected to stay at home and raise the family although this is changing with the younger generations

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

1**. Life Force (Chi) and Body balance**
It is believed that health is based on keeping the body elements in 'balance' and that certain kinds of diet, lifestyle, treatments and external factors can influence this balance. Maintaining the balance of the Life Force or Chi is essential for good health.

- **Yin-Yang** (a well-known but somewhat misunderstood principle in the west) is a dynamic and complementary system consisting of 2 forces that need to be kept in balance. Each contains an element of the other and when the one reaches its extreme it becomes the other
- Yin in excess gives way to "cold" illnesses, e.g. depression, hypo activity, hypothermia, abdominal cramps and indigestion
- Yang in excess would underlie conditions such as hyperactivity, hyperthermia, stroke and seizures
- Treatment of hot/cold illnesses is through the use of the opposite force to achieve balance. This can be done by regulating body temperature, or through food and other means. (e.g. the common cold is treated with hot soup made from bean sprouts

2. **Spiritual** factors where moral retribution by ancestors, or deities for misdeeds and negligence, is experienced (including fate or karma)
3**. Cosmic disharmony** or astrological factors such as a person's combination of year, month, day and time of birth, and whether these may clash with those of a family member
4. **Supernatural** forces where there is an interference from evil entities such as malevolent ghosts and spirits or impersonal evil forces
5. Poor **Feng Shui** (the impact of the natural and built environment on the fortune and wellbeing of inhabitants)
6. **Superstitions** – many things can bring bad luck, (e.g. number 4 has similar connotations as number 13 for western cultures because it sounds like death in Chinese, Korean & Japanese languages)
7. The **Western** concept of disease causation is accepted by many and may co-exist along with any of the other attributions of illness

3.2 Common Traditional treatments and practices

1.Traditional Chinese Medicine (TCM) and Chinese practices

Click on headings below for details

1. **Patent medicines**
2. **Acupuncture**
3. **Acupressure or Massage**
4. **Coining or Scraping**
5. **Cupping**
6. **Moxibustion**
7. **Herbal remedies** and dietary therapy

8. Use of shamans
9. Feng Shui
10. **Qi Qong, Tai Chi**

2. Western medicine

This is commonly practised alongside TCM in China and most Southeast Asian countries.

3.3 Important factors for Health Practitioners to know when treating Chinese clients:

1. The client's understanding of the cause and meaning of their illness is an important factor and their perception of the practitioner's interest in this is likely to influence trust and compliance
2. Clients may integrate traditional medicine practice with western treatment, this needs investigation for drug interactions and conflictual goals by the practitioner
3. Same gender practitioners are preferred (especially by women)
4. Open discussion about sexuality is often considered taboo
5. Many people expect a tangible form of treatment, e.g. a prescription. If one is not given, an explanation will be needed
6. It is expected that family members will be involved in consultations about treatment
7. The 'sick role' is conventionally adopted by a family member who is ill and health practitioners may be seen as uncaring if they push for independent behaviours from the client too soon. The benefits of rehabilitation programmes may need to be explained
8. There is a strong tendency to somatise social and psychological problems
9. Some traditional techniques (e.g. coining, cupping, moxibustion) may leave marks on the body and providers need to investigate these before assuming abuse)
10. It is necessary to identify the dialect in order to find an appropriate interpreter
11. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times

3.4 Diet and Nutrition

- Foods are considered to have the qualities of either 'hot' or 'cold' and diet is balanced according to needs around these elements (health needs, climatic conditions, taste etc.)
- Daily meals generally consist of four food groups: grains, vegetables, fruit, and meat
- Because of a general lactose intolerance, Chinese do not consume large amounts of dairy products; soymilk and tofu are the normal substitute

- Rice and noodles are the staple. Too much bread and pasta in hospitals can cause distress to clients
- A common food, and much loved comfort food for most Chinese, is the rice porridge which can be eaten at almost any meal. For clients who find difficulty with western hospital food, families are usually happy to supplement foods and could be requested to provide this porridge. They can also advise re cultural dietary needs and preferences
- Herbs and special ingredient soups are used to replenish energy levels when a person is feeling unwell, and to maintain health (called "gin bou," in the North and "bo sheng" in the South). These may need to be prepared by skilled home cooks
- When in hospital, meals may remain untouched if dietary needs cannot be met

3.5 Stigmas

Mental illness and disabilities are regarded as stigmas

3.6 Death and dying

- Traditional Chinese bereavement customs are based on the blend of four primary religions/practices (Buddhism, Taoism, Shamanism and Confucianism). Funeral rites and burial customs are taken very seriously as improper arrangements are believed to have dire consequences for the family of the deceased
- Traditionally a younger person cannot be shown respect by an older person so young children and babies have no funeral rites and are buried in silence, a young man may not be taken home but left in a funeral parlour before the burial
- The third day following the funeral and burial is ceremonially significant, and ceremonies are also held on the 21st, 35th, 49th and 60th days following the death
- Great respect is shown to Chinese dead throughout the lifetimes of surviving relatives, both in memory and in ceremony over the years

4. HEALTH RISKS

- After migration Asian people may have an increased risk for cardiovascular disease and diabetes due to lifestyle changes, physical activity and changes in diet
- Asian immigrants have higher than average rates of communicable infectious diseases, in particular TB
- In New Zealand it is reported that Asian people have statistically higher rates of traffic injuries
- In addition, Kemp and Rasbridge (2004) list the following as risks for new immigrants from China:

    - Amebiasis
    - Dengue Fever
    - Filariasis
    - Gnathostomiasis
    - Hemorrhagic fever with renal syndrome
    - Hepatitis
    - Histoplasmosis

- Hookworm
- Leprosy
- Malaria
- Schistosomiasis
- Strongylodiasis
- Trachoma
- Trematodes (several varieties, e.g., blood, intestine, liver)
- Tuberculosis

5. WOMEN'S HEALTH

- Women are encouraged to rest, avoid heavy work and eat well during pregnancy
- Superstition often plays an important part of practices
- 'Cold' foods are avoided during the different phases of pregnancy for fear of miscarriages
- Chinese women usually want to eat before labour to enhance their energy levels for the process. The western practice of avoiding food for fear of vomiting before labour has been a difficulty for Chinese women, including the fact that they are often offered cold water or ice to suck on when preferring warm water to drink
- Traditionally men do not play a role in the delivery process although this is changing with modern younger men
- Self-care immediately after childbirth is seen as crucial in restoring health. The period (termed the "sitting period") may last from one to three months
- During the 'sitting period' certain practices are observed such as no bathing, hair washing or exposure to cold temperatures, food etc. This often presents a difficulty as many cold foods are offered during hospital stays
- More western conventional pre- and post-natal care is increasingly accepted as families become acculturated

6. YOUTH HEALTH

Adolescent Health

- Limited or no sexual education amongst new immigrants (particularly the foreign student) is a risk factor for unwanted pregnancy and high abortion rates – 36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)
- Many of the young Asians residing in New Zealand are students with families abroad. Difficulties they commonly face include:
  - loneliness
  - homesickness
  - communication
  - prejudice from others
  - finance
  - academic performance pressures from family back home
  - cultural shock
- Others face:
  - status challenges in the family with role-reversals
  - family conflict over values as the younger ones acculturate
  - health risks due to changes in diet and lifestyle
  - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as they become more acculturated

- some young Chinese New Zealanders report not feeling safe at school, and for some this leads to absenteeism

7. SPECIAL EVENTS

Chinese New Year is a special occasion, and in particular being with family on the Lunar New Year's Eve. The dates are determined by the Chinese Lunar Calendar and it usually falls around January to February. There is a reluctance to spend this time in hospital or to have diagnostic tests during the celebrations and so these are often postponed to the 15th day of the Lunar New Year (when the period ends). Amongst traditional superstitions surrounding this time there are a number of subjects which are considered inauspicious to talk about and death is included in the list.

8. SPIRITUALITY

- **Buddhism** is the primary religion
- **Christianity** has increasing numbers in China
- The major philosophical systems that have great influence on the culture and are blended with religion are:
    - **Confucianism**
    - **Taoism**
- **Shamanism** is also still practiced by some

Many people may practice a blend of any of the above, or have their world view at least influenced by a number of systems or faiths.

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Resources

1. The http://spiral.tufts.edu website has Patient Information by language with many resources in Chinese

Hanbok, traditional dress

Korean CULTURE

Background information

Koreans have suffered a long history of political conflict. The war between the northern and southern regimes (between 1949–1953) was particularly debilitating leaving the North of Korea communist, poor and isolated. In contrast the South has a burgeoning economy. The Demilitarized Zone (DMZ), the symbol of the ideological dispute between North and South Korea, is a poignant reminder of the war and winds 155 miles across the Korean Peninsula. It highlights the fact that the war did not actually end and that an uneasy truce continues between the two zones.

Koreans have been immigrating, in large numbers to the US since before the war, and in New Zealand they constitute the second highest numbers in the population of Asian immigrants. Many migrate for improved lifestyles, education opportunities, and healthcare facilities.

Both China and Japan have had significant impact on the Korean culture (and vice versa) and as a result there are traditions and values recognizable from both of these cultures.

Photos: 1st author's own, 2nd and 3rd Wikipedia, Korean Culture. (Gnu Free Licence, and Creative Commons Licence, respectively).

1. COMMUNICATION

Greetings video clip

- Welcome *an nyung haa se yo/euh suh o se yo*
- Hello *an nyung haa se yo*
- Good morning *an nyung haa se yo*
- Good afternoon *an nyung haa se yo*

Main language

Han-gul is the main language. There are several dialects of *Han-gul*, but they are similar enough that the speakers have little trouble understanding each other**.**

Koreans tend to be reticent about using a new language until they feel able to express themselves adequately and so they may be relatively more reserved in interactions than some other immigrants.

Gestures and interaction

- The appropriate greeting for Koreans is to bend the upper body slightly (unlike the Japanese, Koreans bow sparingly)
- **Shaking hands** amongst men is acceptable
- Use **surnames/second names** and titles, premature familiarity is unacceptable and considered disrespecful
- Too much **eye contact** is avoided amongst new acquaintances
- Over–familiar **touch** is poorly tolerated although accepted as necessary in health care ('therapeutic touch' is less likely to be accepted)
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

Special concepts

- **"*Silence is golden*"** Confucian principle which discourages small talk
- ***Harmony and balance*** are fundamental ideals of Korean culture and beliefs
- ***'Kibun'*** is a concept with no direct translation in English. It refers to mood, feelings and state of mind. Koreans value maintaining equanimity of their *Kibun* and it is considered the responsibility of people interacting with a person to assess their *Kibun* so that they can best meet needs and communicate effectively. Making the assessment of another's *Kibun* is called *nunchi*. An example of *Kibun* being disturbed is when someone communicates rudely to another, or shouts

2. FAMILY VALUES

- There is a strong sense of filial duty
- Fathers and sons are heads of household and decision makers
- Eldest sons inherit family leadership and wealth and will look after the parents
- Younger sons are expected to leave the home and live close by
- Traditionally women were expected to stay at home and raise the family, although today they hold many roles within society

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

1. Fate/karma may be seen as a reason for ill health. Korean Buddhism (from the Mahayana tradition) has greatly influenced Korean culture and many beliefs around health are based on Buddhist principles resulting in sickness and death being seen as part of life

2. Disharmony in the natural forces (e.g. *Um* and *Yang*), or the Life-force of the body, called *Kior Chi. Um* gives way to 'cold' illnesses such as depression, hyoactivity, hypothermia, abdominal cramps and indigestion, while *Yang* imbalances will result in hyperthermia, hyperactivity, stroke and seizures. Treatment is through the use of the opposite force to achieve balance and so foods are prescribed accordingly

3. The **Western** concept of disease causation is accepted by many Koreans and may co-exist along with other attributions of illness

3.2 Traditional treatments and health practices

1. **Acupuncture**
2. **Acupressure or Massage**
3. **Cupping**
4. **Moxibustion**
5. **Herbal remedies** and **dietary therapy**
   Various medicinal herbs are boiled in water in specific proportions or mixed with "wine" and consumed, for example, in the postpartum, to restore balance. Ginseng is a commonly used herb, and this and other herbs may be added to foods as well as taken medicinally. Medicines may be received from a 'Hanui', a traditional herbal doctor and clients may be reluctant to discontinue these
6. **Shamans** (although used more rarely nowadays) are consulted as a last resort and they will practice *hanyak* which is the use of herbal medicine to create personal harmony
7. **Traditional medical treatment** involves physical assessment as well as observation of behaviour and thereafter the use of metaphysical and cosmological treatments. Medical treatments tend to be more curative and there is less attention given to preventative medicine. This is currently changing as health promotion is more encouraged. Many traditional medicines are available through Asian grocery stores and by Chinese medical practitioners in New Zealand

3.3 Important factors for Health Practitioners to know when treating Korean clients:

1. It is useful to encourage health promotion because resettled Koreans are reported to have typically focused on curative rather than preventative measures
2. The family is usually involved in treatment decisions. When there is a terminal illness, it is best to consult the client about how much s/he wants to know about the diagnosis and prognosis, and who else in the family s/he wants to be involved in decision making. The process of Informed Consent may be new to many families and this process will need to be explained. If the client does not want to make any decisions for themselves, they will need to have a Durable Power of Attorney
3. The family usually wishes to care for the member (even if hospitalized) for both acute and chronic illnesses
4. Alternative forms of healing (see 3.2 above) might be used in conjunction with western medicine, especially traditional herbs. Potential drug interactions may need to be considered
5. Some traditional techniques (e.g. cupping, moxibustion) may leaves marks on the body and providers need to investigate these before assuming abuse
6. Migrated Koreans do not traditionally use social workers since they do not have such roles in Korea. Clients can be encouraged to use personal resources such as the church as well as the use of the social worker when appropriate, although their role will need explaining.
7. It is useful to provide treatment instructions in varying forms such as spoken word, written and pictorial. If possible, written instructions could be provided in Korean (through the interpreter) or demonstrations for treatments can be used
8. Some Asians believe that western medicine is too strong for them and some may alter the dosage, both in quantity and in frequency. Explanations about the dosage being customized for the client may need to be given
9. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times

3.4 Diet and Nutrition

For traditional Koreans the typical diet is mostly vegetables, with rice the main staple along with vegetables and small amounts of meat. It is reported that the sugar, fat and caloric intake are usually lower than other groups in the US and this may also apply to those living in New Zealand. Ginseng is a herb that is commonly added to foods and drinks and may have interactional effects with prescribed medications.

3.5 Stigmas

- Children with disabilities are seen as punishment on parents from ancestors
- Physical problems are more readily accepted than mental illness which is seen as stigmatizing and threatening. This may result in psychological and social problems being presented somatically
- *Hwabyung* is a Korean culture-bound illness, common amongst women and develops as a result of suppressed anger or emotions (these usually stem from conflicts within the family). The client would likely present with symptoms of headache, decreased appetite, insomnia, and decreased energy, anxiety, irritability and flushing). The illness is seen as fate and treatment is focused on management of the symptoms only
- Homosexuality is not tolerated and would likely remain repressed so as to avoid community (and family) ostracization

3.6 Death and dying

- Bad health news, especially terminal illness is often shielded from the family member (see **3.3 Important factors for Health Practitioners to know when treating Korean clients: 2.**)
- Organ donation is uncommon
- Much of the patient's care is given by the family while hospitalized
- Pain responses vary considerably (family can provide a lot of information about how the client copes with illness and pain) but there is a tendency amongst Koreans to be stoic and to contain emotions. It is best to offer pain medication rather than to ask questions about degrees of pain
- Traditional beliefs used to value dying at home. If the person died in hospital it was considered a misfortune to bring the body back home. However, although few Koreans hold this belief nowadays, it is worth checking with the family
- For those who die at home the body must be kept for at least a few hours for viewing and showing respect
- Cremation is common for those without relatives
- Respect for the dead is shown by an outward display of emotion – crying and moaning rituals
- The eldest son must remain near the body and show his emotions

4. HEALTH RISKS (these are outlined on the Charles Kemp website for Koreans living in the US, and some of these may apply to Korean immigrants in New Zealand)

- anaemia
- osteoporosis and decreased calcium intake
- spontaneous hypoglycaemia - insulin autoimmune syndrome
- parasitic infections from raw foods
- liver cancer and hepatitis
- diverticulosis or inflammatory bowel disease
- peptic ulcer disease
- CVA
- hypertension
- hypercholesterolemia for Korean-Americans eating high fat American diets leading to obesity, coronary artery disease and other cardiovascular disease
- circulatory effects from alcohol consumption including facial flushing, palpitations, and other unpleasant effects

- vitamins A and C deficiencies
- protein deficiency is common
- gum and oral disease
- lung disease and TB
- alcoholism and tobacco abuse

5. WOMEN'S HEALTH

Pregnancy and Childbearing Practices

- With a high birth rate (possibly due to the valuing of boys over girls resulting in many pregnancies for families not successful in producing boys) the South Korean government used to require that households limit their number of pregnancies to two children. This was promoted through the use of contraception and abortion which is legal, practiced and accepted in Korea. However, since a significant drop in the birth rate over the last 20 – 30 years Koreans are encouraged to have more children. As a result of the old law there may be some Koreans with a history of abortion/s
- It is reported that Korean women living in the US tend to underutilize mammography and clinical breast examinations, and also cervical smears
- Women begin pregnancy with the *Tae Mong,* a dream about the conception of the child, usually reported by an elder in the family
- During pregnancy women are taught to avoid certain foods and smoking, and introversion is common during this time
- The woman focuses on *Tae Kyo* during pregnancy which involves avoiding unpleasant thoughts and focusing on what is good and beautiful. This practice is believed to be the education of the foetus and to influence how it will be in the future
- Women usually give birth in the supine position much like the Western methods
- Traditionally the placenta was saved after the birth and then burned and the ashes kept. During periods of illness, the mother would use the ashen powder in a liquid as a healing potion. This tradition was commericialized by some companies who would keep the placenta for the family. This tradition is no longer common in Korea, although there may be some families who would wish to follow this in some form in New Zealand
- Traditionally the first meal the mother has is seaweed soup
- For 30-40 days after birth, tradition requires that the mother does not return to work while she recuperates and "the body is made whole again"
- 'Cold' situations are avoided e.g. not putting feet or hands into cold water or going outside, and partial baths are given
- After her period of rest, mother will carry her baby 'piggyback' so that – their hearts are aligned

6. YOUTH HEALTH

Social Values

- Children tend to be indulged until school age, after which proper behaviour is required as undisciplined children are seen as a disgrace on the family. Boys and girls are separated before puberty. Overall, children are to be 'seen and not heard'

Issues reported for 'Asian' Youth in New Zealand, in general:

Newborn & Child Health

- Newborns tend to be kept warm at all times, even in summer
- Babies are kept close to stop excessive crying, and may share a room with parents until at least a year old
- Children are usually highly valued and seen as an asset to the family, so childhood illness causes immediate anxiety

Adolescent Health

- In Korea children generally receive minimal teaching about sexual practices with the only formal instruction concerning the menstrual cycle, which is taught to the females only. As a result, there is limited knowledge about sexual practices amongst new immigrants (particularly the foreign student) leaving them at risk for unwanted pregnancy and high abortion rates. The 2001 Census in New Zealand reported that 36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)
- Low levels of physical activity are reported for adolescent Asian New Zealanders, especially amongst females
- Many of the young Asians residing in New Zealand are **students** with families abroad. Difficulties they commonly face include:
    - loneliness
    - homesickness
    - communication
    - prejudice from others
    - finance
    - academic performance pressures from family back home
    - cultural shock
- Others **migrants** face:
    - status challenges in the family with role-reversals
    - family conflict over values as the younger ones acculturate
    - health risks due to changes in diet and lifestyle
    - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as they become more acculturated

7. SPECIAL EVENTS

The Lunar New Year '*Seol-nal*' (also known elsewhere as 'Chinese New year') traditionally holds much importance for Koreans, as it does for most Asians. During this 3-day holiday, most people make pilgrimages to their hometowns where they gather together with their extended families. The holiday includes many traditions and opportunities for food preparation and ancestor worship. The dates are determined by the Chinese Lunar Calendar and it usually falls around January to February. There is a reluctance to spend this time in hospital or to have diagnostic tests during the celebrations as time with family is really important. So these are often postponed to the 15th day of the Lunar New Year.

8. SPIRITUALITY

It is not uncommon for a Korean to encompass several spiritual views into a religious belief system. These include:

- ***Buddhism***
- ***Christianity***
- ***Confucianism, Taoism, Shamanism***

Some sources report that Shamanism in Korea is not widely practiced today, but has woven a colourful and rich tradition into many aspects of the culture. Other sources claim that shamanism has been kept alive and that the number of shamans in Korea is in fact growing, although it has not been encorporated into any religious system. Either way, we can assume that there may be some Koreans who are influenced by some of the principles whilst for others shamanism will be a heritage.

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Additional Resources

1. The http://spiral.tufts.edu website has Patient Information by language with many resources in Korean



INDIAN CULTURE

Rangoli Patterns

Background Information

India has a history of many dynasties, religions and conquerors, resulting in a rich blend of cultures and many different ethnicities residing in the country. The British occupation and later rule of India which ended with the Indian Independence Act in 1947, also left a strong influence on the culture. The act established Pakistan and India as separate nations with Hindus tending to establish residency in India and Muslims in Pakistan. The conflict that arose during this partition continues today.

Improved education and economic opportunities are amongst the reasons why many Indian families migrate to countries like New Zealand.

1. COMMUNICATION

Greetings video clip

Hello/goodbye salutation	*Namaste* 'I recognize the Self in you' (Hindus)
Hello greeting	*Salaam aleikum* 'peace be upon you'(Muslims)
Goodbye greeting	*Khuda Hafiz* 'God be with you' (Muslims)

Main languages

India is the largest country in South Asia. There are 17 principal languages and more than 200 (some texts report up to 300) dialects spoken in India. **English** is the official language; **Hindi** is the national language and is spoken by about 40% of the population.

Pakistan is located in the western part of the Indian subcontinent. The national language is **Urdu**; **English** is also the official language, and there are five other principal languages. Pakistan is predominantly a Muslim nation.

Gestures and interaction

- **Hands** are held in the prayer position when using the salutations for Hindus and Sikhs
- It is appropriate to **shake hands** with men, though usually not with women (the younger Hindu women are becoming accustomed to the practice, but it is inappropriate with most Muslim women)
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

Special concepts
'Saving face' is important in Indian culture

2. FAMILY VALUES

- Traditionally families are extended, and currently this practice still prevails in the West. However nuclear families are becoming more common in resettled areas and in urban areas back home
- Although the whole family plays a role in childcare, the grandparents' role in raising children is highly valued as they are the link to culture, heritage and religion
- Siblings are close knit and brothers will often live together
- Independence and privacy is highly valued (people may consult other family members before seeking outside help)
- Traditionally women manage the home, financial matters and social issues. In some families the husband or an elder might also manage these
- Men are usually breadwinners and represent the family in the community (with the implication that they have the authoritative role because they are

the primary point of contact with society. Women may therefore be isolated, especially after migration)
- Modesty is highly valued
- Arranged marriages are still common within some families, with mixed marriages becoming increasingly accepted nowadays
- Children are taught respect for elders and discipline is believed to come naturally if the child is taught the appropriate values and principles

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Traditional and current treatment practices

1. The Indian system of medicine is known as **Ayurveda**, which means "knowledge of life." Indian medicine mixes religion with secular medicine, and involves observation of the client as well as the client's natural environment
    - *Ayurvedic* medicine is a holistic system with great emphasis on prevention
    - Diagnosis according to *Ayurveda* is based on finding out the root cause of a disease, which is not always inside the body (to give permanent relief, the root cause has to be addressed)
    - Maintaining the equilibrium of 3 major forces in the body (termed *dosha*) is perceived as good health; the state of imbalance is disease
    - Once the aggravated or unbalanced *dosha* is identified, it is brought into balance by using different kinds of therapies. The three *dosha* are called *Vata*, *Pitta*, and *Kapha*. Each *dosha* represents characteristics derived from the five elements of space, air, fire, water, and earth and also certain bodily activities
    - When curing disease, it is important to not cause new symptoms by suppressing the presenting symptoms
    - There are approximately 1,400 plants used in Ayurvedic medicine, none of which are synonymous with instant pain relievers or antibiotics. The herbs used in Ayurvedic remedies tend to gradually metabolize and have few side effects on the body
    - Fasting (to remove excess toxins), and mild sweating (to digest the toxins) is used in treatment in conjunction with dietary management, herbal medicines and massage regime referred to as *Panchakarma*

2**. Homeopathy** is also well known and used throughout India

3. **Traditional remedies**, prescribed by a traditional healer (prevalent in more rural communities) include herbal drinks, roots and other herbs worn in amulets or around the neck, specific diets, the proper use of the confluence of the heavenly bodies, and the use of precious and semi-precious gems. Additionally, disease is often perceived as a result of bad karma (Hindus), the evil eye (also Muslims and Hindus) or just bad luck. Often religious rituals are conducted to rid the client of the evil influence and give them and their family hope

4. **Western medicine** is highly regarded, particularly in urban areas, and is used, often in conjunction with 'alternative medicine' (i.e. homeopathic and Ayurvedic medicine)

3.2 Important factors for Health Practitioners to know when treating Indian clients:

1. Indians tend to perceive the health care provider as the authority. Their role is likely to be passive and respectful, and they will seldom ask questions as it is considered rude (so there is the need to explain how treatments etc. work)
2. If a Western treatment is at odds with the traditional treatment in Indian communities, the family is likely to ignore the provider and stay with tradition (so it is important to find out what traditional treatments may be being followed and try to incorporate these where possible). Many may stop treatment if it is perceived as not working, so delayed effect, prophylactic effects, and consequences of stopping medications prematurely may need explaining
3. Most Indians are not accustomed to being informed of every negative aspect of a prescribed treatment. The western model of informing patients can lead to confusion and fear, so in explaining a procedure, providers should balance discussion of the risks with realistic assurances
4. Religious practices and personal hygiene customs are different from Western ones (i.e. sometimes no bathing, only showering)
5. Religious symbols worn on the body should not be cut or removed without the client's or family's permission, e.g.:
    - a sacred thread worn by high-caste Hindu men over one shoulder and around the waist, and by women, young babies and children around the neck, waist and wrist
    - a 33 bead bracelet worn by Muslims around the neck or wrist
    - a Sikh man's bracelet and *kirpan* (see 'Spirituality' under Asian section for more detail)
    - a strictly observant Sikh man cannot cut his hair (if it must be cut, the need must be explained fully to both client and family)
6. Family members are usually involved in treatment decisions. A hospitalized client is not told his or her diagnosis, only the family is told (many Indians believe that a client who knows the truth may lose hope). Family members and client need to be given a detailed description of the length of stay, recommended tests and treatments, and that they may bring ethnic foods to replace or supplement the client's hospital meals
7. Personal privacy is important and same-sex health care providers and interpreters are preferred, particularly by women
8. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times

3.3 Stigmas

Emotional problems bring shame and guilt to the family so seeking treatment tends to be delayed. When a client is finally brought to a provider, family members are often in a state of crisis. The practitioner should be prepared to make an immediate assessment on suicide attempts and thoughts.

3.4 Diet and Nutrition

- Vegetarianism is universal among devout Hindus. Many Hindus do not eat beef as the cow is considered sacred, and not all Hindus eat pork and its products
- Muslims have several food restrictions. Devout Muslims will only eat *halaal* meat. Beef is eaten by Muslims but pork and its products are prohibited for all practising muslims
- Spices are the essence of Indian food
- Rice or Indian Bread ('Roti' or 'chapatti') are staple for almost every meal
- Nutritional deficiencies are common amongst migrated Indians but may not be a factor in 2nd and 3rd generation Indians

3.5 Death and dying

Hindus

- Many Hindu clients will elect to die at home; and some will go back to India, their motherland to die if possible - especially to the sacred city of Varanasi
- Organ donations are seldom approved because of religious implications (although blood transfusions, bone marrow or organ transplants are usually acceptable)
- The idea that suffering is inevitable and the result of karma may result in difficulty with symptom control
- Family members are likely to be present in large numbers as death nears
- Chanting and prayer, incense, and various rituals are part of the process
- After death, healthcare staff should touch the body as little as possible. Ideally, just before cremation or burial the family should be the ones to clean the body and this person should be of the same sex as the deceased. After being cleaned, the body is wrapped in a red or white cloth, white being the mourning colour for Hindus
- The preference is for cremation for married people, and burial for babies, children and youth. Ideally, the ashes are spread over the holy river, The Ganges (*Ganga Ma*), or if this is not possible, over any other river or sea
- The mourning family may wish to have a Brahman priest at the funeral to perform a prayer and blessing

Muslims

- When death approaches, a Muslim will recite "There is no god but Allah, and Muhammad is His Messenger"
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, not cremation
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife
- The body is laid out in specific ways and prayers recited before it is taken to the cemetery

Sikhs

- When death approaches, friends and relations are called to be together and to recite from the holy book, the *Guru Granth Shib*
- Families are encouraged not to see death as a sorrowful occasion
- The dead person is to be washed, clothed in clean clothes and placed in a coffin with ornamental flowers and wreaths
- Cremation is traditional
- The deceased will need to have fulfilled the baptismal ritual *Amrit* before the 5 K's (see **5. Spirituality,** Section II Asians) can be included in the casket
- At the crematory chapel a poem 'Sohila' is recited
- A male person turns on the cremation oven. Ashes are later collected for spreading in running water. Many families will send the ashes to India

4. HEALTH RISKS

- Health problems (reported on the Charles Kemp website) prevalent among Indians include:

    - respiratory infections such as tuberculosis and pneumonia
    - malaria (especially in South India)
    - hypertension and cardiovascular disease
    - rheumatic heart disease
    - nutritional deficits
    - high risk behavior such as alcoholism and cigarette smoking
    - dental caries and periodontal disease for most of the adult population
    - sickle-cell disease with the gene detected in 16.48 percent of selected populations
    - prostitution in India is common and HIV infection is a growing problem

- Communicable diseases relatively common in India (also reported on the Charles Kemp website) include:

    - Boutonneuse fever
    - Cholera (especially after flooding in the monsoon season)
    - Dengue fever (including dengue hemorrhagic fever)
    - Filariasis
    - Hepatitis
    - HIV
    - Hookworm
    - Hymenolepiasis
    - Leishmaniasis, visceral (kala azar) and cutaneous
    - Leprosy
    - Malaria
    - Strongyloidiasis
    - Typhus
    - Trachoma
    - Tuberculosis

- Nutritional deficiencies in women are common in India (symptomized by: generalized weakness, fatigue, muscle wasting, oedema, smooth tongue, mental confusion, paralysis, diarrhoea, and low haemoglobin and haematocrit levels).The following forms of deficiency are noted:

    - protein malnutrition
    - beriberi or thiamine deficiency (lost through washing and cooking of rice and allowing it to remain in water overnight)
    - pellagra or niacin deficiency
    - iron-deficient anaemia (leading to Goitre)
    - lathyrism (characterized by irreversible muscular weakness and paraplegia resulting from consumption of large quantities of seeds of the pulse khesari and lathyrus sativus over a long period of time
    - osteomalacia (related to deficient calcium and vitamin D in regions where the cow is sacred

5. WOMEN'S HEALTH

- **Nutritional deficiencies** (see 4. Health Risks above) are prevalent.
  Teaching nutrition is essential in these cases and should be focused first on assessing the cultural diet of the woman. Information on making healthy food choices needs to be made available whilst continuing to allow the client her cultural foods. This is especially important for the pregnant or the lactating woman and for those with illnesses.
- **Traditional fertility practices** have influenced the health of Indian women. These include:
  - Marriage and childbearing traditionally occurred at an early age (a problem especially if the young mother is poorly nourished). However, the legal age for marriage is now 18 so these practices will likely occur in rural areas only, and are less likely to apply to Indians who have migrated to New Zealand
  - Closely spaced multiple pregnancies
  - Low acceptance rate of contraceptives such as birth control pills and Depo-Provera injections (information on intrauterine devices, condoms and the rhythm and withdrawal methods may be helpful). Sterilization may also be an option. In general, it is considered to be more appropriate and often more comfortable for a client to receive teaching regarding this topic from someone of the same sex, although both husband and wife may want to be present during the teaching session
- **Pregnancy**
  - Pregnancy is believed to be a "hot state," or a time of increased body heat. Diet is adjusted to accommodate this. More traditional families may perform rituals and use amulets to protect the mother and the unborn baby from evil spirits as the baby is believed to be particularly vulnerable pre-natally
  - Traditionally in India, it is illegal to reveal the gender of the baby before it is born. The tradition stems from the high preference for producing boys over girls, and migrated families may wish to continue this for protection of the family back home. Younger migrants claim that it is also for the 'suspense' factor that this tradition is observed
- **Labour and Delivery**
  - The role of the Asian Indian woman in labour is passive. She follows instructions from health care providers or family members
  - A stoic approach by the mother to the labour and delivery process is considered desirable. Men are usually not present in the delivery room at the time of birth, although this is not prohibited. Often, an older female family member or traditional birth attendant (dais) assists the mother in the birth process
  - Pain medications are usually not used, as they are believed to complicate the delivery. Staff should be prepared to assist the mother with alternative relaxation or breathing techniques if needed
- **Postnatal care**
  - Generally, breast-feeding by Indian women is practiced and encouraged. It is usually continued anywhere from six months to three years. It is common for breast milk to be supplemented with cow's milk and diluted with sugar water. The child is given diluted milk because the infant's stomach is believed to be weak initially. Additionally, the working mother may also combine breast-feeding with formula for convenience

- The recuperation time for the mother and baby usually lasts for forty days after birth. Rest and special food is traditional

- **Religious Ceremonies Related to Birth**
  - In many Hindu families, a ritual is performed on the sixth day after delivery and the baby is officially named on the eleventh day
  - In Muslim families, it is common for the father or the grandfather of the child to recite the *Azan* in the child's right ear and the *Iqama* in the child's left ear just after birth to confirm that the child is Muslim.
  - Christian families may wish to pray or anoint the infant for blessings and health

Pregnancy is sometimes the first encounter an immigrant woman has with the health system in a new country. Indian immigrants often find pregnancy and childbirth a stressful and isolating time without the community to support them with nurturing and traditional practices. Indian men do not usually know much about these practices and so cannot substitute for kindred women.

6. YOUTH HEALTH

Traditionally Indian youth health has been influenced largely by the strong preference for male babies over female babies. One of the reasons for this preference is that the oldest son in a family is traditionally given the responsibility of taking care of his own family. If parents do not have a son, they believe that they will have no one to care for them. As a result of this tradition, parents commonly neglect young girls growing up in India, giving them smaller portions of less nutritional food, withholding medical care, and often removing them from school earlier than boys.

Issues reported for 'Asian' Youth in New Zealand, in general:

Newborn & Child Health

- In some Asian populations breastfeeding is lacking due to:
  - the belief that bottle-feeding is modern and superior
  - misinformation about breastfeeding and infant feeding practices
  - concerns about privacy and modesty
  - communication difficulties with health professionals
  - lack of family support
- Newborns tend to be kept warm at all times, even in summer
- Babies are kept close to stop excessive crying, and may share a room with parents until at least a year old

Adolescent Health

- Limited or no sexual education amongst new immigrants (particularly the foreign student) is a risk factor for unwanted pregnancy and high abortion rates –36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)
- Low levels of physical activity are reported for adolescent Asian New Zealanders, especially amongst females
- Many of the young Asians residing in New Zealand are students with families abroad. Difficulties they commonly face include:
  - loneliness
  - homesickness
  - communication
  - financial difficulties

    - academic performance pressures from family back home
    - cultural shock
- Others face:
    - status challenges in the family with role-reversals
    - family conflict over values as the younger ones acculturate
    - health risks due to changes in diet and lifestyle
    - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as they become more acculturated.' Risky behaviour' is reported as more likely amongst young male Indian New Zealanders as compared with the females
    - prejudice from others, and bullying in particular at school

7. SPECIAL EVENTS

Ramadan is celebrated by Muslims in the 9th month of the lunar Islamic calendar and is regarded by many as the holiest time of the Muslim year. During this month Muslims fast from dawn until sundown (including no water or other liquids). Those with ill health are exempt from the fast although many nevertheless like to partake and clients may need to have the possible consequences explained, or to be assisted through the period. Young children, menstruating, pregnant and nursing women are also exempt from fasting. In addition to fasting, the following are prohibited: putting eye drops in the eyes, saliva leaving the mouth and re-entering, sex, listening to music and harsh words or arguments.

Diwali, the 'festival of lights' is celebrated by Hindus all over the world around October/November of each year. It is a 5 day celebration of joy and rejoicing and represents the triumph of good over evil. There are regional differences in celebrations and meaning, also for different sects (e.g. Sikhs and Jains etc.). For migrated Hindus it also offers an opportunity for community participation.

8. SPIRITUALITY

Most major religions are represented in India. The 2006 Census of India reports the following percentages of spiritual followers:

Hindus	80.46%
Muslims	13.43%
Christians	2.34%
Sikhs	1.87%
Buddhists	0.77%
Jains	0.41%
Others	0.65%

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Vietnamese culture

Background Information

Vietnam has a complex culture comprising ethnic Vietnamese, Chinese (mostly Cantonese), Khmer, Hmong and a number of other minority groups. Colonialism, like in most other Southeast Asian countries, wrought its destruction and left its mark first by the Portuguese, then by the Dutch, the English and most significantly by the French. Under French rule the Vietnamese lost their script which was converted to the Roman alphabet (the writing style is known as 'quoc ngu') and they found themselves second-class citizens.

In an attempt to take control of Vietnam from the French (and Japanese) Ho Chi Minh established the Vietminh in the North in 1942. Political battles between North and South ensued, involving China, Japan, Britain and France. In an attempt to end the conflict the Geneva accord of 1954 divided the country by the 17th parallel into North and South. The North became backed by Soviet aid and the South by US aid and military intervention, and a long and devastating war saw the US retreating in 1973 after a cease-fire. Shortly thereafter the communists took control of the country, already ravaged by the horrors and violations of the war.

The first wave of refugees fled to the US in 1975. Most were urban professionals associated with US interests in the South and were assisted by US social agencies to resettle. The second wave, escaping the rising repression and human rights abuses of the communist regime, left during the late 1970's to the mid 1980's and included a higher number of less educated people who suffered severe hardships in the exodus. Many of those who survived the perilous boat journeys spent years in refugee camps before being resettled. Many from the North went to Thailand, Indonesia, Hong Kong, Malaysia and China, and from there to the US, or to other countries of resettlement. The third wave, continuing into the 1990's, left through UNHCR assistance programmes based on their status as political prisoners (from 're-education' camps in Vietnam) and through family re-unification schemes. Many continued to escape in boats. New Zealand has been a country of resettlement since 1976, with the majority arriving between 1979 – 1980. A small number have entered New Zealand since then as migrants, students or to join their families.

Many Vietnamese have been severely challenged in their resettlement in New Zealand by unresolved war- and post-war trauma, culture shock, economic dependence, low English proficiency, poor pre-migration education, and difficulty in accessing healthcare facilities. Second generation Vietnamese still carry some of the unhealed wounds of their parents. It is hoped that an understanding of this culture and the legacy of its immigrants will facilitate better access to healthcare and culturally appropriate service.

Photo: Wikipedia (Gnu Free Licence).

1. COMMUNICATION

Greetings video clip

Hello	*Xin Chao* (pronounced 'Sin Chow')
Goodbye	*Tam Biet* (pronounced 'Tam be it')

Main language

Vietnamese (*kinh*) is the official language with 3 main dialects, and is generally understood by most Vietnamese. It is a monotonic and complex language hybridized from Mon-Khmer, Thai and Chinese. Some Vietnamese may speak French and some, English. In addition there are 53 ethnicities all with their own dialects.

Gestures and interaction

- Many Vietnamese may **greet** each other by bowing their heads slightly to each other
- Women **do not shake hands**
- Use **first names** plus Mr. or Mrs. etc. (e.g. Mr. Mark)
- "*Thua"* (meaning 'please') is sometimes placed before the first name as a sign of respect (this would be most appropriate with the older generations)
- Premature **familiarity** is unacceptable and considered disrespectful
- Using hand **gestures** to summon someone is considered insulting
- It is disrespectful to **touch** another's head (except for medical examination)
- Direct **eye contact** is acceptable and in fact, expected (if no eye contact is made, Vietnamese tend to ask themselves 'what is s/he hiding?')
- Vietnamese smile and laugh easily, regardless of **underlying emotion**, so a smile is not necessarily indicative of happiness
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- Vietnamese may not take **appointment times** literally
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

Special concepts and behaviours

'Saving Face' is a strong principle and will be used over confrontation or questioning of those in authority

2. FAMILY VALUES

- Traditionally fathers and sons are heads of household and decision makers
- There is profound respect for elders and those in authority
- There are often as many as 4 generations under one roof. The immediate family (*nha*) includes nuclear family plus husband's parents and grown sons' spouses and children. The extended family (*ho*) include family members of the same name and relatives who lives close by
- Individuals are oriented towards the good of the whole family and mutual dependence is valued over independence

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

The diagnosis of illness is frequently understood from three different perspectives. Vietnamese may often understand their illness as an interaction of these. One of the implications is that treatments from all three models may be combined by the client and this needs investigation by the practitioner.

1. The first could be considered **supernatural or spiritual**, where illness can be brought on by a curse or sorcery, or non-observance of a religious ethic. Traditional medical practitioners, amulets and other forms of spiritual protection, and religious practices may be employed in the treating of the illness. Buddhist principles of acceptance of fate and the understanding that life involves suffering will often influence clients to endure pain and illness and seeking help can be delayed.
2. Secondly, an obstruction of '*chi*' (the life energy) or **imbalance** of the opposing vital forces "*Am*" and "*Duong*" (similar to the concepts *yin* and *yang*, respectively in China) can cause illness.
3. The **Western** concept of disease causation is generally accepted although for many there is a distrust of western practices (i.e. multiple techniques for diagnosis and intervention) by more rural dwellers. Some (e.g. the H'mong), believe that minor illness is organic whereas more serious illness has a supernatural/spiritual cause.

3.2 Traditional treatment and health practices

Balance can be restored by a number of means, including dietary changes to compensate for the excess of "winds" or imbalance in "hot" or "cold" states, western medicines and injections, and traditional medicines. These practices and medications include:

- *Coining* (*cao gio*)
- *Cupping* (*gia*)
- *Pinching* (*bat gio*)
- *Steaming* (*xong*)
- *Balming*
- *Acupuncture*
- *Patent Medicines* (available in New Zealand from Asian grocery stores and Traditional practitioners)
- *Acupressure or Massage*
- *Moxibustion* (used mostly by the Mien, mountain dwelling cultures)
- *Herbal remedies*
- *Talisman* in the form of amulets for protection

3.3 Important factors for Health Practitioners to know when treating Vietnamese clients:

1. People from rural areas who have had less exposure to western health care are more likely to distrust the system and only present when traditional methods have failed. It is important to check with clients about interventions already used.
2. The expectation of immediate symptom relief and cure is likely to be a goal when entering the western health system. **When a medication is not prescribed initially, the patient is likely to seek care elsewhere.** In addition to the myriad of traditional healers and other traditional medicines and practices available to resettled Vietnamese, Western pharmaceuticals, especially vitamins and even antibiotics, are obtainable, either through specialized "injectionists," or from relatives in other countries such as France where some of these medicines are available without prescriptions. When medication is not an appropriate intervention, treatment plans will need careful explanation by the practitioner.
3. It is reported in American literature that **Vietnamese frequently discontinue medicines after their symptoms disappear; similarly, if symptoms are not perceived, it is believed that there is no illness.** Hence preventive, long-term medications like anti-hypertensives must be prescribed with culturally-sensitive education. It is quite common for Vietnamese patients to amass large quantities of half-used prescription drugs, even antibiotics, many of which are shared with friends and even make their way back to family in Vietnam.
4. It is often considered that Western pharmaceuticals are developed for westerners whom they believe have a different physiological constitution. Often dosages are seen as too strong for the more slightly built Vietnamese, so self-adjustment and discontinuation of dosages is not uncommon.
5. Some Vietnamese resist invasive procedures which they believe are potentially harmful to the spirit. Less educated people often do not realize that more blood can be produced by the body and think venapuncture will weaken them. These issues will need to be clearly explained if treatment compliance is required.
6. Some traditional techniques (e.g. coining, cupping, moxibustion, pinching) may leaves marks on the body and providers need to investigate these before assuming abuse.
7. Vietnamese traditionally do not have a concept of ‘mental illness’ as distinct from somatic illness. Mental illness is seen as a spiritually based illness and often presents somatically.
8. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times

3.4 Diet and Nutrition

It is reported that many adults are lactose intolerant as they do not consume much milk. Traditional diet is mostly rice, fish and vegetables, plus pork and chicken when available. Fasting may be used when someone is sick with only hot water or thin rice gruel consumed.

For some Vietnamese the diet is guided by the hot/cold foods of the Chinese medicine system, and this will likely be followed when the person is unwell. It is believed that some foods have medicinal value. Vietnamese clients will likely expect a dietary element to be part of treatment.

3.5 Stigmas

Mental health is seen as a stigma with the result that family members suffering from mental health symptoms may be hidden from the public (in New Zealand by the family, but back home they are often abandoned in hospitals). Alternatively these clients are likely to present with somatic symptoms.

3.6 Death and dying

- Beliefs and practice about death are strongly influenced by the Buddhist attitude of equanimity. Dying with mindfulness and awareness is highly valued
- Pain and other symptoms are often endured with stoicism. This is a critical issue in caring for Vietnamese. It is necessary to ask very directly and specifically about each symptom. Clients may elect for a greater degree of alertness over complete pain control or being in a highly sedated state
- Dying at home allows significantly greater cultural/community support than a hospital death and ceremonies and visitations are very helpful to the family
- The family will likely want to be present for the member's last days. If the client is hospitalized and is Buddhist, they should be told directly that a monk will be welcomed by the institution. The presence of a monk is helpful to the client and the family

4. HEALTH RISKS

Tests for the risks below are outlined for Vietnamese refugees when they arrive in the USA (with an asterisk, also for Australia) and may be applicable to those in New Zealand.

- Nutritional deficits
- Hepatitis B *
- Tuberculosis*
- Parasites (roundworm, hookworm, filaria, flukes, amoebae, giardia)*
- Malaria*
- HIV (STD's - Australia)
- Hansen's disease*
- PTSD*
- VDRL should be considered
- Dental caries (Australia)
- Some lactose intolerance (Australia)

Higher mortality rates for cancer of the digestive system are reported for Vietnamese men in Australia than for population in general.

5. WOMEN'S HEALTH

- Acceptance and knowledge of family planning will depend on the ethnic origins of families. The contraceptive pill is not accepted by some as it is believed to be a 'hot' medicine which may cause handicaps in babies. IUD's and rhythm method is more commonly used in Vietnam. However, people more recently migrated, and from urban regions are likely to be familiar with contraception since the introduction of strong government policy and 'two children families'
- It is reported that resettled women in US seek conventional prenatal care when pregnant. However pregnancy in an unmarried woman is considered dishonourable to the family and so it is hidden or abortions may be sort
- Husbands are not usually present at deliveries
- Women whose beliefs are based on Chinese medicine (more often the lowland peasant groups) may refuse to bathe, drink juices or water, or wash their heads post partum so as not to create imbalances in the body, particularly considering the loss of blood that occurs during delivery
- Women are considered to be weak and vulnerable after delivery and rest and quiet is preferred, ideally for up to a month
- Women will usually breastfeed for the first 6 – 12 months
- Women are reported to have higher rates of cervical cancer than for the rest of the population in Australia, and it is also noted that they suffer disproportionately from fractures

6. YOUTH HEALTH

Social Issues

- Filial obedience and respect of elders is very important
- Corporal punishment is common in Vietnam and parents are often not aware that this is unacceptable in New Zealand, nor how to manage their children when this form of discipline is prohibited. Guidance by the health practitioner may be needed, or appropriate referral
- Children of survivors of torture and trauma may often display social withdrawal, chronic fears, depression and dependence

Issues reported for 'Asian' Youth in New Zealand, in general:

Newborn & Child Health

- In some Asian populations breastfeeding is often lacking due to:
    - the belief that bottle-feeding is modern and superior
    - misinformation about breastfeeding and infant feeding practices
    - concerns about privacy and modesty
    - communication difficulties with health professionals
    - lack of family support
- Newborns tend to be kept warm at all times, even in summer
- Babies are kept close to stop excessive crying, and may share a room with parents until at least a year old
- Children are usually highly valued and seen as an asset to the family, so childhood illness causes immediate anxiety
- Queensland health reports a condition common amongst Indo-Chinese babies referred to as the 'Mongolian blue spot' which is a bluish pigmentation present in the lumbo-sacral region and can be misdiagnosed as child abuse. It is commonly present at birth and remains up to 18 months

Adolescent Vietnamese Health:

- Many **overseas students** residing in New Zealand with families abroad face:

- Loneliness, and often as a consequence they become involved in circles where risky behaviour is practiced (i.e. unsafe sex, binge drinking, smoking, marijuana and other substance use)
- Opportunities to flat with partners (often out of isolation), and having to conceal this from families abroad
- Lack of sex education with resulting unwanted pregnancies and high abortion rates (36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population) (Census 2001)
- Homesickness
- communication difficulties
- racial prejudice from others
- financial difficulties
- academic performance pressures from family back home
- cultural shock

- Other **migrated** Vietnamese adolescents face:
  - status challenges in the family with role-reversals (where children hold power with education and language capabilities)
  - family conflict over values as the younger ones begin to identify themselves as 'kiwi' and reject their old culture
  - health risks due to changes in diet and lifestyle
  - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as they become more acculturated
  - lack of sex education and ensuing problems similar to foreign students. (It is reported by local community members that even if sex education is offered, students will often not attend as they do not want to be seen to be attending such gatherings (particularly as word may get back to the parents). Health practitioners may find it a useful opportunity when consulting with Asian adolescents to provide them with the needed information
  - declining value in education in the Vietnamese community as both the parents and the children are reported to be considering money as preferable to spending time learning

7. SPECIAL EVENTS

'Tet' is the Vietnamese New Year. It is celebrated on the first day of the first month on the lunar calendar, usually between 19 January and 20 February. The celebration traditionally lasts 3 days. It is an important cultural celebration and much expense is put into the event. It represents new beginnings and different religions have contributed various rituals to the celebrations. Most clients would prefer not to be hospitalized or to have diagnostic tests during this time as being with family is highly valued.

8. SPIRITUALITY

- **Buddhism** – this is practiced by most Vietnamese. Both Hinaya (south) and Mahayana (north) forms are practiced
- **Confucianism**
- **Taoism**
- **Catholicism**
- Various forms of **Shamanism**
- **Cao Daism**

  This is a religion practiced only in Vietnam, largely in the Mekong Delta (about 2 million adherents) and is a synthesis of Buddhism, Christianity, Taoism, Confucianism and Islam. It was founded in Southern Vietnam in the 1920's and was at that time a religion and a nationalist movement. The number of practitioners within the movement are continually growing

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Additional Resources

1. The http://ethnomed.org/ site has patient education materials in Vietnamese on various types of cancer, and on diabetes and exercise

2. The http://spiral.tufts.edu website has Patient Information by language with many resources in Vietnamese

CAMBODIAN CULTURE

Background Information

Cambodians, like most Southeast Asian peoples have experienced political domination and instability for the last couple of hundred years. However the reign of terror of the extremist Maoist regime, the Khmer Rouge (from the 1960's), and the ensuing struggles that continued after they were ousted in 1979 (by the Vietnamese) devastated the country and the people.

Cambodians suffered severe brutality, starvation, virtual obliteration of their culture and desperate poverty during this reign. As a result there have been enormous numbers of refugees fleeing Cambodia whilst the Khmer Rouge was in power, and since, to escape the continued struggle and poverty. Most Cambodians who came to New Zealand as refugees arrived with high health needs. However many issues including access difficulties, poor mental health and culture differences made it difficult for them to make use of the new resources. As a result, many Cambodians suffer with less than satisfactory physical and mental health, and for many there is still significant pain related to past trauma and difficulties. It is therefore, particularly important to be aware of the cultural factors that could assist their access to much needed care.

Photos by kind permission of Refugees International www.refugeesinternational.org.

1. COMMUNICATION

Greetings video clip

Hello	*Choum Reap Sur*
Goodbye	*Choum Reap Lir*

Main language

The main language spoken is *Khmer* (also known as Cambodian). Some speak French, and a little English may be spoken although the latter is mostly understood by the young people who have learned it at school since migrating.

Gestures and interaction

- When Cambodians **greet** each other they place their hands, palms together at chest level and bow slightly. This is called a *Som Pas*. It is considered impolite not to return this gesture when greeting. It is tantamount to refusing to do a handshake in Western culture. It is appropriate to make the gesture and then greet them in your own language
- Older people should be **greeted** first and last before leaving
- Some men will **shake hands** in the west, but women prefer to S*om Pas* instead (especially with males)
- The **second name** is traditionally a Cambodian's given name, and they place the family name first. This can be confusing for records. It is useful to check whether they have adopted the New Zealand system or retained their own name order
- Use **Mr. or Mrs. and the given name**, or both names. It is not usual to address someone using the second name only as westerners do (it is considered impolite as this would be the name of the father or ancestor)
- Traditionally it is not appropriate to have direct **eye contact** with someone considered superior or older
- It is **insulting** to touch an individual's head (unless necessary for medical examination)
- When **walking in front of** someone other than a child it is respectful to bow slightly from the waist as you pass
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner, and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions
- **Over-familiarity** is not appreciated
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- It is considered bad luck if a baby is **praised** too much (without the protection from the 'evil eye')

2. FAMILY VALUES

The nuclear family is more common in Cambodia than in the other Southeast Asian countries although extended families also live together or in close proximity. The roles of both men and women are well respected within Cambodian culture. The wife in a family is leader in some ways and responsible for handling financial matters, seeing to the education of the children and doing housework. Men bring in the income. Families value having meals together.

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health: (the focus is on Khmer from rural backgrounds)

In general, the Khmer are comfortable with western medicine and with traditional or indigenous healing practices, both spiritual and medicinal. Often both factors will be seen to be equally influential.

Illness is understood:

1. To be an **imbalance** in natural forces. However, this concept is often not directly expressed and the influence of "wind" or *kchall* on blood circulation (and hence on illness) will be noted instead
2. To be an **imbalance** of "cold" or "hot" conditions (similar to the other Asian cultures presented in this resource, this does not necessarily imply body temperatures, but rather body states)
3. To have **spiritual/supernatural** causes where illness can be brought on by a curse or sorcery, or from non-observance of a religious ethic

3.2 Traditional healing and indigenous practices are used to treat ill health**:** Some of the procedures below are carried out by family members and some by traditional healers or *kruu Khmer*. Some *kruu Khmer* specialize in medicinal practice with a spiritual component, while others specialize in magic with a medicinal component. Irrespective of whether the procedures are carried out by *kruu Khmer* or lay people, they are often accompanied by prayer and other spiritual activities:

- **Coining (Dermabrasion)** (Kooí'kchall) is used to treat a variety of ailments, including fever, upper respiratory infection, nausea, weak heart, and malaise.
- **Pinching** (Jup) and **Cupping** (Jup *kchall)* is used to treat headache and malaise. The first and second fingers are used to pinch and thus bruise the bridge of the nose, neck, or chest. *Jup* also refers to the practice of "cupping" or placing a small candle on the forehead, lighting the candle, and placing a small jar over the candle. The flame consumes the oxygen and creates a vacuum, thus causing a circular contusion. As many as three contusions may be seen on a person's forehead
- **Moxibustion** (*Oyt pleung*) is used to treat gastrointestinal and other disorders
- **Massage** or manipulation is practiced by *kruu Khmer* and others
- *Traditional or* **natural medicines** are available in stores and from individuals. Such medicines include a wide variety of plant (leaves, bark, extracts) and other substances. Some are brought to countries of resettlement, or even, occasionally, found there) by individuals. Others are found pre-packaged and imported from Thailand or other Southeast Asian countries. These are often taken or applied topically in some combination of medicines and/or mixed with "wine" (usually vodka). Some substances may be classified as "Chinese medicine" such as those

medicines/substances sold in Chinese pharmacies worldwide. Sometimes *kruu* will administer medicines (often topical or magic in nature) to hospitalized patients

- **Magico-religious articles** such as amulets, strings, and Buddha images are common. The amulets (that look like a piece of string) may be worn around the neck by children or around the waist by adults. Permission to remove these articles for medical interventions needs to be gained from clients beforehand
- **Yuan** are magical pictures/words placed over doors or sometimes kept in pockets
- **Tattoos** with magical designs and religious words can be found on the chest, back and arms of men
- **Blowing** on the sick person's body in a prescribed manner and showering or rubbing with blessed water is another spiritual treatment
- **Western** medicine

3.3 Important factors for Health Practitioners to know when treating Cambodian clients:

1. Cambodians have traditionally dealt with illness through self-care and self-medications. This may have been due to lack of resources, and also to the ready availability of drugs over-the-counter at low cost. As a result Many Khmer are slow to seek healthcare from western practitioners and self-care or traditional measures may be tried first. Clients may therefore present only when the condition is serious.
2. Traditional treatment may be used simultaneously with western medicine
3. Communication is a major issue in assessment and all other phases of care. This might be due to language or cultural issues. A cultural problem might involve using an interpreter who for gender, age, social status, or past relationship incompatibilities, may be rejected or not listened to by the client
4. Communication can often be indirect with questions couched in vague terms, or no response being given if the answer is negative. It is best to ask open ended questions which avoid responses where the negative is masked
5. Accurate and complete assessment are major issues in providing quality care. There is a reluctance to complain or express negative feelings and it is common for patients to not report or even to deny symptoms or problems. Answers such as 'it's OK', or 'no problem' are common when there is actually a problem. In other cases, symptoms or problems may be reported to several sources or to one source and not another.
6. Non-compliance with medications and treatment is another problem and may be due to several factors:
    - The patient may not believe that he or she has communicated the problem successfully and so have little faith in the solution. Careful questioning is therefore crucial
    - A common Khmer orientation to symptoms (vs. cause) of illness may result in discontinuation of treatment as soon as symptoms have resolved
    - Treatment through dietary measures is very difficult because of difficulty in food substitutions, differences in perceptions of foods, and in some cases, financial issues
    - Difficulty in independently obtaining refills or new appointments. This might be due to access and language difficulties, or sometimes to

financial ones. The business aspects of the health care system can be challenging and upon receiving a large bill, some will react by simply not returning to the practitioner
    - Rather than report that the treatment has been unsuccessful, some Cambodians may report "no problem" or "its okay". This may be due to lack of faith in the medicine, or to lack of motivation, or to access difficulties
7. Most Khmer are oriented more to illness than prevention of illness. Childhood immunizations are accepted, but adult immunizations (influenza, pneumonia) are usually not sought until illness is evident. Most Khmer do not value early detection or disease screening. This has implications for breast and uterus cancer check-ups amongst other things. (See http://ethnomed.org/ for tutorials and information in Cambodian on various types of cancer)
8. Some traditional techniques (e.g. coining, cupping, moxibustion, pinching) may leave marks on the body and providers need to investigate these before assuming abuse
9. Mental health problems are more likely to present somatically
10. There are some culture-bound presentations, e.g. 'sore-neck' syndrome presents with symptoms similar to panic attacks, 'thinking too much illness' with some depressive and anxiety symptoms (see http://www3.baylor.edu/~Charles_Kemp/cambodian_health.htm for more information and references)
11. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times

3.4 Diet and Nutrition

White rice with accompanying vegetable soup is the staple diet with fish and meat when available.

3.5 Death and dying

(From an article by Kemp and Rasbridge in the *Journal of Hospice & Palliative Nursing,* printed on the website http://www3.baylor.edu/~Charles_Kemp/cambodian_health.htm

- Dying, for resettled Cambodians, is often accompanied by more "baggage" than in other cultures. Besides the usual physical, personal, interpersonal, and spiritual issues, many may have been left with unresolved issues around survivor guilt, guilt over decisions made during the Holocaust, grief, lack of cultural support, lack of family support, and others. Most often they will only display acceptance or resignation
- It is preferable to discuss end-of-life issues with the family rather than the client. There is a tendency to "protect" the client from knowledge of a poor prognosis. In some families there is an almost mystical faith in Western medicine and so there is an eagerness to accept even the most futile of treatments. Withdrawal of treatment usually requires extended discussion with all family members and in many cases, repeated explanations
- Pain and other symptoms are often endured with stoicism so it is important to ask very direct and specific questions about each symptom. General or passing questions are meaningless and will likely gain little useful clinical information. The

strong Buddhist heritage makes equanimity in the face of death highly valued. It is believed that one should go into death calmly and mindfully, so maintaining a state of awareness is valued over pain control. It may need to be explained that alertness can be experienced with some pain control

- Dying at home is preferred as this allows more cultural/community support than a hospital death and ceremonies and visitations are very helpful to the family
- Family expressions of grief vary significantly. In literature on Cambodians resettled in the US it has been noted that persons in acute mourning are often extensively coined - as if to say, without words, "see my terrible pain" as this is otherwise difficult to express
- Ideally, the family prefers to wash and prepare the body of the deceased. The hands are placed in a prayerful position holding candles and incense. Some families place a coin in the mouth of the deceased. Usually after the death, neighbours and friends visit in large numbers and are expected to contribute to expenses and related ceremonies by making financial offerings to the family
- Cremation is preferred, though some resettled Cambodians may be buried. Ceremonies are usually held the weekend after the death and again at 100 days after the death. Offerings commemorating the deceased are also made at the Khmer New Year in April

4. HEALTH RISKS (these are outlined for Cambodians arriving in the US and **some** of these may apply to Cambodians in New Zealand)

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

5. WOMEN'S HEALTH

Family planning in Cambodia is uncommon and women will often have a number of children. Herbal medicines, Depro-provera injections and birth control pills are used rather than condoms. In Cambodia the midwife is consulted for pre-natal care. In resettled places women will often use herbal medicines and a variety of foods and activities which are thought to be good for the baby. It is reported that for women resettled in Seattle, US, that there is more acceptance of pre-natal care although it often avoided because of pelvic examinations. Same gender practitioners are preferred. This may be the case for women resettled in New Zealand.

The post-partum period is considered to be the most important time in a woman's life. It is called "*Sor Si Kjey"* or "*Saw Sai Kachai*". Recovery lasts for a month during which time traditionally there is no bathing, the woman rests, special foods are eaten and people assist with care of the baby. However, in resettled countries it is often not possible to have a month to rest and many babies are delivered in hospitals and traditional breastfeeding is replaced with bottle feed if the mother has to return to work. The whole process can be quite foreign for an immigrant woman and it would be helpful if some of the traditional practices could be included in her care. It is best to consult the client about these matters.

6. YOUTH HEALTH

Social issues:

- Children are expected to be respectful to their elders, well disciplined and to help around the home. They are encouraged to attend school and do well as this is perceived as the best route to a good job
- Changes in roles, different cultural norms around parenting styles and acculturation of the youth make some of the traditions difficult to follow
- Parents who are still struggling with their own grief and traumas may have been unable to attend to what would normally be considered unacceptable behaviour resulting in problematic social patterns
- Destructive behaviour, like involvement in gangs is increasingly common and of concern to community leaders and elders

Newborn & Child Health

- In some Asian populations breastfeeding is lacking due to:
  - the belief that bottle-feeding is modern and superior
  - misinformation about breastfeeding and infant feeding practices
  - concerns about privacy and modesty
  - communication difficulties with health professionals
  - lack of family support
- Newborns tend to be kept warm at all times, even in summer
- Babies are kept close to stop excessive crying, and may share a room with parents until at least a year old
- Children are usually highly valued and seen as an asset to the family, so childhood illness causes immediate anxiety

Adolescent Health

Issues reported for 'Asian' Youth in New Zealand, in general:

- Limited or no sexual education amongst new immigrants is a risk factor for unwanted pregnancy and high abortion rates – 36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)
- Low levels of physical activity are reported for adolescent Asian New Zealanders, especially amongst females

- Some face:
  - status challenges in the family with role-reversals
  - family conflict over values as the children adopt 'Kiwi' values and activities which differ from traditional ones
  - health risks due to differences in diet and lifestyle
  - engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as migrants often attempt to 'fit in'

7. SPECIAL EVENTS

- The Lunar New Year is celebrated from 13 – 15 April with the Water Festival
- The Khmer New Year, is celebrated on 14, 15, and 16 April and has great cultural significance when all business stops and families come together

8. **SPIRITUALITY**

- **Buddhism** – this is practiced by most Cambodians and has a strong influence on the way of life, even for those who follow other practices
- Evangelical **Christianity**, particularly the Church of Jesus Christ of Latter Day Saints (Mormon)
- Various forms of **Animism**
- Some Cambodians, mostly the Cham-Malays (about 500,000) who live around Phnom Penh are **Muslim**

Many Khmer would be comfortable with attending or combining Christian and Buddhist practices and worship

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Additional Resources:

The http://ethnomed.org/ site has patient education materials in Cambodian on various types of cancer, and on diabetes and exercise.

The http://spiral.tufts.edu website has Patient Information by Language with many resources in Cambodian

Loa Democratic Republic Coats of Arms 1975 – 1991 Since 1991

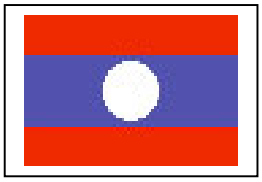
LAOTIAN CULTURE

Background Information

There have been many years of political conflict in Laos, and particularly since the French colonial rule ended in 1954. The communist party under Pathet Lao eventually took power in 1975 and formed the Lao People's Democratic Republic, beginning a 20 year rule of terror. This government was backed by the Soviet Union and the Northern Vietnamese Army which was given considerable influence in the country. To escape the atrocities perpetuated by the communist regime (in what became known as the Killing Fields of Laos) Laotians began fleeing to Thailand to refugee camps. Many of these refugees spent over 10 years in camps before resettling elsewhere. Most arrived in New Zealand in the late 1970's and early 1980's under the NZ quota system, totaling 239 displaced Laotians at that time. Although dissidents (largely Hmong people) have been in conflict with the communist regime since they took power, media reports suggest that this is waning. However, since all dissent in Laos is repressed, this picture is not necessarily reliable. In New Zealand less people arrive as refugees, more recent arrivals have been through family re-unification schemes.

Although the Laotian community has integrated well into new Zealand, many of those who came as refugees suffered extensive trauma during the Killing Field era, and subsequently during flight and in refugee camps. Some of the older generation may live with unresolved trauma which can sometimes be passed on to the next generation. Although the Laotians are known as an industrious and resilient people, health providers need to be aware of heritage of our settlers.

The population consists of three main ethnic groups: Lao Lum (lowlanders), about half the population; Lao Theung (highlanders), including the Khmu; and Lao Sung (mountain people), including the Hmong and Mien. There are more than 30 tribes all speaking different languages. The information below is generalized except when stated.



1. COMMUNICATIONS

Greetings video clip
Hello *Sawadee*
Goodbye *Lagorn*

Main language
Lao or Laotian is the country's official language. The Lao alphabet and many words were derived from Pali and Sanskrit, languages of ancient India. The Hmong have their own written language, but only a few are literate. Some people will also speak Thai as a second language.

Gestures and interaction

- The traditional means of **salutation** (coming or going) is called *wai*, which involves placing one's hands together as if praying and inclining the head. The height at which the hands are held designates status of the person being greeted
- **Respect and politeness** is critical for Laotions
- Respect also involves **explaining** about procedures and treatments, practitioners being on time for appointments, addressing elders first
- Showing an **interest** in the culture and practices will likely enhance the relationship with the practitioner and compliance
- Since there is a very strong emphasis on personal privacy it is important to ensure **confidentiality**
- Women do not **shake hands**
- Using **hand gestures** to summon someone is considered insulting
- It is disrespectful **to touch** another's head (except for medical examination)
- It is important that **children** should NOT be used as interpreters as this puts the family in a difficult position of the child having superior status over the adult/s
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

2. FAMILY VALUES

- Migrated Laotians have tended to live in more closely knit communities than most other refugees from Southeast Asia
- Families are patrilineal with extended households
- Elders of both genders are given great respect
- Some health decisions may be made by the elder even if the client is an adult
- Filial respect and reverence to ancestors is practiced
- Clan obligations were important in the homeland but for many refugees they may be the only member of their clan in the new country
- Role reversals and small communities have altered many traditional social structures
- Laotians have a lot of pride and will usually be reticent in asking for help or in using local charity and services

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

Practices around health are related largely to *Phram* beliefs (Brahmanistic and animanistic) rather than Buddhism. However some of these will occur in the context of Buddhist beliefs and practices. The views on health and illness are complex and multidimensional and strongly spiritually based:

1. The first could be considered **supernatural**, where illness can be brought on by hostile spirits, spells or curses, or violation of taboos.
2. Secondly, a **spiritual** belief is that illness may be caused by loss of soul (or more specifically to the loss of one of 32 spirits responsible for maintaining health). The loss may occur when being startled whilst alone, being unconscious (including from anesthesia), feeling sad or lonely, having an accident and many other causes. An acharn or teacher/healer (not to be confused with a monk) is called on to perform a ceremony to call the soul/spirit back to the body. A visit to the temple where prayer and lustral water are used is also sought to relieve the problem.
3. Thirdly, as with other Southeast Asians, an **imbalance** in "winds", and hot and cold forces also play a role in health and illness, and restoring balance restores health or well-being.
4. There is also some acceptance of the **western** concept that illness can be the result of external factors such as accidents and infectious diseases. As with many resettled peoples, the degree to which traditional practices are modified varies enormously.

3.2 Traditional treatments and indigenous practices:

- **Coining** (Khout lom)
- **Cupping**
- **Pinching**
- **Traditional Lao medicines** (imported or ingredients grown and gathered locally)
- **Massage and manipulation** (performed by healers and elders with knowledge of healing techniques)
- **Chinese medicines** often soaked or dissolved in vodka (called 'wine') and consumed in small quantities
- **Monks** and **acharns** are involved in health care and illness
- Wearing a sacred **talisman** :
    - one that has been spiritually prepared by monks and holy men
    - Buddha images around the neck
    - a *katha,* which is a metal string inscribed with Pali prayers around the wrists (similar to Cambodians)
    - a *haksa,* which is a small bag given by grandparents or parents as protection and worn around the neck
    - adorning a *Yarn* (a protective tattoo) on the chest, back and arms for men (similar to Cambodians)

Permission needs to be gained (in a culturally sensitive manner) from clients before these articles are removed for healthcare interventions

3. 3 Important factors for Health Practitioners to know when treating Laotian clients:

1. Health histories may be incomplete for several reasons, the most basic of which is a reluctance to volunteer information. Privacy in personal matters, especially related to family, sexual, and illness (vulnerability) issues is highly valued, and this as well as trust or its lack, are major issues when it comes to divulging information. With trust based on relationships, one might assume that the history will evolve over time, rather than be complete in one or two interviews
2. Language barriers are often an issue for older Laotians, especially those from a rural background. Because health care situations present unique challenges in understanding, particularly given the diversely different practices between traditional and New Zealand health systems, and also the cultural gradations in decision-making, even the presence of a bilingual family member may not be sufficient for some circumstances
3. Cultural issues present are sometimes difficult to identify and increase problems in understanding. Laotians may feel alienated and isolated when confronted with the extensive and foreign western health systems
4. Most Laotians focus on acute illness and otherwise do not place high value on disease prevention and health promotion
5. Seeking health care from clinics or hospitals is usually deferred until family, community, and spiritual resources are exhausted. Using clinics or hospitals as a last resort, coupled with reticence in complaining, results in some clients presenting with advanced illness
6. Note that traditional practices are often continued while utilizing western medicine
7. It is useful to provide treatment instructions in varying forms such as spoken word, written and pictorial (see http://spiral.tufts.edu/laotian.html for Patient Information in Laotian on a wide range of illnesses for adults and children. However, dialect issues may be a problem and an interpreter may still be needed)
8. Some traditional techniques (e.g. coining, cupping, pinching) may leave marks on the body and providers need to investigate these before assuming abuse
9. The values and practices of some 2nd and 3rd generation Laotians may be little different from the host New Zealand culture
10. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times
    - Dress modestly

3.4 Diet and Nutrition

Rice, meat (traditionally a preference for beef over fish and chicken) is the staple diet. Since the culture also considers hot/cold body states as factors in health, diet will play an important part in treatment and the client's preferences may need to be encorporated in interventions

3.5 Death and dying

- When there is a terminal illness, it is best to consult the client about how much s/he wants to know about the diagnosis and prognosis, and who else in the family s/he wants to be involved in decision making. The process of Informed Consent may be new to many families and this process will need to be explained. If the client does not want to make any decisions for themselves, they will need to have a Durable Power of Attorney
- Families prefer terminally ill members to return home to die as it is believed that the soul of a person who does not die at home may wander and not be reincarnated
- The entire family will want to be present for the member's last days. If the client is hospitalized and is Buddhist, they should be told directly that a monk will be welcomed by the institution. The presence of a monk is helpful to the client and the family

4. HEALTH RISKS (these are outlined for Laotians living in the US and **some** of these may apply to Loatian refugees in New Zealand)

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

5. WOMEN'S HEALTH

Pregnancy, childbearing and post-partum practices

- Early menopause is common
- Contraceptives are avoided as having many children is highly valued However, oral contraceptive and barrier methods are preferred when used
- Menstrual blood is considered a pollutant and so missing a period is a worry to women
- Amongst Laotians modesty is highly valued, especially in women from waist to knees - and most especially in younger women. Women may refuse vaginal examinations, especially by male doctors. This may be a reason for late presentations for antenatal care and non-attendance at post-partum checks. Pelvic examinations of unmarried women should therefore not be a routine practice, especially by male providers. Same gender practitioners should be used whenever possible

- In part because of issues of modesty, there is often resistance to breast self examinations among Laotian women
- It is recommended that double gowning of hospitalized clients should be practiced as much as possible
- In Hmong culture, mothers and mothers-in-law assist with the birth (traditionally squatting position) and the husband cuts the cord and helps wash the infant. Women are reported to prefer natural tearing and healing to episiotomies
- Traditionally the placenta is required for reincarnation and so is usually buried at the place of birth. It is reported that in Australia some Laotian women prefer the hospital to bury the placenta. This needs to be discussed with women resettled in New Zealand
- It is customary to keep warm for 3 days post-partum and touching cold water is prohibited. Special foods are required to restore and maintain appropriate body states
- A necklace is traditionally placed on the newborn's neck. Praising the baby is not encouraged as it could cause harm from the spirits if there is no protection from the 'evil eye'
- Breast feeding is common although resettled mothers who work might adopt bottle feeding for convenience

6. YOUTH HEALTH

Traditionally girls have lower status than boys. They gain status with producing children. No circumcision is practiced in Laos.

Issues reported for 'Asian' Youth in New Zealand, in general:

Newborn & Child Health

- In some Asian populations breastfeeding is lacking due to:
  - the belief that bottle-feeding is modern and superior
  - misinformation about breastfeeding and infant feeding practices
  - concerns about privacy and modesty
  - communication difficulties with health professionals
  - lack of family support
- Newborns tend to be kept warm at all times, even in summer
- Babies are kept close to stop excessive crying, and may share a room with parents until at least a year old
- Children are usually highly valued and seen as an asset to the family, so childhood illness causes immediate anxiety

Adolescent Health

- Limited or no sexual education amongst new immigrants (particularly the foreign student) is a risk factor for unwanted pregnancy and high abortion rates – 36.4% of known Asian pregnancies resulted in abortions compared with 22.6% for the whole population (Census 2001)
- Low levels of physical activity are reported for adolescent Asian New Zealanders, especially amongst females
- Some face:
  - status challenges in the family with role-reversals
  - family conflict over values as the children adopt 'Kiwi' values and activities which differ from traditional ones
  - health risks due to differences in diet and lifestyle

- engaging in 'risky' behaviour (i.e. unsafe sex, binge drinking, smoking, marijuana use) as migrants often attempt to 'fit in'

7. SPECIAL EVENTS

The Lao New Year is celebrated from 13-16 April and is also known as the *water festival.* It has its origins in the Hindu tradition.

8. SPIRITUALITY

For Laotians, the beliefs and symbolism of the different traditions are combined and adapted to one another quite readily in practice. Overall, Buddhism has been a strong force in Laos and the basic tenets of Buddhism guide most traditional Laotians

- The main **Buddhist** practice is Theravada. There are however, regional variations in Laotian Buddhism, with the northern region influenced by Burmese Buddhism, while central and southern regions are influenced by Khmer Buddhism. The easy combining of practices can be seen in the relatively common approach to shrines where the shrine inside the home is dedicated to Buddhist faith, and the shrine outside the home is reserved for the spirits in the form of a *Phi* (a small 'house' on top of a pole or column)
- Many Laotians also practice a mix of Buddhism and Brahmanism (this predated Hinduism) or **Phram**
- Most mountain people practice **animism**, again in conjunction with other faiths

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Additional Resources:

1. http://spiral.tufts.edu/laotian.html provides a wide range of Patient Information in Laotian on health issues for adults and children and can be downloaded

Burmese Culture

Burma is currently known as Myanmar, and the people as Myanmarese, so named by the present government

Background Information

Burma is ruled by a military dictatorship that took power in 1962. Since then, and particularly since the 1988 state of martial law, refugees have been fleeing a country rife with blatant and systematic human violations. The army constantly scours the forests and hillsides razing villages, murdering and raping inhabitants and displacing communities who may re-build their homes and 'villages' numbers of times. Families becomes separated and many children end up orphans in their communities, or in refugee camps. Youth are enrolled as soldiers and a large number of minorities and dissidents are forced into involuntary labour for the government.

Thousands of Burmese refugees and also Karen, Shan, Chin and other ethnic hillside tribes have fled across the Thai-Burma border and some to refugee camps in Thailand. Burmese who arrive in Thailand often find themselves marginalized, rated as second-class citizens and seen as cheap labour for the government. Life in the refugee camps is often not much better than outside the camps and so many of the Burmese seeking refuge in New Zealand have been deprived of basic human rights including health care, safety and wellbeing, education, and food, for a considerable period of time. Many suffer with psychological (and some, physical) trauma from their pre-migration experiences, their journeys and the extensive losses of family and community members.

Since the host cultures and language of New Zealand is so different from that of the Burmese, the acculturation process, particularly following the hardship of pre-settlement conditions, can be experienced as very challenging and alienating.

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1. COMMUNICATION

Greetings video clip
Welcome *'mingalaba'*
Goodbye *'Twe ohn mae nor'* (actually means 'see you again')

Main language
The main language spoken in Burma is Burmese, a tonal language. There are many tribes with different languages and dialects, and most don't understand each other's language. However, many do speak Burmese. It is important when treating a Burmese client to find out whether they speak Burmese or another dialect before engaging an interpreter. The current situation in New Zealand is that there are a number of dialects without available interpreters. Sometimes it will be necessary to engage a Burmese interpreter and a responsible community member who speaks the client's dialect to work together. The interpreter assistant will need **pre- and post-session briefing** along with the interpreter.

Gestures and interaction

- It is respectful to use **specific forms of address** when speaking with a Burmese:
  - *'U'* is a term of respect used for addressing a male
  - *'Daw'* would be used to address women
  - *'Saya'* would be used to address a teacher, master or traditional healer
- It is disrespectful to **touch** another's head (except for medical examination)
- Pointing a finger or **gesturing** using a finger is considered insulting
- Prolonged **eye contact** is usually avoided, although if eye contact is made, it needs to be returned
- **Shaking hands** is usually acceptable (except with very traditional and older women)
- 'Yes' can be an **ambiguous response**, sometimes used to indicate that the listener is paying attention. It does not necessarily indicate agreement (ask open-ended questions)
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

Special concepts
'A-nah-dah' expresses the Burmese cultural value of solicitousness for other people's feelings.

2. TRADITIONAL FAMILY VALUES

Years of repression have had a negative impact on the traditional Burmese culture. However, it remains a family and religion-oriented culture with the following features amongst most ethnicities:

- Families are usually extended, although many refugees and immigrants have more nuclear families (this may be due to immigration policies rather than to changing traditions)
- Parents are valued and honoured highly. It is considered a sin to disobey parents
- Social class lines are strong and so there is little social mobility

- Initiation in adulthood begins at nine and for boys with the *shin-pyu* ceremony which is traditionally followed by several weeks in a monastery as a novice (this is often not possible after resettlement)
- The *nahtwin* ceremony for girls is followed by having the ears pierced
- *Thanaka*, a pale yellow paste applied to the cheeks and forehead is still used and some refugees may arrive in New Zealand wearing this application (more often girls and women)
- Marriages are still often arranged and this will involve consultation with the family astrologer

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

- Traditionally, health is considered to be related to harmony in and between the body, mind, soul and the universe. ***Imbalances*** amongst these elements (e.g. the "hot" and "cold" states within the body) can cause illness. As in most other Southeast Asian cultures treatment would then be with medicines or foods, and practices that hold the opposite quality to restore balance
- **Supernatural** factors such as spirit possession by a Nat or an ancestor can cause ill health
- **Spiritual** factors such as bad karma or non-observance of a religious ethic is seen as a possible causative factor
- **Traditional** beliefs:
    - A culture bound illness referred to as *Koro* in which there is a fear that the genitalia will recede into the body and that if they recede completely, death will occur
    - Among women, menstrual flow is thought to be critical to health and, depending on the flow, an indication of good or poor physical and mental health
- **Western medicine** and the concept that illness can be the result of external factors such as accidents and infectious diseases is accepted by many, especially those who have lived in refugee camps or come from urban areas. As with many resettled peoples, the degree to which traditional practices are adapted and modified varies enormously

3.2 Traditional treatments and practices

- **Dietary** changes are commonly used to treat illness. Depending on the illness, an increase in or reduction of one or more of the six Burmese tastes (sweet, sour, hot, cold, salty, bitter) may be indicated
- **Herbal** medicines are used by many Burmese, particularly for minor ailments (e.g. *Yesah* which is a herbal cure-all substance, lotions for aches and pains, pastes applied to wounds and abscesses)
- **Western** medicine has been integrated into much of the urban Burmese culture. For those from the hill tribes who may not have been exposed to western medicine, many come to New Zealand as refugees and will likely have had some experience of it in the refugee camps
- **Integrated** practices are common and many clients may integrate herbal and other traditional practices with western interventions. Practitioners may need to assess for potential drug interactions

3.3 Important factors for Health Practitioners to know when treating Burmese clients:

1. Given the traumatic circumstances that many Burmese refugees will have experienced by the time they arrive in New Zealand, they may feel vulnerable and powerless, particularly in the face of authority and need sensitive and respectful healthcare service
2. A history of sexual assault and abuse amongst refugee women and girls may evoke strong emotional and psychological responses to gynecological examinations. Same gender health providers are vital for these examinations
3. Women are often not forthcoming about their induced abortions, many which might have resulted from rape
4. Whilst women traditionally have pre- and neonatal support from the midwives, women in the refugee camps will not have had this, nor will they necessarily have had adequate information on reproductive health due to cultural and language barriers, and to access difficulties
5. Migrated Burmese women are likely to suffer isolation from their kin networks who provide childrearing and moral support
6. Traditional practices are often continued while utilizing western medicine
7. *'A-nah-dah'* (solicitousness for other people's feelings) may result in Burmese clients agreeing to suggestions that they are not comfortable with. It is best to check with clients whether treatment prescriptions are compatible with other beliefs and practices, and that the instructions are understood
8. It is useful to provide treatment instructions in varying forms such as spoken word, written (an interpreter can assist with this) and pictorial
9. Despite extreme deprivation and poverty, trauma during flight and exceptionally difficult living conditions in refugee camps, many Burmese arrive in New Zealand with remarkable personal resource, courage and positive outlook towards a better future. It is important that practitioners harness this potential in encouraging self-care, use of resources and opportunities to improve their physical and mental health
10. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home (notice whether there is a collection of shoes at the front door)
    - If food or drink is offered, it is acceptable to decline politely even though the offer may be made a few times
    - If the father/head of household is required for the interview/family session this will need to be arranged in advance as traditionally this would not be seen as part of his role
    - Dress modestly

3.4 Diet and Nutrition

Rice and both meat and fish are eaten. Traditionally foods are seen to have 'hot' and 'cold' qualities and when available these will be consumed as appropriate. Dietary changes as prescribed by western health practitioners may need to incorporate this system. Current rife poverty has created food insecurities and there is a high degree of malnutrition amongst the population.

3.5 Dying and Death

- Like many of the other Buddhist-based cultures, the Burmese value approaching dying and death with an attitude of equanimity and mindfulness. In some cases this may be more valued than measures to manage symptoms. For example, clients or families may elect for a greater degree of alertness over complete pain control and being in a highly sedated state. It is important to counsel clients and families that with current standards of care, many clients can have some degree of pain control and remain alert
- Clients with terminal illness, or who are dying need to be informed through the family, particularly an elder. In New Zealand there may not be an appropriate family member in which case a caretaker or close friend may be the one to give the news. Practitioners need to check with clients who they would like involved in their treatment and decisions. The process of Informed Consent may be new to many families and this process will need to be explained. If the client does not want to make any decisions for themselves, they will need to have a Durable Power of Attorney
- Clients generally will prefer to die at home
- The services of a monk need to be made available to Buddhist clients
- Buddhists will generally allow hospital staff or funeral directors to prepare the body for burial
- Burial needs to take place by the 3rd, or 5th or 7th day

4. HEALTH RISKS and CONDITIONS (these are outlined for Burmese living in the US and some of these may apply to Burmese in New Zealand)

- AIDS
- Amebiasis
- Angiostrongyliasis
- Anthrax
- Capillariasis
- Chikungunya
- Cholera
- Cryptococcosis
- Cryptosporidiosis
- Cysticercosis (tapeworm)
- Dengue Fever (including dengue hemorrhagic fever)
- Filariasis: (Bancroftian filariasis and Malayan filariasis)
- Gnathostomiasis
- Helminthiasis (ascariasis, echinococcosis/hydatid disease, schistosomiasis)
- Hepatitis B (15% carriage rate)
- Hookworm
- Landmine casualties
- Leishmaniasis
- Leprosy (still endemic)
- Leptospirosis
- Malaria, including multi-drug resistant (MDR) from *Plasmodium falciparum* resistant parasites and especially from malaria re-infection. MDR malaria is especially common on the Thai-Burma border, where most refugees are found. Other malaria-causing parasites in Burma include *P. Vivax*, and much less commonly *P. malariae* and *P. ovale*.

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- Melioidosis
- Mental Health concerns (depression, anxiety, PTSD)
- Mycetoma
- Paragonimiasis
- Sexually transmitted infections, including HIV/AIDS, cervical cancer, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, syphilis)
- Strongylodiasis
- Thalassemias
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzia; intestine-dwelling; and lung-dwelling)
- Tropical sprue
- Tuberculosis (Burma is one of 22 countries worldwide designated by WHO as "high burden" for tuberculosis)
- Typhus, Scrub
- Yaws (frambesia)
- Physical sequelae of torture
- Injuries from landmines and unexploded ordinance
- Malnutrition
- Anemia

5. WOMEN'S HEALTH

- Women in Burma face considerable health problems because of extremely poor living conditions, inadequate health services, and lack of basic education. Health care is even more deficient in the ethnic minority regions, where constant relocations and heavy losses of men's lives have left women with the complete responsibility of raising their children
- Maternal mortality rates are 580 per 100 000 live births (as compared to 80 for Malaysia and 10 for Singapore). Most maternal deaths result from induced abortions, largely conducted in secret and unsanitary conditions
- 17-22% of women use modern contraception (substantially lower than the goal of 30% set in 1997 by United Nations Fund for Population Activities) and the Ministry of Health. Women frequently resort to abortion to control family size. 14% of married women aged 15-49 years have had an abortion during

their married lives. This rate is much higher in the major teaching hospitals in Rangoon and Mandalay where the abortion rate is 330-500 per 1000 live births
- Oral contraceptives are avoided by many as they are believed to cause menstrual irregularity, while Depo-Provera injections are thought to provide regularity (despite the common adverse reaction of irregular bleeding)
- In more rural areas prenatal and neonatal care is provided by a midwife or '*let-thare'* (traditional birth attendant). In cities however, clinics and hospitals are frequently used. Beliefs about diet during this period make nutritional counseling essential, especially amongst the hill-tribes
- Iron-deficiency is found in 60% of pregnant women (more than 700 000)
- For women with more traditional practice, the postpartum period is viewed as a time of susceptibility to illness particularly after the blood loss (a 'cold' condition). The body should be kept warm with external heat and 'hot' foods eaten. This would be particularly significant in New Zealand given the change in climatic temperatures

6. YOUTH HEALTH

Serious economic deterioration resulting in extreme poverty, inadequate health services and deprived living conditions have rendered child health in Burma one of the lowest in Southeast Asia:

- UNICEF reports the national infant mortality rate in 1996 as 105 per 1000 live births (as compared with 33 in Vietnam, 31 in Thailand, and 11 in Malaysia)
- Because of the lack of potable water and sanitation, intestinal and respiratory infections, malaria, malnutrition, and vaccine-preventable diseases are rife
- About 28% of schoolchildren have goitres, and in some areas these rates are even higher
- Young girls are frequently abducted, raped and trafficked into sex work. Migrated adolescents who have experienced these conditions will likely need mental health support, as well as their families
- Some young boys are taken by the army and trained as soldiers from an early age. Migrated adolescent boys who have been through this experience will need mental health support and reintegration programmes

7. SPECIAL EVENTS

The Burmese New Year *Thingyan* (based on a lunisolar calendar) usually around 13 April, also known as the *water festival*, has its origins in the Hindu tradition. It is also when many Burmese boys celebrate *shinpyu* a time when a Buddhist boy enters the monastery for a short period as a novice monk. It is considered an obligation of Buddhist Burmese parents that sons spend some time in service at a Buddhist monastery.

8. SPIRITUALITY

- **Buddhism** in Burma is predominantly of the Theravada tradition and practiced by about 90% of Burmese. Practitioners are mostly among the dominant ethnic Burmese, the Shan, the Rakhine, the Mon, the Karen, and the Chinese who are well integrated into Burmese society. The culture and world view of the people of Burma is very influenced by Buddhism, and although some of the ethnicities mentioned also practice other religions, it is often in conjunction with Buddhist principles. There are 12 Burmese festivals, each for one calendar month and most are related to Buddhism

- **Nat** worship is practised usually in conjunction with Buddhism mostly by the ethnic Burmese and more so in rural areas. *Nats* are a collection of deities including spirits of trees, rivers, ancestors, snakes and the spirits of people who are believed to have met violent or tragic deaths, and wreak destructive vengeance on people who annoy them. Originally they were thought to be infinite, but a canonical number of 36 was fixed with Buddha included as the 37th. Many houses contain a *nat sin* or *nat ein*, which essentially serve as altars to nats. Villages often have a patron *nat*
- A small percentage of Burmese are **Christian** including Catholics, Protestants, Baptists and followers of the *Wa* church (an ethnic minority from China) which is Baptist in character

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SECTION III
Eastern Mediterranean & African Cultures

Sudan

Ethiopia

Afghanistan

Iraq

Iran

Somalia

Burundi

Background Information

Eastern Mediterranean Region and Central Africa

'Eastern Mediterranean' is a new term proposed by the World Health Organization (WHO) and includes countries previously referred to as 'Middle Eastern' and 'North African', including the Horn of Africa. This section covers cultures from Iraq, Iran, Afghanistan, Somalia, Sudan, Ethiopia and Eritrea. A chapter on Burundi, a ***Central African*** country is also included.

Although the new reference 'Eastern Mediterranean' arose primarily from the shared health issues of the area, most of the cultures in this section, despite their obvious diversity, share some beliefs and practices inherited through deeply embedded and ancient cultural traditions, many of which pre-date Christianity or Islam. This introduction provides more detail on the common health and religious practices that are listed in the individual chapters.

A high percentage of the people from these cultures who have resettled in New Zealand arrived as refugees (as well as the Burmese, Vietnamese, Cambodian and Laotian cultures in the 'Asian' Section II). Some information on refugee issues is also provided in this chapter.

1. Communication and Gestures

Particular gestures and greetings for each of the cultures are provided in the individual cultural sections, however since Islamic practice has a significant influence on many of the cultures in Section III, the following is a general guide. For those cultures that do not follow Islamic practice, or for the Christians living in the Muslim countries, the following would not be offensive and so can safely be followed:

- **avoid prolonged or direct eye contact** (*for some cultures eye contact is avoided out of respect for others, particularly authority/elders, and for others because of the belief in the '**evil eye**'. Most of the resettled people accept direct and prolonged eye contact from the host culture of New Zealand, however, many will decline to return it for the aforementioned reasons*)
- **shaking hands is best between members of the same sex only**
- **the right hand ONLY is used to shake hands**
- if male, or in doubt, use **customary greeting with women**
- assume that **respect for authority will prohibit people asking questions** of the health practitioner, or answering in the negative; offer explanations and invite questions from the client
- **'yes' may be ambiguous** (because saying 'no' is not acceptable in some cultures)
- Western custom of asking direct questions is unfamiliar to some cultures and may evoke reticence to engage. Preface interactions with questions of wellbeing, including about the family
- **respect, especially to elderly** is appreciated
- **over-familiar touch** is not appreciated**,** especially **amongst Muslims**

1.1 Table of greetings in different languages

Culture	*'hello'*	Form of address	Customary gesture	Eye contact
Afghan	***salaam aleikum*** Afghan Video Clip	**title** and **second name**	hand shake with **right hand** with same gender, otherwise use customary greeting	less direct and prolonged than in New Zealand
Iraqi	***salaam aleikum*** (Muslim) ***shlamalugh*** *(masc.),* ***shlamalagh*** *(fem.)* (Christians) Iraqi Video Clip	**title** and **second name**	hand shake with **right hand** with same gender, otherwise use customary greeting	less direct and prolonged than in New Zealand

Iranian	***salaam*** Iranian Video Clip	**title** and **second name**	hand shake with **right hand** with same gender, otherwise use customary greeting	less direct and prolonged than in New Zealand
Somali	***salaam aleikum*** Somali Video Clip	**first names** are expected	hand shake with **right hand** with same gender, otherwise use customary greeting	less direct and prolonged than in New Zealand
Sudanese	***salaam aleikum*** Sudanese Video Clip	**title** and **second name**, although first name is acceptable	hand shake with **right hand** with same gender, otherwise use customary greeting	less direct and prolonged than in New Zealand
Ethiopian/ Eritrean	***tena yistilign*** Ethiopian Video Clip	**first names** are acceptable with younger people, or **title** and **first name** with older people (above 35)	hand shake with **right hand** with same gender, otherwise use customary greeting	direct but less prolonged than in New Zealand
Burundian ***(and also Rwandans)***	***mwaramutse*** Burundian Video Clip	**first names** are expected, otherwise '*aunt*' and '*uncle*' as a term of respect for the elderly can be used	hand shake with **right hand** with either gender, and customary greeting	Burundians and Rwandans will avert eye contact out of respect

2. HEALTH CARE BELIEFS AND PRACTICES

Interesting note: It is reported by most of the community representatives consulted for this resource, that subscription to many traditional beliefs in general, but particularly about spirits and sorcery, are diminishing amongst those who have received formal education, and by many resettled people. However it is interesting to note that the traditions that embody the beliefs have become so embedded in the cultures that some of the related practices continue, in spite of changed beliefs. For example, Burundian women do not reveal pregnancy until absolutely necessary. This tradition has its origins in precaution against evil spirits, and although many educated and/or resettled Burundians no longer subscribe to beliefs in spirits, they nevertheless continue to conceal pregnancy, even from relatives and close friends.

2.1 Factors seen to influence health[1]

There are factors believed to influence health that are common to some Arabic and African cultures in this resource. Some of these pre-date Christianity and Islam. More detail is provided in this chapter than in the individual cultural sections.

- **Supernatural/religious factors**

A hierarchy, headed by a most powerful deity (God, or a god), followed by spirit entities or angels (good and bad), ancestral spirits, persons, animals plants and other objects, is seen to influence health. Entities can interact causing ill health or restoring health and reduce or enhance the power of a person.

- Ill health can be as a result of punishment by ***God*** for sins committed
- In Islam spirits called ***Jinn*** can be good or bad and are recognized assistants of God. The 'good' help people whist the 'bad' punish sinful actions. Possession by either can cause 'mad' behaviour
- ***Zar*** spirits are believed to influence mental health. They occur in Sudan, Somalia, Ethiopia and Iran. *Zar* possession explains unusual or inexplicable behaviours, including those that might be attributable to sin. Attributed possession also removes responsibility from the individual for actions or events. The spirits may be helpful or harmful. The condition is treated by a *Zar* doctor (or a traditional healer) who negotiates between spirits and humans and offers particular kinds of treatment. Although both genders are affected by *Zar,* it is suggested that women are more likely to be affected by them. *Zar* possession is associated (by western practitioners) with powerlessness and it has been noted that after resettlement possession can increase amongst refugees in general, but also in men, perhaps in response to their experiences of powerless
- ***Evil Eye*** is a common Muslim concept throughout the Eastern Mediterranean Region. It is believed by many that people (in some cultures it is particular people imbued with supernatural powers, or born with an *evil eye*, whilst in others it can be anyone) can put a curse on another by looking at them, or through prolonged eye contact. For this reason any or prolonged eye contact is avoided in these cultures. Babies and young children are believed to be particularly vulnerable and for this reason it is best not to praise a child openly. It is believed that the child may be protected if the person offering the praise immediately follows this by touching the child, or the parent may make a negative statement about them, spit, put dirt on the child or recite religious verses. Some may wear amulets as protection. Others protect their newborns by keeping them away from community and the public during the first couple of months after birth. It is believed that the *evil eye* generally causes physical rather than psychological illness, and in particular, epilepsy. Many educated and resettled people may no longer subscribe to the belief
- ***Sorcery*** occurs (in both Arabic and African cultures) as a result of the combined actions of humans and evil spirits and is performed by a sorcerer at the request of a client. It is believed to cause significant distress, disrupt social relations and can create sexual dysfunction in men. The belief in these spirits is pre-Christian and pre-Islamic although it has been incorporated into the Koran and is widely accepted. The beliefs and attributions are more likely amongst less educated people and those with little power

[1] Much of the information in this section is sourced from Jackson (2006), Chs.2 and 12.

- ***Ancestors*** can protect, or they can cause harm if they are angered, either by disrespect or by neglect. Some refugees who have fled war situations may not have been able to fulfill specific obligations to ancestors before or during flight and may need to complete these in order to restore a sense of wellbeing as part of their treatment

- ***Balance***

Maintaining 'balance' is seen to be essential to good health. Imbalance causes ill health. Balance may refer to the humours within the body and can include concepts of hot/cold, dry/moist which need to be restored with the opposite foods or conditions. These terms do not refer to temperatures but to qualities. They differ from one culture to another. In some cultures balance is also needed to be maintained between subjective and objective worlds (e.g. feelings and social relations) and between the physical and psychological.

2.2 Traditional and current treatment practices

Most people of the cultures in this section are familiar with and accept Western biomedical intervention, particularly once they have resettled. Traditional medicines may be used in the countries of origin because of scarcity of medical resources, as well as out of tradition.

Some traditional practices may continue in New Zealand however, and it is reported that in some cultures substitute herbal treatments are being used. Such remedies may be beneficial physiologically, and because the client has faith in them. However, research indicates that some herbal treatments may produce interactive effects when used in conjunction with biomedical interventions. It is necessary to ascertain what other treatments the client may be utilizing since it is not unusual for people to use a number of different treatments concurrently, including religious, herbal and biomedical.

Since traditional, indigenous and religious frameworks do not usually encoporate a mind-body split, both physical and psychological conditions are often treated with similar interventions. Clients may also not make the distinction. For this reason, psychological symptoms are often expressed somatically. Jackson (2006) lists a few other reasons for what might be described as 'somatisation' by western practitioners:

- No familiarity with mental health terminology and conceptions because of lack of mental health facilities in countries of origin
- Because of the absence of the split between mind and body, people readily recognize that ill health may be a combination of both
- In different cultures the 'sick' role is prescribed in certain ways and people may need to conform to these to be acceptable and receive attention
- There are differences in the range of words available in each culture to express emotions
- Metaphors are sometimes used to describe psychological distress, e.g "I have pain in my heart"
- The stigma of mental illness, and in particular 'weakness' that is sometimes associated with it, would encourage people to express problems in physical terms
- Physical symptoms are sometimes more easily accepted and understood in environments where verbal dissent is punishable and unacceptable

2.3 Traditional treatments/practices	
Traditional and Religious/ Supernatural Healing	Religious practitioners or traditional healers may recite holy verses, write prayers which can be worn in amulets on the body, or may perform rituals for cleansing or purification. Some rituals may involve the healer requesting assistance of God, spirits or ancestors, through trance states, and receiving instructions through these states. Traditional healers also use herbal treatments (see below). Some traditional healers are trained by elders and healers within their community, others inherit powers and skills. Their official status differs across countries, with some countries giving recognition and status to the practitioners.
Herbal treatment	The use of herbs to treat ill health is widespread in both Arabic and African countries. Herbs, plant extracts, roots and animal products can be boiled in water, heated or dried and inhaled, ingested or made into potions which are applied externally. The remedies are often administered as enemas (inducing severe complications from frequent use). Herbal treatment is an essential component of Traditional African Healing. There are however, dangers of unknown pharmacopoeia, and particularly of drug interactions when used in conjunction with western biomedical medicine.
Ritual cutting/ scarification	Some conditions are treated by ritual cutting, or blood letting, which may leave marks on the body.
Cupping 	A series of heated 'cups' are placed on the skin, forming a vacuum that draws on the underlying soft-tissue. Different cultures use different objects to create the suction. The process can be repeated a number of times and can leave marks
Moxibustion	A soft combustible material (e.g. a herb) is heated and burned indirectly at specified spots on the skin. This may also leave marks on the body
Patent Medicines	Some patented medicines are reputed to be available from Asian and Middle Eastern stores in Auckland

3. Other cultural practices relating to health

3.1 ***Female Genital Cutting (FGC)***

(*Most of the information in this section is sourced from Kemp and Rasbridge (2004), and www.who.int)*

What is it?	FGC is a collective name given to various traditional practices that involve the partial or total removal of the external parts of the female genitalia (also known as Female Genital Mutilation (FGM), or female circumcision), for cultural or non-therapeutic reasons. The WHO regards the practice as a human rights violation and there are international agencies providing information and education on the issue. It is reported that many subjects of the practice and particularly the men in the respective cultures are not aware of the consequences other than those immediately following the procedure. However, it must be noted that for many women the tradition is considered a rite of passage for womanhood, is an ancestral practice and provides status and preparation for marriage.

	Some cultures believe that the uncircumcised woman is unclean (*haraam*) by Islamic law, and some erroneously believe it is required by Islamic law and Christianity. It is also practised by non-believers and animists. Families who are unable to have the procedure performed in the country of resettlement will often try to send the female children home for the purpose.
What age?	The procedure commonly takes place between the ages of 4 to 12, however the range can vary as much as from birth through to a first pregnancy across different cultures. It is usually performed by traditional practitioners or lay persons (elders or birth attendants) in the community, and often in unsanitary conditions using non-sterilized instruments such as broken glass, blades, kitchen knives etc. The more affluent are increasingly obtaining the procedure by trained health practitioners in medical clinics.
What countries?	FGC is practised in 28 African countries, and in parts of Asia and the Middle East. The practice is increasingly performed where immigrants from these countries of origin have resettled.
Reasons for the practice	There are varyied and complex reasons for the practice. Refer to http://www.who.int/mediacentre/factsheets/fs241/en/ for more details.
Types of FGC	4 types are defined: • **Type I** – the removal of the prepuce, and/or all of the clitoris ('Sunna circumcision', is considered a non-WHO classification) • **Type II** – the removal of the clitoris with partial or total removal of the labia minora • **Type III** (infibulation) – the removal of part or all of the external genitalia followed by the stretching of the scraped sides of the vulva across the vagina. The sides are then sewn to narrow the vaginal opening. A small opening is left for urinating and the passing of menstrual fluids. An infibulated women usually needs to be cut before intercourse can take place, or at least before childbirth • **Type IV** – includes a number of practices which involve pricking, piercing or excision of clitoris or labia, stretching of both, cauterization of the area, scraping of the tissue surround the vaginal orifice (*angurya* cuts)and cutting the vagina (*gishri* cuts), and introducing caustic substances for the purpose of narrowing the vagina. Type II is the most common, accounting for up to 80% of most cases.
Sequelae	Long-term and immediate consequences of FGC depends on type and conditions under which the operation is performed • Shock • Chronic and severe pain • Haemorrhaging and infection (sometimes leading to death) • Ulceration of genital region

	• Cysts and abcesses • Long-term difficulties with intercourse and childbirth • Difficulties with menstruation • Sterility • Increased risk of vaginal infection • Increased risk of HIV infection • Urinary retention • Incontinence • Increased risk of urinary infections • Psychological problems between couples because of painful intercourse

4. Religion/Spirituality

For most Arabic and some African cultures, religion plays a more central role in life than is common in many Western cultures. It provides a framework for understanding all aspects of living, including illness and health. For those who practice Islam, it is a belief system, a culture, a structure for government and a way of life. It is important to acknowledge the role of religion with clients and to have some understanding of the implications of the belief systems.

For some cultures the beliefs and practices are a composite of a number of traditions. Such diversity in spiritual beliefs require that assessment precede implementation of any type of spiritual care during illness. The most common of the faiths amongst those cultures in this section are:

FAITH	**DESCRIPTION**	**COUNTRY** (where significant numbers practice)
Islam 	A unifying belief of all **Muslims** is the belief in One God (Allah). The Koran (*Qur'an*) provides the scriptures, revealed from God through the prophet Mohammed. The cornerstone of Islamic faith, the 'Five Pillars' are the obligations which are required of every Muslim. They are: *shahadah* (statement of faith), *salat* (prayers x 5 per day), *zakat* (giving alms), *sawm* (fasting from sunrise to sundown), and *hajj* (pilgrimage to Mecca). Sunni Muslims constitute 85-90% of followers and Shiites about 10-15%. Sunnis believe that Mohammed died without appointing a successor, whilst Shiites believe that Ali was appointed. Sunni Muslims are contained in their expression of grief whilst Shiites grieve more openly. Sufi Muslims can be Shiite or Sunni oriented and focus on the ascetic and mystical elements of Islam. In all the cultures in this section, Sunni Muslims are the majority except in Iran where they are mostly Shiites. **Implications:** o that ill health may be God's will. Some Muslims may passively accept this whilst others will seek treatment o during **Ramadan** practitioners need to ascertain whether clients	*Afghanistan* *Iraq* *Iran* *Somalia* *Sudan* *Ethiopia* *Eritrea*

	intend to observe regular or modified fasting and advise re medication, particularly for clients with chronic systemic illnesses (sometimes doses are doubled, tripled or missed by clients to accommodate fasting). Practitioners can also remind clients of the exemptions stipulated by the *Qu'ran* o practising Muslims with ill health, or those hospitalized may be challenged to meet the obligations of the 5 daily prayers and fasting and may need assistance to meet these o dietary restrictions include pork and meet that is not *halaal* (blessed by a Muslim clergyman) o ritual washing is required before prayers (5 x a day) and can present difficulties for devotees in non-Muslim environments including schools and places of work	
Holy days	These include: o ***Ramadan*** is celebrated by Muslims in the 9th month of the lunar Islamic calendar and is regarded by many as the holiest time of the Muslim year. During this month Muslims fast from dawn until sundown (including no water or other liquids). Those with ill health are exempt from the fast although many nevertheless like to partake. Young children, menstruating, pregnant and nursing women are also exempt from fasting o ***Moulid*** (Milad) marks the anniversary of the birth of Prophet Mohammed and occurs during the month after Ramadan. Some Muslims celebrate whilst others do not since this day also marks the anniversary of his death o ***Eid (Eid Al-Fitr)*** (celebrating after fasting) '*Eid*' is the Islamic word for 'feast' and is celebrated at the end of Ramadan and the month long fast. The *Eid* prayer is performed as a ritual and food and non-alcoholic drinks are offered in mosques and homes, with the celebration lasting for 3 days o ***Eid Al –Adha*** (important holiday for making pilgrimages to Mecca) This is celebrated 70 days after *Eid al-Fitr*. The holiday is in honour of the sacrifice of Abraham to God, and it is also the day when Muslims from all over the world try, at least once in a lifetime, to go to Mecca. The occasion is commemorated with an early morning prayer and ritual, and celebrations follow for 3 days. In New Zealand, many families will buy a goat or sheep from a butcher in their name in place of performing a sacrifice themselves.	
Special Concepts	The ***Hijab*** is generally known as the head scarf worn by many Muslim women. In its broadest sense, however, it means modesty which includes behaviour as well as dress. *Hijab* includes a head covering (actually called a *khimaar)*, and also a garment covering all but hands, feet and eyes. Full covering is referred to as *purdah*. Modesty and covering, is part of a code of morality and many women wear *hijab* with pride and to make a statement that they are followers of their faith. Westerners often associate *hijab* and some of the related principles with the oppression of women in Islam. This is not necessarily the case and practitioners need to assess client's attitude and positions on an individual basis. Different cultures, clans and	

	sects vary in their adherence to modesty protocol.	
Animism and Indigenous Religions 	Whilst animism and indigenous religions are not necessarily synonymous, what they commonly share is that all aspects of the environment are seen to have life. Both share the belief in positive and negative entities/spirits which affect humans. Shamans or traditional healers can traverse at will, between the worlds of the spirits and the consensus-reality world, and influence the entities and the effects they have on humans. It is believed that the traditional healer can not only avert bad luck, but also be instrumental in resolving tensions and conflicts between the living and the dead. The influence of ancestors is central to this practice. The correct burial rituals following the death of a relative are thought to ensure wellbeing for the individual and family. **Implications:** o That external forces are responsible for ill health and that appeasing the forces either through their own actions, or with the help of a traditional healer, will resolve the problem o Many refugees who have experienced displacement and flight may not have been able to perform the necessary obligations to ancestors for some time and may need to do this as part of therapeutic intervention to restore a sense of wellbeing	*Somalia* *Sudan* *Ethiopia* *Eritrea* *Burundi*
Christianity 	Christianity is a monotheistic religion and includes the doctrines based on the teachings of Jesus Christ. Divisions within the faith are based on whether the Bible is seen as the literal or inspired word of God. The earliest division was between the Church of Rome (Catholics) and the Eastern Orthodox Church (includes **Assyrian Church of the East** and the Ethiopian and Eritrean Coptic Churches). The forms of Christianity practiced by people in the Eastern Mediterranean region have their roots in the oldest forms of Christianity, some aspects of which are pre-Christian and are evident in current practice even though they may not be formally accepted by church leaders. These include the belief in spirits (*'zar'* and *'adbar'*) and the need for protection or purification. The Christian elements of the **Ethiopian Coptic Church** (and Eritrean Orthodox Church) include God, angels and saints, where the angels and saints are messengers of God. Fasting and ritual is involved in practice and only those devotees following required practice can partake of communion. An ark (tabot) dedicated to a church's patron saint is consecrated (not the church) and this is carried in procession on holy days. Lay followers are required to fast for 165 of the year including Wednesdays and Fridays and the two months of the year that include Lent and Easter. Memebers of the Assyrian Church also practice fasting. **Implications:** o Medication during fasting may require monitoring and adjustments o For those who believe that illness is a result of God's will, a	*Sudan* *Burundi* *Iraq* *Ethiopia* *Eritrea*

	fatalistic attitude may prevail o For those who encoporate spirits into their beliefs, purification may be a necessary aspect of treatment	
Zoro-astrianism 	This is a very old faith pre-dating Christianity and Islam. It developed in Persia and is a monotheistic religion based on the teachings of the prophet Zoroastra (Zarathustra). *Ahura Mazda* is the supreme God, and the *Avesta* the holy text. The faith is based on the belief that good and evil are the two forces in the world and that humans have to decide which one to follow. It is believed that ultimately good will prevail and the forces of evil will be overcome. **Implications:** o Purification is an important aspect of the practice and clients who are ill may require religious rituals to assist in the healing process	*Iran*

5. Refugee Health

Refugees require **special consideration in health care** due to their traumatic pre-settlement experiences and related resettlement challenges. Unlike migrants who usually migrate out of choice, refugees' re-location is forced and associated with trauma, and often war and torture. They necessarily flee persecution, often in fear of their own and their family's lives, and without opportunity to plan their re-location.

New Zealand can be for many, a 2nd or 3rd place of refuge after internal displacements within the home country, long journeys to find protection, and finally extended periods of hardship in refugee camps (for some, as much as a generation). Conditions within refugee camps are often not much better than the place from which refugees fled. Scarcity of food, lack of physical security, separation from family members and loss of life purpose are a few of the challenges that accompany many refugees during their wait to be resettled, or return home to enjoy their human rights.

Many refugees have had inadequate health care before coming to New Zealand, and arrive with high needs including significant mental health needs. Of the 35% (per average intake) of refugees arriving at Mangere Refugee Reception Centre (MRRC) who elect to use mental health services, only 3% of these suffer from a diagnosable condition. However, people present with a significant number of **symptoms** of mental health disorders, many of which evolve into full-blown syndromes and disorders if they remain untreated. PTSD (Post Traumatic Stress Disorder) often only emerges after a person has settled.

United Nation's definition of a refugee:
". . . *owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it*".

5.1 'Quota refugees', 'Asylum Seekers' and 'Convention Refugees'

- **Quota refugees** are refugees who have been recommended by the United Nations High Commissioner for Refugees (UNHCR) and have been accepted for resettlement by New Zealand Immigration Service. Most of these people will be re-located from refugee camps. Quota refugees arrive in New Zealand with permanent residency status and are entitled to the benefits available to all New Zealanders
- **Asylum Seekers** are people who arrive in New Zealand of their own accord and petition for permission to remain here because of the threat of persecution in their home country. They are assessed in accordance with the criteria for refugee status set out in the 1951 Geneva Convention. Those who are granted permanent residence fall under the category '**Convention Refugees**'. Their application follows a legal process and can take from weeks to years before a decision is made, leaving the person living in uncertainty for long periods of time. Those who arrive with valid entry documentation (e.g. visitor or student visas) are usually permitted to remain while their application is being processed. Those who arrive without valid documentation may be detained in Mount Eden prison or at the Mangere Refugee Reception Centre until identity and security issues have been resolved. There are considerable disparities between services provided for quota refugees and asylum seekers.

5.2 Factors that impact on a refugee's physical and emotional health

Pre-settlement trauma	Re-settlement challenges
• War • Rape and assault • Physical injuries • Lack of safety • Imprisonment and torture • Family separation and disappearances • Refugee camp life with daily struggle for survival and safety • Disempowerment • Lack of justice • Witnessing of violence and atrocities • Extreme poverty and deprivation	• Cultural shock, as well as loss of own culture • New language, people, religions • Lack of personal belongings • Separation from, and loss of loved ones • No extended family for support • Authority issues due to previous experiences (torture and persecution) and disempowerment • Loss of control over own and family's life • Sense of shame • Confusion • Loss of confidence, dignity • Loss of previous lifestyle and career • PTSD symptoms start • Fear of being sent back (the threat is often used by authority figures, sometimes those in the family, to maintain control)

Notable statistics for New Zealand (provided by RASNZ)

- 19% of refugees entering New Zealand have survived torture and trauma
- 79% have survived severe trauma
- 68% of these are women and children

5.3 Common health presentations of refugees

Physical symptoms	Mental health symptoms
• Pains in different parts of body • Headaches/dizziness • Heart palpitations • Heightened state of arousal • Hypertension • Nausea • Ulcers • Breathing difficulties • Sleep problems • Tremors, numbness, weakness, fainting, sweating • Stomach disorders • Dairrhoea and constipation • Specific sequelae from torture	• Social withdrawal • Irritability, aggressiveness, anger • Impulsiveness • Suicide attempts • Sexual dysfunction (severe) • Fear, anxiety, panic • Confusion, disorientation • Memory disturbances • Loss of concentration • Rumination • Lack of motivation • Attention blocking • CTSD[2]

5.4 Chronic and long term physical sequelae of torture.

ORGANS	COMPLAINTS	POSSIBLE CAUSES. WHAT TO CHECK FOR.
Eyes	Blurred vision, double vision, problems with accommodation	Chronic conjunctivitis, possibly caused by wearing a dirty hood for long periods. If no abnormality, **check for** whiplash syndrome, paying special attention to status of cervical spine
Ear, Nose, Throat	Impaired hearing, vertigo, tinnitus, earache, poor air flow through nose	Blows to face and ears. Beating both ears at the same time (*telefono*) can result in damage to middle and inner ear, and chronic otitis media. If tinnitus and vertigo cannot be explained, whiplash syndrome should be considered
Teeth	Teeth missing/ broken/aching, bleeding gums, poor chewing, headaches, pain in face, possibly dyspepsia	Possible causes: • blows to face. • teeth may have been extracted without anaesthesia • poor food and poor dental hygiene **Check for** gingivitis
Lungs	Sometimes persistent irritable cough	Possible cause: • By aspiration of dirty water during mock drowning (*submarino*) • Other infection a result of poor and insufficient food and stress during imprisonment **Check for** TB and other infectious illness
Heart	Brief stabbing precordial pain, palpitations, difficulty breathing	Often no physiological cause found but precordial pain may be an after effect of suspension. Pain from vertebral column and whiplash syndrome may imitate precordial pain
Alimentary canal	Complaints of symptoms very common. May complain of symptoms typical of gastric ulcer - epigastric pain, hunger pains with	Despite complaints, gastroscopy reveals that only small numbers have ulcers May have pain and bleeding from anus and rectum,

[2] CTSD (Chronic Traumatic Stress Disorder) is a term used by STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) in Australia indicating that PTSD in a refugee population usually involves more than one major stressful event. It usually involves a multiple of sequential events, any or all of which could cause PTSD symptoms in the average population.

	relief on eating, acid regurgitation, loss of weight, nausea and, less commonly, vomiting Complaints of constipation/diarrhea	fissures etc. Probably from sexual torture when objects forced into rectum May show signs of previous infections with Hepatitis A, although B and C also seen Depending on country of origin, may present with chronic parasitic conditions, e.g., bilharzia, malaria, and intestinal worms. (In NZ refugees who have spent their first few weeks at MRRC are checked for parasites and infections, but others who arrive as asylum seekers or under the family reunification scheme may not have had these checks)
Urogenital system	Complaints of dysuria and frequency Women may complain of chronic stress, disturbances of menstruation (oligomenorrhea), lower back pain, problems with urination and defecation, dysfunction of pelvic muscles and joints Men may complain of anal problems, premature ejaculation, reduced potency	Physiological basis for these complaints are rare May be sequelae of sexual torture. Check for chronic inflammation of internal sex organs. Check also for referred pain from the spine May be sequelae of sexual torture **Check** men and women for AIDS and Hepatitis B
Central and peripheral nervous system	Headache (many types, including migraine) reduced ability to concentrate, reduced memory, cognitive difficulties, vertigo, tiredness Parasthesias. Complaints of strong shooting pain in localised area, neuralgia. If this pain occurs in bouts, it may be described as muscle cramps. Complaints of superficial burning, smarting sensations in area, caused or aggravated by light touch, but decreasing with firm touch	Probable causes: • many direct blows to head, especially if client has been rendered unconscious • electric torture causing convulsions • mock drowning (*submarino*) resulting in anoxia to brain **Check for** whiplash syndrome, dysfunction of teeth as possible causes of headache Symptoms similar to dementia, especially poor memory may be psychogenic and respond to psychotherapy Probable causes: • constriction of extremities by cuffs or rope • hanging from arms when arms tied behind the back (*Palestinian suspension*) • repeated and violent trauma to areas of body where peripheral nerves close to surface, including soles of feet (*falanga*) Depending on area about which complaint is made, **check for** damage to trigeminal nerve, brachial plexus, nerves of soles of feet. Check also for sensory disturbance to pinprick and temperature Pain may be chronic or intermittent. Failure to find physiological basis for pain can be harmful to psychological well-being of client
Musculo-skeletal system	Complaints about muscles, tendons, nerves and joints extremely common Pain in arms, radiating to corresponding extremity, parasthesiae and tiredness. Pain	Probable causes: • continuous beating of body and extremities, electric torture • high levels of stress causing extreme muscle tension and sometimes faulty posture Suspension by arms. Besides **check**ing **for** damage to brachial plexus, **check for** strained and malfunctioning muscular connections of

	in/around the heart	arms/shoulders and thorax. This may trigger precordial pain
	Lower back pain without radiation to lower extremities	Possible cause: • Being forced to crouch in restricted cage for long periods. May cause over-stretching of stabilizing ligaments and joint capsules of spine. This results in segmentary instability and malfunction. May also cause irritation of afferent sympathetic nerves with segmentary radiation to viscera and skin. Depending on the segment of the spine that is affected, symptoms may mimic cardiac, gastrointestinal, urogenital conditions etc.
	Intermittent, often burning pain of lower legs and feet, Made worse by walking	Damage to tissue of feet as a result of beatings to feet (*falanga*). Destruction of fatty pads of foot during beatings
	Varied complaints of pain in the neck possibly with radiation to one or both upper extremities. Blurred vision, dizziness, tinnitus, migrainous head, paraesthesie of face, toothache, chest pain	Possible cause: • whiplash from being beaten or pushed from behind while blindfolded and unable to predict the blow • damage to cervical spine, discs and ligaments, also to vessels and nerves supplying head and neck
Skin	Not usually associated with complaints of pain	**Check for** scars from whipping, cigarette burns, electric torture, cutting and stabbing, application of acid

Sourced from Jackson (2006), Appendix 2.

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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. RMS Refugee Resettlement can provide information on resettlement issues and contacts for community leaders. Contact the Auckland Co-ordinator on +64 9 621 0013.

3. www.aucklandras.org.nz for information on refugee services and links to related sites

Burundian Culture

The ***Great Lakes Region*** is beset with endemic conflict and struggle. Hutu and Tutsi ethnic groups, armed rebels, and various governments seek control over the populated and resource areas of the region. Rwanda, Uganda, Tanzania, Democratic Republic of Congo as well as Burundi form part of the territory. Whilst Burundian culture is the focus of this chapter, some aspects of culture, beliefs and traditions may be shared by the neighbouring countries. Health practitioners may assume some similarities between the cultures, but particularly between Rwandans and Burundians.

* * * * * * * * * *

Burundi, officially known as the **Republic of Burundi** gained independence from Belgium in 1962. Since then it has experienced decades of extreme ethnic tensions, including the Burundian genocide against Hutu in 1972. The ongoing unrest and violence has been fuelled by the struggle for power between the majority Hutu and the ruling Tutsi ethnic groups. Various military dictators from the Tutsi minority held power, with violence escalating during 1988 between the Tutsi army and Hutu opposition. About 150 000 people were killed during this time alone and hundreds of thousands fled to neighbouring countries.

In 1991 a multi-ethnic government was constituted under international pressure, with the first Hutu president, Melchior Ndadaye elected in 1993. After his assassination in the same year and 2 more the following year (including the President of Rwanda, triggering the Rwandan genocide of 1994) Burundi was plunged into a vicious civil war. Extremists from both the Hutu and Tutsi groups massacred thousands of people from the opposing ethnicities. In 1996, the third-time president Pierre Buyoya, took power and later handed over to his Hutu Vice President Domitien Ndayizeye, after which a post-transitional government was established with approval from most Burundians in 2005. In spite of this achievement instability has continued with a second ceasefire agreement being signed since then between the extreme Hutu group, the 'FNL' and the government in September 2006.

The humanitarian disaster of Burundi resulted in over 300,000 deaths and over 700,000 Burundians fleeing to western Tanzania, Rwanda, the Democratic Republic of Congo and others, or being displaced within their own country. Gross human rights violations including murder, rape, torture and 'disappearances' have been rife during the struggle. These continue, noticeably along the Burundian Tanzanian border. Many of the women and girls have suffered sexual assault and domestic violence in the camps. Poverty is rife with over half the population living below the breadline. Burundi is one of the poorest countries in the world.

Many Burundians have been, and continue to be repatriated by the UNHCR although tens of thousands still reside in refugee camps in neighbouring countries. New Zealand has resettled about 170 people since 1996 most of whom live in Auckland. Burundians continue to arrive as refugees or through family re-unification programmes.

Photos: by kind permission of Refugees International, www.refugeesinternational.org

1. **COMMUNICATION**
Greetings video clip

Hello greeting	(Burundi and Rwanda)	*Mwaramutse (you are alive!)*
Goodbye greeting	(Burundi)	*Nagasaga (stay alive)*
	(Rwanda)	Murabeho

Main languages

The official languages of Burundi are **Kirundi** and **French.** Some speak Swahili. Ethnic groups are Hutu (85%), Tutsi (14%) and Twa (pygmies) (1%).

Whilst French interpreters will be able to interpret for many Burundians (those with formal education have learned French), a Burundian interpreter is recommended whenever possible as there are some significant cultural issues that are likely to need clarification during clinical interviews and interventions. Kirundi and Kinyarwanda, the language of Rwanda are similar enough that both groups will understand one another.

Gestures and interaction

- It is expected that **First names** will be used by practitioners in greeting
- **Hand** shaking is acceptable across genders. The **right hand** is used for shaking, the left hand used to support the lower right arm when respect is being shown
- It is common for Burundians to hug, kiss cheeks and touch heads with people they are familiar with
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Traditionally, **direct eye contact** is considered rude. Lowering or averting the gaze is a sign of respect. Most Burundians in New Zealand accept direct eye contact from the host culture, but may decline to return this out of respect
- The Western custom of **asking direct questions** can result in reticence to engage. Asking general questions about the wellbeing of the client (and importantly, family) will assist with establishing rapport and for the client to volunteer information for further questioning
- **Answering directly** is not customary in Burundian culture so an affirmative response from a client may not necessarily mean agreement or acceptance. 'Yes' may sometimes mean 'no' and vice versa. Further investigations may be necessary to gather relevant information. Burundians regard their privacy highly
- Health practitioners are usually highly regarded and clients are very unlikely to **ask questions** as it is considered disrespectful, even if invited to do so. It would be helpful for practitioners to offer any information they might think the client would need or want
- **Proverbs** are an important part of Burundi expression and will likely not be explained. They are intended to make the listener think

Special concepts
Belief in, and the practice of **witchcraft** is a common heritage in Burundian culture. Many people who have had formal education and who have migrated no longer subscribe to the beliefs or practices. However the caution and mistrust which arises from the legacy underlie many customary attitudes and traditions.

2. FAMILY VALUES

- In Burundi families are extended and live rurally in a compound called a '*urugo'*. In New Zealand the nuclear family is the norm due to the benefit system and to housing limitations
- In the homeland extended family members maintain close ties (influenced by geographical factors), and this tradition continues in New Zealand as far as is possible
- Children are important to Burundian families and seen as security for the parents' old age. They are brought up to expect to take responsibility for the elderly relatives (a common Kirundi saying is '*Nta ndagukunda nka kwankira umwana'* –'You cannot say you like me, if you do not like my children').
- Fathers are heads of the family
- Traditionally women take care of household duties and the children. However there is increasing equality in responsibilities amongst younger resettled couples
- Young boys and girls are trained to follow the example of the same sex parent
- Children live at home and are supported financially until they are married
- After they leave home, filial duties are expected to continue
- Intermarriage between Hutus and Tutsis is common, despite the political inter-ethnic hostilities

3. HEALTH CARE BELIEFS AND PRACTICES

Most of the information in this section is taken from Jackson, K. (2006) *Fate, spirits and curses* book. Refer for more detail to chapter 9. Local community members have also provided additional material.

Consultation with community members reveal that whilst the practices outlined below are true for many (not all) people living in Burundi, there are no known Burundian traditional healers in New Zealand, and that no equivalent or substitute herbs have been found. Resettled Burundians accept and utilize Western medical care. There may, however, be some exceptions in the community.

3.1 Factors seen to influence health

1. **Physiological Factors**
    - The concepts of blockage and flow are believed to be important in maintaining health. Fluids in the body should flow without excess or blockages from the top of the body down
    - Poison, imbibed through food or drink that has been contaminated intentionally by a malevolent person (known as a witch or poisoner, an '*umurozi')*
2. **Western** biomedical concept of disease causation is accepted in Burundi and in New Zealand
3. **Spiritual/supernatural** (as per practice in Burundi)
    - Objects which have been symbolically poisoned can be used to create harm and ill health (also prepared by an '*umurozi*')
    - Spirits (which vary from one region to another, and have their own specific effects) can cause harm through spells and poisoning.

Ancestors are believed to provide protection, however if they have been neglected or offended they may abandon the individual. It is believed by many that the aforementioned spirits or poisons do not cross the waters and so are unlikely to occur in New Zealand. However, current medical conditions may be perceived to be the result of spirit or '*umurozi*' influence that occurred prior to re-settlement

- A small number of people believe that illness can be caused by punishment from God as a result of sin

3.2 Traditional and current treatment practices

1. **Western medicine**
   This is commonly practiced in urban areas and accepted by most Burundians who have received formal education. **Traditional medicine** is used when biomedical interventions are not effective, when the illnesses/misfortunes are ongoing, or when the illness is sudden or unusual. However, Western health care and medicines are scarce (3 physicians per 100,000 people; *UNDP 2006*) or unaffordable for many, and so for some, 'traditional' or herbal remedies are relied on out of necessity rather than choice.
2. **Traditional/complimentary practices**
   - **Herbs**, plants or animal and insect parts are used in all treatments, irrespective of their cause. These are ingested either through drinking potions, inhaling smoke or herbal powders. It is reported that to date (February 2007) no known substitutions are being used in New Zealand (although they may be being sought)
   - *'Abapfumu',* or practitioners invested with special powers will pronounce incantations and give instructions to the sick person or family for the remedies to be effective (there are no known '*abapfumu*' to date in the Burundian community in New Zealand)
   - **Moxibustion** (*'indasago')* (using a sharp instrument) or making incisions on breasts, hands, feet or back is practised, particularly for pain. Scarring may result, so abuse should not be assumed (it is reported that this is unlikely to be practised in New Zealand)
   - **Magico-religious articles** and **religious/supernatural rituals** may be used by some

3.3 Important factors for Health Practitioners to know when treating Burundian clients:

1. As many Burundians who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5. below).

2. Traditionally it is taboo to discuss any sexual matters. Practitioners will need to explain that in New Zealand it is acceptable and normal to give information about sexual matters for the purpose of treatment, and in fact **necessary in order for them to receive appropriate treatment**. Interpreters can assist in informing the clients about protocol in this regard. However, it may still take a few sessions of rapport building before the client will disclose.

3. Burundians generally value their privacy highly and disclosure is often limited, particularly amongst people with little formal education. Practitioners may need to rely on their observation, investigations and examinations. Older people are often willing to disclose but may lack the vocabulary to do so. It is reported that

Rwandans tend to be more disclosing than Burundians.

4. Pregnancy is customarily concealed for as long as possible (see 5. below) and is unlikely to be disclosed in a routine interview, or when a client is presenting with other issues (particularly amongst newly settled people). Practitioners will need to enquire as to whether a client is pregnant or not. **NB** Other family members, including children, should not be informed about pregnancies without the mother's permission.

5. In the case of terminal or serious illness (including HIV/AIDS), the practitioner should not disclose this fact to **any** other family member without the permission of the client first.

6. If treatments require the co-operation of a partner or family members, practitioners need to invite the parties to a consultation as clients (particularly husbands) often do not reveal the information to their spouses.

7. In Burundi, injections are a standard form of treatment for many ailments and are therefore expected. If other interventions are offered here in New Zealand, an explanation would be helpful.

8. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

9. Due to reticence to disclose, to the need for stoic attitude to hardship, and to unfamiliarity with counseling, it is reported by local community members that counseling services are very unlikely to be effective.

10. However, contrary to the privacy around emotional and relational issues, Burundians will speak out when they have health problems believing that discussing the problem will help alleviate it.

11. Violence towards women is common in the home country, particularly during the ongoing civil unrest, and women themselves have become resigned to this. As a result women may not feel supported by their community if they make use of the assault laws in New Zealand, and would be afraid of losing face.

12. As blood is an important part of the culture, explanations will be needed for blood sampling, particularly if drug levels need monitoring on a regular basis, or if a number of samples need to be taken.

13. Some women may wear decorative beads around the waist. These may be removed for examination purposes.

14. Informed Consent may be a new process and will need explaining.

15. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit
    - It is customary to address the male adult or elders of the household first
    - Food or drink may be offered. It is acceptable to decline politely, although accepting would be appreciated, particularly on a first visit, as some clients may feel disrespected if their hospitality is rejected

3.4 Stigmas
Mental illness is not stigmatized in the same way as in most other non-African cultures. Spirit possession can be seen as responsible for strange behaviour.

3.5 Diet and Nutrition
Beans, particularly red kidney beans and rice are staples, and also sorghum. Plantains, sweet potatoes, cassava and peas are common foods. A 'wine' made from bananas called, '*urwarwa*' is drunk quite often. Meat and butter are highly valued. Meat is eaten when available although cattle are seen as a status symbol so the slaying of own animals, other than poultry, is limited in Burundi.

3.6 Death and dying
Death is marked by prayers, speeches and rituals. Close family members do not take part in all the activities. Traditionally they do not work in the fields or have sexual relations, or eat meat during the mourning period. Resettled people may take time off work during mourning. When the period is over, the family will hold a special ceremony.

4. HEALTH RISKS
- Poor life expectancy (rated on average at 44 years of age by UNDP 2006)
- HIV+ is rated at 3.3 % for adults aged 15-49 by UNAIDS 2006
- Malaria (risk from P.falciparum throughout the year in the whole country. Resistance to chloroquine and sulfadoxine-pyrimethamine reported (WHO 2006)
- TB cases are rated at 343 per 100,000 (WHO 2006)
- Malnutrition resulting from the prolonged period of civil war

5. WOMEN'S HEALTH
For Burundian women who have resettled as **refugees** a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general, but it has been particularly widespread in Burundi during the civil war and in the refugee camps. Disclosure may take some time and will depend on rapport and trust. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Burundi women re-locate alone as a result of family losses, separations and displacements.

Various sources report that Female Genital Cutting (**FGC**) is not practised in Burundi. It is reported however, that Rwandans practice what may be classified as a Type IV procedure where the labia minora is stretched to increase size (by the individual themselves, under instruction from an elder) over a few months from around the age of seven. The effect is believed to heighten sexual pleasure for both men and women.

- **Traditional fertility practices**
  Breast feeding (up to three years) was the natural birth control. However, the use of contraception is a growing practice in Burundi, due particularly to efforts at population control and to the spread of HIV and AIDs.
- **Pregnancy**
  - Pregnancy is usually concealed for as long as possible to avoid poisoning by an *abarozi* or intervention by malevolent spirits (see 3.1.1 above).

Although it is reported that fears from the dangers of spirits and *umurozis* are minimal in New Zealand, the belief is deeply ingrained and so concealment takes place irrespective. Pregnant Burundian women are reluctant to disclose the stage of pregnancy or the date of the last menstruation. Rapport and trust is crucial. The pregnant state is not revealed to friends or other family members, **including children**.

- Traditionally, enemas are used weekly by some Burundian women, from 5 months onwards during pregnancy for the relief of indigestion, discomfort and heartburn

- **Labour and Delivery**
  - Traditional birth attendants were customarily chosen for the birth, particularly by older mothers with previous delivery experience
  - Younger people will elect hospital births when this service is accessible
  - Traditionally men are not present at the delivery, but this is changing with resettled people due mainly to the lack of extended family
  - Caesarians are only expected in emergencies
- **Postnatal period**
  - Breast feeding is the norm and continues for two to three years (is also used as a natural form of contraception)
  - Mothers and infants are massaged after the birth with a substance much like *ghee* (a clarified butter) and warm water. Massage of the lower back and stomach continue after the birth
  - In addition, fabric is tightly tied around the mother's abdomen to encourage flattening of the stomach, for up to 6 months
  - It is important that the baby is not touched by strangers (apart from health professionals) after the birth. Visitors to the home will not be invited to see that baby for the first month and no-one should expect to touch or pick up the infant (to avoid any possible malevolent action)
  - Mothers do not leave the home for the first three to four weeks
  - Mothers do not share the same bed with their husband during the first three to four weeks, their food is prepared and served by relatives/friends and they eat alone during this period. Some re-settled people may not have family and will need to manage alone
- **Religious Ceremonies Related to Birth**
  - After the first three to four weeks a naming ceremony takes place after which the mother is allowed to leave the home
  - Family are invited to the ceremony, the baby is displayed to the gathering on a traditional 'tray' and rotated around to face each of the cardinal points. Sometimes a corn or bean seeds are planted in commemoration of the birth
  - At this ceremony the mother is given assistance with learning how to tie the baby on her back

6. YOUTH HEALTH

- **Newborn & Child Health**

  Infant mortality is rated at 114 per 1,000 live births (UNICEF 2007)
  Malnourishment is common with 45% of children underweight (UNICEF 2007)
  Immunization is being used more extensively in recent years

- **Adolescent Health**
  - In addition to resettlement issues, some children and adolescents may be carrying trauma from pre-settlement experiences and conditions. It is

noteworthy that these children often present with poor school performance, lack of motivation or concentration, 'bad' behaviour, and physical complaints as symptoms of post-traumatic stress, depression, anxiety and other mental health conditions

- Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women
- No sex education is given to adolescents and the subject is not discussed at home. Of concern are illegal abortions, pregnancy–related dropouts from school, and potential risk of HIV infection

7. SPECIAL EVENTS

- **Independence day** (1 July) is celebrated on the 1st Saturday in July in New Zealand
- **21st October** is a day of remembrance for all those who died during the struggle for democracy, and also for the first elected Burundian president, Melchior Ndadaye who was assassinated

Noteworthy is the importance of drumming to Burundians who have practised the art for centuries. The drums are considered sacred and represent power and a means of communication. The Drummers of Burundi are a 14-member troupe, who tour major cities of the world. They dance as well as perform on the drums. Each member takes a turn beating a large drum called an *inkiranya*, which sets the rhythm for the other drummers. In New Zealand the resettled Burundians continue this tradition with their own troupe. They have become well-known, hold status and play an important role in creating identity for the community.

8. SPIRITUALITY

Burundians and Rwandans are predominately **Christian.** A smaller minority practice **indigenous religion** and some combine Christianity and indigenous beliefs. Spirits of dead relatives, called *abazimu* are messengers for God to the human world. The *abazimu* can dispense good or bad luck.

Photos: Margaret Wilson of http://www.survival-international.org and Refugees International www.refugeesinternational.org

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Useful Resources

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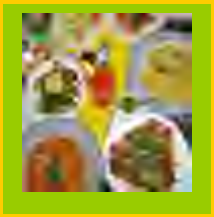

SOMALI CULTURE

Like many countries in Africa, Somalia was divided and colonized during the 1800's with independence being granted during the mid-later 1900's resulting in ensuing warfare and border disputes. The north, originally controlled by France, is now known as Djibouti. The former Italian and British colonized areas were united into an independent Somalia, and areas governed by neighbouring Kenya and Ethiopia continue with border-disputes.

Until 2005 Somalia had effectively been without a central government since 1991 when General Mohammed Siad Barre was exiled. He had led the country from 1969 under an increasingly oppressive and autocratic regime with a reprehensible record of human rights violations. Since then clan based wars and civil unrest have mired the country in mass starvation and horrific levels of rape and torture. The internal conflicts and border clashes have resulted in nearly 400,000 refugees fleeing to neighbouring countries, over 370,000 people being displaced internally, and 2.5 million deaths. The Somali Transitional Federal Government, established in 2005 is challenged by continued localized clan conflicts, a destroyed economic infrastructure and health and education system, and severe malnutrition, particularly in the south. Most of the country relies on international aid for food, health and education services, and water. However, the insecurity and unrest hamper international agencies in providing the aid. The resultant starvation is exacerbated by natural disasters (Tsunami and frequent droughts).

Those who belong to ethnic minorities and who are not protected by local authorities or clans suffer additional hardships accessing food and services. Displaced women and children are particularly vulnerable to exploitation and violence. Many children have been smuggled into Europe in hope of a better future but are vulnerable to benefit fraud, domestic labour, and prostitution. The Benadir and Bantu are amongst the tribes subjected to prejudice and persecution.

During the war Somalis have fled to Djibouti, Ethiopia, Kenya, Burundi, Tanzania and Yemen. Some have been resettled in other countries of refuge after surviving extreme hardships in boat journeys (to Yemen) or in refugee camps. Many are being repatriated by the UNHCR.

By 2001 there were 1,740 Somalis resettled in New Zealand. Some continue to arrive as refugees or through family re-unification programmes.
(Somalia is not to be confused with Somaliland which seceded from the Somali Republic in 1991).

Photos: Wikipedia, public domain.

1. COMMUNICATION

Greetings video clip

Hello greeting	*Salaam aleikum* 'Peace be upon you' (Muslims)
Goodbye greeting	*Ma'a alsalama* 'God be with you' (Muslims)

Main languages

The official language is **Somali.** It has 3 distinct dialects and is written in Latin script. English, Italian (especially in the south) and Arabic are spoken by educated Somali. A small number are of Swahili and Bantu origin and speak these languages.

Gestures and interaction

- It is appropriate for men to **shake hands** with men and for women with women but cross gender handshaking is **not** appropriate
- Hand gestures are used expressively in conversation:
  - A quick **twist of the open hands** can indicate 'nothing' or 'no'
  - **Pointing a finger** is considered rude
  - The western **'thumbs up'** is an obscene gesture
- The **right hand** (the 'clean' hand) should be used for passing objects and shaking hands
- Elders are treated with **utmost respect** and a courteous address can include 'aunt' and uncle' even if the elder is a stranger
- **Eye contact** is likely to be less that in New Zealand out of respect
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are generally highly regarded and deference usually accorded to their opinions. It would be helpful for practitioners to **invite client's** to share their opinions and questions

2. FAMILY VALUES

- Allegiance to the clan is of utmost importance, as is loyalty and devotion to the family
- Extended families are traditionally the norm
- Genders are generally separated in most spheres of life as per Islamic culture
- Males are heads of families and women usually responsible for the care of the members
- Boys and girls receive the same education, and literacy amongst women is higher than in some other Islamic cultures
- Marriages can be arranged or be of the individual's choice although family will need to approve of the match
- It is customary for marriage to take place at 14 or 15 and for men to have more than one wife. Laws in countries of resettlement alter these norms

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health

1. **Western biomedical** concept of disease causation and disease communicability is accepted as explanation for some illnesses rather than for all. Other attributions of ill health may be preferred or may co-exist along with western concepts.
2. **Spiritual/supernatural**

Beliefs in spiritual and supernatural causation are reported in the literature to be common. Generally Somalis believe that spirits reside within the individual and can cause harm or illness if they are angered. Local resettled residents in New Zealand report that these beliefs are not common amongst the younger generations and those who have education.

- '***Zar***' spirit possession is common. However it is reported that some Somalis believe that these spirits do not accompany them when they resettle in New Zealand
- Belief in the '***evil eye***' is common and it is believed that an individual can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackson Ch.2, 2006 for more information). Local resettled community members report that this belief is not common amongst those with education, or with the younger generation
- Many Somalis believe in ***jinn*** spirit possession. Symptoms are more likely to be of a spiritual/psychological nature than a medical one, and can range from minor to serious conditions
- **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together (similar reports by local Somalis suggest that some of these beliefs are also outdated amongst the educated and the younger generation)
- Ancestors can cause ill health if offended or neglected

3.2 Traditional and current treatment practices

1. **Western medicine**
   This is commonly practiced in urban areas. Most Somalis will have had some exposure to Western medicine, however the medical conditions customarily taken to doctors and clinics can be circumscribed. Herbal and biomedical remedies may be used together
2. **Traditional/complimentary practices**
   Traditional medicine is practised by '**traditional doctors**' who are usually elders of the community and have learned their skill from other elders in the family. Midwives, bone-setters and religious practitioners provide service for various conditions. Many herbal and 'traditional' remedies are used, some of which are ingested or applied externally, others involve rituals or procedures. The most common practices are:
   - Use of the herb *Khat* (**Note:** it is possible that there is cross-tolerance for amphetamines by *Khat/qat/chat/kat* users. See Jackson 2006, p.134 for more detail). This herb is reported to be available in New Zealand and is often used as a drug, not just for medicinal purposes
   - *Fire-burning* (has some similarity to **moxibustion**). This may leave scars which should not be assumed to result from abuse

   See Kemp and Rasbridge 2004, p. 321 for examples of specific conditions and treatments). Some practices are less common in New Zealand due to lack of availability or prohibition. However, substitutions may be found and this needs careful exploring by the practitioner in view of possible drug interactions.
3. **Magico-religious articles** and **religious/spiritual rituals** may be used.

3.3 Important factors for Health Practitioners to know when treating Somali clients:

1. As many Somali who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below)

2. Men are heads of households and will often attend consultations with family members and expect to speak on their behalf. Make sure there is agreement from clients.

3. Women do not take the husband's name after marriage and records need to accommodate this preference.

4. Same-sex practitioners are appreciated by Somali women in general, but are imperative for gynaecological examinations.

5. Literature reports that female genital cutting (**FGC**) is common throughout Somalia, with infibulation (Type III) the most common. Less severe forms are also practiced (see 5. Women's Health below). Respectful handling of the issue is crucial with assistance and/or education as needed. This is part of the culture and is expected and accepted as such by many women. Of some concern to resettled women is how their infibulations will be dealt with at childbirth. Practitioners need to familiarize themselves with the needs and sequelae.

6. Women who follow traditional custom cover their bodies and veil their faces. Some may wish to keep a veil/headscarf on during examinations for modesty reasons, and will want male family members to leave the room.

7. It is reported that Somalis associate doctors and clinics with ill health in their homeland. The concept of preventative medical care is not familiar and families may need education regarding the benefit of preventative health care, depot treatments, prophylactic medications and routine check-ups.

8. In Somalia professionals are consulted for symptom relief which is usually given, setting a precedent for expectations. When no tangible intervention is provided in New Zealand, it would be helpful for practitioners to give the rationale behind treatment decisions and lack of medication particularly when it is expected that the condition will resolve naturally. It is reported by local residents that clients will otherwise 'doctor shop'.

9. A term *'walli'* will sometimes be used in describing ill health. However the meaning can range from 'not feeling oneself, through a number of other symptoms to schizophrenic symptoms so this needs careful investigating (see Jackson 2006, pg. 133 for more detail).

10. Herbal and traditional remedies may continue to be used after resettlement and practitioners may need to assess for drug interactions.

11. Compliance is likely to be enhanced if some traditional practices can be encorporated within the current treatment plan where possible, and if clients are involved in decision making regarding their treatment. *Qu'ran* readings are an

important part of traditional healing and can be used in conjunction with western treatment. The services of a religious practitioner can be offered during hospitalization.

12. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

13. Muslim clients will fast during **Ramadan** which may affect medication and/or dietary compliance (medications are likely to be taken at night). Assistance in this regard may be needed.

14. Clients and family are not usually informed of terminal illness, although the severity of the symptoms is explained. Since New Zealand health law contravenes this custom, sensitive handling of the matter is needed and the elder of the family may need to be consulted first. If in doubt, consult a community leader. RMS or RAS will have access to appropriate contacts. (See references for contact details)

15. Corporal punishment is customary; the family may need assistance or counselling with alternative means of disciplining their children.

16. Informed Consent may be a new process and will need explaining.

17. The extended family and friends may want to stay with a client during hospitalization. Hospital protocol may need explaining; however it would be appreciated by the family to have some of their needs accommodated where possible.

18. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit
    - It is usually appropriate to remove shoes before entering the home
    - It is customary to address the elders of the household first
    - Food or drink will usually be offered. However, it is acceptable to decline politely, although accepting would be appreciated (especially by recently settled people) as offering food is a gift of hospitality
    - Modest dress is appropriate
    - Be aware that no food or drink is consumed from sunrise to sunset during Ramadan

3.4 Stigmas

The condition and term 'mental illness' is stigmatized since it is associated with dissociative states and behaviours. In Somalia people in such conditions are often institutionalized or chained for safety reasons if no institution is available.

3.5 Diet and Nutrition

Southern Somali's diets generally include more vegetables whereas those with a nomadic lifestyle in the north have diets heavier in meat and milk. People in the cities tend to be familiar with western foods. Rice is a staple. It is noteworthy that malnutrition is common in the south given the long-term situation of scarce resources.

3.6 Death and dying

Muslims

- Terminally ill clients will be attended at home, whenever possible, by the family. It is considered both a responsibility and a privilege to look after family members, especially parents
- Islamic rituals are important at death for Somalis. The ill person will be faced towards Mecca, verses from the *Qu'ran* will be recited with a sheikh or elder leading the prayers
- After death the body will be ritually prepared and wrapped by members of the same sex
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, not cremation
- Mourning lasts for several days and is shared by community
- Transfusions, transplants, autopsies and life-support are controversial issues amongst the Somali as in accordance with Islamic law, it is believed that life is given and taken by God

4. HEALTH RISKS (as listed by Kemp and Rasbridge, 2004)

- Amebiasis
- Anthrax
- Boutonneuse fever (African tick fever)
- Chikungunya
- Cholera
- Dracunculiasis (Guinea worm disease)
- Echinococcosis (hydatid disease)
- Filariasis (Bancroftian and Malayan filariasis, loiasis or loa loa, onchocerciasis (all of the later found in tropical Africa, but potential exists)
- Hemorrhagic fevers (HFs): Lassa HF, Marburg and Ebola HFs, Crimean-Congo HF, chikungunya fever, dengue fever and dengue HF, and Rift Valley fever)
- Hookworm
- Leishmaniasis
- Leprosy
- Malaria (including multi-drug resistant)
- Malnutrition
- Measles
- Plague
- Poliomyelitis
- Relapsing fevers (tick-borne)
- Sexually transmitted infections, including HIV/AIDS, cervical cancer, chancroid, chlamydia, gonorrhea, granuloma inguinale, lymhogranuloma venereum, syphilis
- Sickle cell disease or sickle cell hemoglobulinopathies
- Strongylodiasis
- Trachoma
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzias; intestine-dwelling; and lung-dwelling: paragonimiasis
- Tuberculosis
- Typhus
- Yaws (frambesia)
- Post-traumatic stress disorder

5. WOMEN'S HEALTH

For Somali women who have resettled as **refugees** a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general, but it has been particularly widespread in Somalia for some time. The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are

often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Somali women re-locate alone as a result of family losses, separations and displacements.

Literature reports that female genital cutting (**FGC**) occurs extensively in Somalia (98%) (see 3.2.4 above and Youth Health below). However, local Somali residents report that the practice is outdated amongst educated families.

- **Traditional fertility practices**
  - Large families are valued so birth control, planning and abortion is uncommon; pregnancy is seen as God's will
- **Pregnancy**
  - Childbearing is encouraged soon after marriage
  - Episiotomies are not common, nor caesarian sections as it is believed these may cause harm
- **Labour and Delivery**
  - Midwives and female relatives will assist in labour in rural areas, however people in the cities and those who are resettled usually prefer hospital care
  - In their homeland women have significant support from their female relative and community members. Due to lack of sufficient community after resettlement, women may need more support from health care providers in New Zealand
- **Postnatal care**
  - Warm baths and sesame oil massages are customary
  - After the birth the mother and baby stay home for 40 days and are visited by friends and family. It is a time of abstinence and female relatives and neighbours assist the mother. This period is known as *afatanbah*. This is for protection purposes (from the 'evil eye' and conditions of the world). Hospital procedures requiring birth certificates have changed this practice
  - The use of diapers is not common. A basin is held beneath the baby at regular intervals and 'potty' training is reputed to happen easily
  - Breast feeding is the norm and can last up to two years although early supplementation is not uncommon
  - Some mothers erroneously believe that colostrums is not healthy for a newborn

- **Religious Ceremonies Related to Birth**
  - *Afatanbah* is followed by a naming ceremony with a large gathering and celebrations
  - Prayers are held at the ceremony which customarily includes a ritual killing of a goat

6. YOUTH HEALTH and Issues

- **Newborn & Child Health**
  - Circumcision, a rite of passage, is universally practiced and is viewed as necessary in order for a person to become a full member of the community in their adulthood
  - Males are circumcised between birth to 5 years (usually by a traditional doctor or in a hospital by nurse or doctor)

- 98% of girls are circumcised from between birth to 8 or 9 years old (see 5. above)

- **Adolescent Health**
  - Many Somali children and adolescents, especially those from rural areas, and those born since the unrest from 1991, may have received little or unreliable education. In such cases they may suffer considerably within a new education system and with low literacy levels, and may require additional assistance and support
  - Most resettled adolescents will be faced with:
    - role changes at home
    - pressures from peers to integrate more quickly than they or their families may be comfortable with
    - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
  - In addition to resettlement issues, some children and adolescents may be carrying trauma from pre-settlement experiences and conditions. It is noteworthy that children often present with poor school performance, lack of motivation or concentration, 'bad' behaviour, and physical complaints as symptoms of post-traumatic stress, depression, anxiety and other mental health conditions
  - Some Islamic traditions and the difficulty in explaining these because of language barriers, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, time schedule for prayers, *halaal* food etc.)
  - Resettled families often bridge the gap between the new and old cultures by allowing children to wear 'western' attire to school (though not shorts) and traditional attire at home
  - Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the FGC. An infibulated woman/girl must be cut on marriage to allow for intercourse
  - Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women

7. SPECIAL EVENTS

Ramadan (fast month)
Id al-Fitr (celebration after fasting)
Id Arafa (important holiday for making pilgrimages to Saudi Arabia)
Moulid (celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan)

8. SPIRITUALITY

Most Somalis are Sunni **Muslims**. Religion plays an important part of all aspects of life for Muslims, and *Qu'ran* readings are a source of comfort and intervention during illness and distress. **Christianity** is practised by a small percentage of Somalis.

References and Resources

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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. RMS Refugee Resettlement can provide information on resettlement issues and contacts for community leaders. Contact the Auckland Co-ordinator on +64 9 621 0013.

3. University of Washington Medical Centre provides information sheets at: http://depts.washington.edu/pfes/cultureclues.html

4. A number of health fact sheets can be found in Somali for download in pdf. format at:
   http://www.healthtranslations.vic.gov.au/

SUDANESE CULTURE

Background information

Sudan is the largest country in Africa and bordered by 9 others, including Ethiopia, Eritrea and the Congo. Since independence from Egypt and Britain in 1956 military dictatorships favouring Islamic governments have dominated politics, and the country has been ravaged by civil war (since 1972) and wrought by strife. The people of Sudan have been experiencing persecution, famine, plagues, oppression and atrocious human rights violations for decades.

The religious struggle between the Islamic fundamentalists in the North against the diverse ethnic groups in the south (including many Christians) has resulted in a genocidal campaign led by government militia leaving the country chronically unstable, both economically and politically, and rife with atrocities. Rape as organized onslaught is pervasive, and famine has been used as a weapon of power with international aid being withheld from the South by corrupt military leaders, resulting in widespread starvation. It is estimated that the war and famine-related effects have created more than 2 million deaths. Sudan is now one of the poorest countries in the world and has one of the lowest literacy rates.

In 1993 more than 5 million people fled the countryside, some into the towns in Sudan and many to neighbouring countries of Ethiopia, Uganda, Kenya and Egypt. It is estimated that over a million of these people died in flight. Many refugees are from the minority ethnic groups in the South, some are political dissenters from the North who fled to escape forced conscription and the fundamentalist oppression. Sudanese began arriving in small groups to New Zealand from the late 1990s and continue to arrive as they flee the deteriorating humanitarian crisis. Most of the refugees who have been accepted into New Zealand come from the Nuer and Dinka tribes, and some from the Zande, Hadendowa (which includes the Beja), Nubs, Lwo and Fur tribes.

There are considerable differences between cultures from the North and South. Differences are highlighted throughout; otherwise the information applies to most Sudanese.

Photos: by kind permission of Refugees International, www.refugeesinternational.org., and flag from Wikipedia.

1. COMMUNICATION

Greetings video clip

Hello greeting	*Salaam aleikum*	'Peace be upon you' (Muslims)
Goodbye greeting	*Ma'a alsalam*	' God be with you' (Muslims)

Main languages

Sudan is linguistically and ethnically very diverse, particularly in the South. However **Arabic** is spoken by most Sudanese as well as their particular **tribal language**.

Arabic Juba is a dialect commonly understood by a number of ethnicities in southern urban areas. **English** is spoken more in the South, and mostly by those with education. (English was the official language before independence in 1956). As literacy is very low it is recommended not to use written material for health education or treatment purposes.

Gestures and interaction

- It is appropriate to **shake hands** with men but **not** culturally appropriate with Muslim women
- Pointing a finger is considered rude, and both hands should be used for passing objects between people
- Traditionally, **direct eye contact** is considered rude. Lowering or averting the gaze is a sign of respect. Most Sudanese in New Zealand accept direct eye contact from the host culture, but may decline to return this out of respect
- The eldest man in the household holds **authority** and should be treated with respect
- **First names** and **'Mr'** or '**Mrs'** can be used
- The wife does not traditionally take the husband's name
- **Respect** is also age related; those who are older are afforded utmost respect
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are generally highly regarded and deference usually accorded to their opinions. It would be helpful for Practitioners to **invite client's** to share their opinions and questions

2. FAMILY VALUES

- Families are extended and live together with all children treated equally
- Males are heads of households and dominate the economic and social domains
- Traditionally women are responsible for childrearing, the sick, old and mentally ill. However, after resettlement fathers may become more involved because of lack of family support
- Gender segregation for eating and socializing is traditional. Resettled young couples may live more like westerners
- Divorce is acceptable as a last resort after families have failed to assist in resolving problems. Often dowry's have to be returned
- After divorce, children irrespective of age, always live with the father's family

North

- In some families the groom's family pay a dowry, usually money

- Marriage is arranged and seen as a contract between families. Sometimes the final decision is made by the woman
- Preference in marriage is given to cousins and relatives

South

- The groom's family pay a dowry, usually with heads of cattle (Dinka and Nuer), or with pigs, goats, crops or money depending on resources. In resettled countries this may be paid in money, or with stock to families in Sudan
- Men may take more than one wife and the number is indicative of wealth
- Marriages are usually outside the tribe, clan, or social group
- Children are raised in distinctive gender roles with girls learning about home management and boys being encouraged to develop endurance, valiance and strength in order to protect themselves and their families later on
- Girls are seen as sources of wealth

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health

1. **Western** biomedical concept of disease causation is established and practiced in the urban areas although other attributions of ill health may co-exist along with western concepts.
2. **Spiritual/supernatural**
   Beliefs in spiritual and supernatural causation are common. However different tribes have different beliefs about which spirits cause which illnesses. In some tribes (e.g. the Dinka) spirit possession is more rare and considered less dangerous). So generalizations should not be made about Sudanese beliefs.
   - Relatives or neighbours can function as 'witches' and harm individuals
   - Spirit possession can cause both mental and physical illness:
     - '***Zar***' spirits can affect both Muslims and Christians (sometimes considered as '*red jinn*' by a northern Islamic tribe) and have long-term affects
     - *Spirits* known as '***Jinn***' in Islam can cause some illnesses. '*White jinn*' are benign, and '*black jinn*' can inflict serious illness for which exorcism may not even be effective (See Jackson Ch. 11 2006 for more information about Sudanese beliefs)
   - Belief in the '***evil eye***' is common and it is believed that an individual can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackson Ch.2, 2006 for more information)
   - **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together
   - Ancestors can cause ill health if offended
   - Punishment from God for sins committed, and God's will are also attributions of practising Muslims

3.2 Traditional and current treatment practices

1. **Western medicine**
   This is more commonly practiced in urban areas. However, Western health care and medicines are scarce and for some, 'traditional' or herbal remedies are relied on out of necessity rather than choice. Herbal and biomedical remedies are often used together

2. **Traditional/complimentary practices**
   There are many **herbal** and 'traditional' remedies used by the Sudanese. Some of these are ingested and others applied externally (see Kemp and Rasbridge Ch. 35, 2004) for examples. These are less commonly used in New Zealand due to lack of availability. However, substitutions may be found and this needs careful exploring by the practitioner in view of possible drug interactions.
3. **Magico-religious articles** and **religious/supernatural rituals** may be used.

3.3 Important factors for Health Practitioners to know when treating Sudanese clients:

1. As many Sudanese who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement conditions (see 5**.** below).

2. Due to low literacy and education levels, and to limited exposure to biomedical care in Sudan, many Sudanese experience difficulty in accessing health care in New Zealand.

3. Since birth certificates are often lost in the chaos of flight and war, and due to the low literacy levels, there can be problems with variations in records (names and birth dates) from one agency/practice to another.

4. Due to the scarce health care situation in Sudan many resettled Sudanese will present with previously undiagnosed conditions. Kemp and Rasbridge (2004) alert us to the most common which are: diabetes, hypertension, food allergies, severe depression, vision and hearing loss, parasitism and dental problems.

5. As a result of severe shortages of medical supplies in Sudan it is not uncommon for Sudanese to share medications for the same symptomatology.

6. Sudanese tend to discontinue medications when symptoms have abated. It is important to counsel about completing medication and treatment courses.

7. Particularly in the South many herbal and traditional remedies are used and practitioners may need to assess for drug interactions or to encoporate the traditions within the current treatment plan where possible.

8. Muslim clients will fast during Ramadan which may affect medication and/or dietary compliance.

9. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

10. Great diplomacy is required when dealing with gyneacological issues. Many Sudanese will avoid the topic, particularly if there are language difficulties. Same-sex practitioners are preferred (particularly by the Muslim women) in

general, but are imperative for gynaecological examinations for all women.

11. Female Genital Cutting (**FGC**) is common in Sudan. Literature reports that Type III (infibulation) is practiced more in the South. However, local resettled Christian Sudanese report that this practice does not exist amongst the Christian community. Respectful handling of the issue is crucial with assistance and or education as needed. For those who have undergone the procedure, it is part of the culture and is accepted as such by many women.

12. Although fathers hold authority in the family, mothers usually have more information about children's health and can provide information on this.

13. It is appropriate to inform patients of terminal illness although the family elder should usually be approached first.

14. Teeth filing is part of male puberty rites for some tribes, especially Dinka. As many as 6 front teeth may be missing. After resettlement some men will request cosmetic dental care so as not to stand out in the new culture.

15. The *Beja* in particular are customarily reliant on their families and clan and it will take considerable time to establish trust and rapport.

16. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit
    - It is usually appropriate to remove shoes before entering the home
    - It is customary to address the male adult of the household first
    - Food or drink will usually be offered. It is acceptable to decline politely, although accepting would be appreciated as offering food is a gift of hospitality
    - Modest dress is appropriate, particularly in Muslim homes during Ramadan
    - Be aware that no food or drink is consumed during sunrise to sunset during Ramadan

3.3 Stigmas

- Mental illness is stigmatized and sufferers may experience shame. However, families will usually take care of the person if they are not harmful to themselves or others, and the community is expected to support the family
- Rape is highly stigmatized. Single women are not able to marry, and married women are not likely to speak about the experience openly as it would bring dishonour to the family. They are likely to be rejected by the husband for this reason. It is believed that pregnancy resulting from rape is not normal and therefore indicates consensual sex. The children of rape are often abandoned. It is noteworthy that rape is common in Sudan and that many women therefore carry the burden not only of the experience but also of the consequences
- Suicide would be stigmatized for Muslims since it is forbidden in Islam

3.4 Diet and Nutrition

Sorghum is the most common starch, sometimes used fermented (especially for the ill and elderly), and also millet and maize. Family members could provide this for

hospitalized clients. Vegetables and greens constitute a substantial part of the diet and meats (beef, goat, sheep, chicken and fish) are also consumed, as well as eggs. Pork will not be part of the Muslim diet and *'halaal'* food will be necessary for hospitalized Muslim clients. Malnutrition is common in some areas.

3.5 Death and dying

Muslims

- Traditionally Muslims need to bury their deceased within 24 hours
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife
- The body is taken to the Mosque for cleansing and ritual preparation by the Imam (cleric) before it is taken to the cemetery
- Burial in a cemetery is required, not cremation
- Mourning lasts between 3 to 7 days
- Women wear black indefinitely but may remarry

Southern Sudanese (Christian)

- The community and relatives gather around the deceased, segregated by gender (children do not view the corpse)
- Traditionally the body is washed by the family and wrapped in a mat of woven grass or a cow skin and buried. Sudanese in New Zealand may have developed different methods
- Burial in the local family site, is traditional. Bodies are not usually cremated
- Mourning is in isolation in the family home for 40 days and is usually ended by a ritual sacrifice to cleanse the mourning spirits
- Husbands are free to remarry, sometimes the deceased's sister so she can care for the children
- The widow remains part of the husband's family and may be taken as wife by the deceased's brother, but the children will take the name of the deceased husband

4. HEALTH RISKS (as listed by Kemp and Rasbridge, 2004)

- Amebiasis
- Anthrax
- Boutonneuse fever (African tick fever)
- Chikungunya
- Cholera
- Dracumculiasis (Guinea worm disease)
- Echinococcosis (hydatid disease)
- Filariasis (Bancroftian and Malayan filariasis, loiasis or loa loa, onchocerciasis (all of the later found in tropical Africa, but potential exists)
- Hemorrhagic fevers (HFs): Lassa HF, Marburg and Ebola HFs, Crimean-Congo HF, Chikungunya fever, dengue fever and dengue HF, and Rift Valley fever)
- Hookworm
- Leishmaniasis
- Leprosy
- Malaria (including multi-drug resistant)
- Malnutrition
- Measles
- Plague
- Relapsing fevers (tick-borne)
- Sexually transmitted infections, including HIV/AIDS, cervical cancer, chancroid, chlamydia, gonorrhea, granuloma inguinale, lymhogranuloma venereum, syphilis
- Sickle cell disease or sickle cell hemoglobulinopathies
- Trachoma
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzias; intestine-dwelling; and lung-dwelling: paragonimiasis
- Tuberculosis
- Typhus

- Yaws (frambesia)
- Post-traumatic stress disorder

5. WOMEN'S HEALTH

For Sudanese women who have resettled as **refugees** a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general, but particularly so in Sudan where it is a rampant practice . The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Sudanese women re-locate alone as a result of family losses, separations and displacements.

Female Genital Cutting (**FGC**) occurs extensively in Sudan (89%) (see 3.2.4 above and Adolescent Health below). Whilst the sources consulted do not make any differentiation between Muslim and Christian women, local resettled Christian Sudanese report this to be a Muslim practice only. For more information on the practice, use the hyperlink above.

- **Traditional fertility practices and Pregnancy**
  - In Sudan it is customarily expected that women should bear as many children as possible, beginning within a year after marriage, and imperatively a son to secure the family's future. Contraceptives are therefore not commonly used
  - Traditionally childbearing begins earlier in some parts of Sudan than in the west. However the age level is raised in resettled communities and local members reports that 18-20 is the youngest age to be expected in New Zealand
  - Women are well supported by female relatives during pregnancy, this support may be absent for resettled women
  - A special kind of clay is chewed during pregnancy to increase appetite and decrease nausea. It is not known whether a substitute is used in New Zealand
- **Labour and Delivery**
  - In villages in Sudan most deliveries are at home with midwives assisting with the birth. In resettled countries people are becoming accustomed to hospital deliveries
  - Traditionally men are not present during labour or at the birth
- **Postnatal care**
  - Most children are breastfed for about 2 years with weaning taking place as the child is walking or ready
  - Soft porridge made from Sorghum and soups of boiled meat are believed to stimulate milk production (sometimes a cow is slaughtered to secure enough meat for the post-partum period)
  - Cow's milk and a soft traditional porridge is used to assist weaning
- **Religious Ceremonies Related to Birth**

  A cow or goat is traditionally slaughtered (for those families who are wealthy enough) so that enough meat is available during the post-partum period

6. YOUTH HEALTH

- **Newborn & Child Health**
  - First-born boys are given special attention and usually raised in the maternal village
  - In Northern Sudan circumcision for males is practiced soon after birth, and for some tribes in the South
  - FGC is usually done between 4 and 12 years but depends on customs of the area
- **Adolescent Health**
  - In Southern Sudan puberty is a rite of passage and marked for both sexes with rituals
  - For girls it begins with menstruation when they begin preparation for motherhood and receive body decoration on the torso done by cutting (scarification) or tattoos with henna (Dinka)
  - Boys also receive scarification lines across the forehead (particularly Dinka and Nuer) and some practice teeth-pulling and filing
  - Circumcision of males at puberty is practised in the Equatorial region
  - Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the **FGC**. An infibulated woman/girl must be cut on marriage to allow for intercourse or for others before delivery
  - Young girls are equally as exposed to rape and sexual abuse as the adult women
  - Given the low literacy levels in Sudan, many children and adolescents may have received little or unreliable education. In such cases they may suffer considerably within a new education system, and need added assistance and support
  - Most resettled adolescents will be faced with role changes in the home, pressures from peers to integrate more quickly than they or their families may be comfortable with, and with the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
  - For Muslim students some Islamic traditions and the difficulty in explaining these due to language barriers, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers etc.)
  - In addition to resettlement issues, some children and adolescents may be carrying trauma from pre-settlement experiences and conditions. It is noteworthy that children often present with poor school performance, lack of motivation or concentration, 'bad' behaviour, and physical complaints as symptoms of post-traumatic stress, depression, anxiety and other mental health conditions

7. SPECIAL EVENTS

National holidays follow the Western calendar, while Islamic holidays follow the lunar calendar.

In the north:

Independence Day	1 January
Unity Day	3 March
Labour Day	1 May

Islamic days:
Id-al-fitr (feast at the end of Ramadan)
Id-al-Adha (feast of the Sacrifice)

Ramadan is celebrated by Muslims in the 9th month of the lunar Islamic calendar and is regarded by many as the holiest time of the Muslim year. During this month Muslims fast from dawn until sundown (including no water or other liquids). Those with ill health are exempt from the fast although many nevertheless like to partake and clients may need to have the possible consequences explained, or to be assisted through the period. Young children, menstruating, pregnant and nursing women are also exempt from fasting. In addition to fasting, the following are prohibited: putting eye drops in the eyes, saliva leaving the mouth and re-entering, sex, listening to music and harsh words or arguments.

Christians will celebrate Christian festivals as well as some of pagan origin, and these are shared by many of the minority ethnic tribes as well.

8. SPIRITUALITY
About 70% of the population are Sunni **Muslims** who predominate in the North and central Sudan, about 25% follow **indigenous** or animist traditions and about 5% are **Christians**. Both of the latter groups are scattered throughout the South with Christians practising across a number of different tribes. Some Pre-Islamic beliefs and practices have been encorporated into Islamic practice. Religious affiliations play a significant role in Sudanese politics.

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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. RMS Refugee Resettlement can provide information on resettlement issues and contacts for community leaders. Contact the Auckland Co-ordinator on +64 9 621 0013.

3. A number of health fact sheets can be found in **Dinka** and **Nuer** languages for download in pdf. at: http://www.healthtranslations.vic.gov.au/

Ethiopian & Eritrean Cultures

Ethiopia and Eritrea are located in the Horn of Africa. They are bordered by Sudan, Kenya, Djibouti and Somalia, and Eritrea by the Red Sea.

Ethiopia, unlike most other countries in Africa was never colonized. It was a monarchy for most of the 20th century with a brief rule by the Italians before World War II. The Emperor Haile Selassie held power until 1973 when he was overthrown by Marxist revolutionaries who established a dictatorship known as the Derg. The Derg's policy of forced collectivization and grouping of traditional settlements into villages, resulted in the devastating famine of the mid 1980's which killed over a million people. In 1991 a coalition, led by Eritrean and Tigrean People's Liberation Fronts overthrew the regime and attempted to establish semi-autonomous ethnic regions. However, much inter-ethnic conflict ensued and in 1993 Eritrea voted to secede from Ethiopia. The two countries, once allies in the fight again the Derg became locked in conflict and a bloody border war raged between them from 1998 and 2000. Over a million people died on either side of the border. The tension and disputes continue today. Although Ethiopians and Eritreans previously shared the same geographical boundaries (for a period of time), since the separation citizens of each country wish to be referred to as Ethiopians or Eritreans respectively. An incorrect reference is likely to be offensive.

Ethiopia itself is also plagued by internal ethnic conflict. In addition, land tenure policies, as well as droughts and soil erosion, leave the country constantly vulnerable to food deficits. It is one of the poorest countries in the world with an estimated annual per capita income of about $100. It is reported that it is likely that more people have died of hunger in Ethiopia in the last 30 years than in any other country in the world. The conflicts have resulted in over 150,000 people being displaced, and in fleeing for refuge to neighbouring countries. Ethiopia also hosts refugees from Somalia and Sudan although these people are in the process of being repatriated.

Eritrea is also now an extremely poor country with about 1.7 million people displaced internally. They have also hosted refugees from Somalia and Sudan. Like Ethiopia, Eritrea faces serious food and water shortages and is in need of constant International Aid.

Ethiopians and Eritreans began fleeing after the coup in 1973. They fled in small groups under extremely dangerous conditions in order to reach the first place of asylum. New Zealand has received approximately 1300 Ethiopians and 300 Eritreans since the late 1990s and about 70% of them live in Auckland. They continue to arrive in small numbers under the quota refugee system and as asylum seekers. Some people immigrate under the family re-unification programme although very few are able to join families due to the prohibitive costs involved in re-location. Many refugees from these countries carry the burden of war, loss and extreme hardship.

1. COMMUNICATIONS

Greetings video clip
Hello/goodbye greeting *Tena yistilign* *(a form of 'good wishes')*

Main languages

Amharic is the official language of Ethiopia, spoken by the Amhara, and **Oromia** (or Oromigna/Oromiffa) is spoken by the Oromo, the largest ethnic group (about 40%). Other tribes include the Tigray[1] who speak **Tigrigna**.

Tigrinya is the official language of Eritrea, spoken by the Tigre.

Although some people speak more than one language, and some Arabic, when working with interpreters it is **essential** that the interpreter is from the same ethnic and linguistic group as the client.

Gestures and interaction

- Ethiopians and Eritreans tend to be formal in their dealings with others, but also courteous
- Use **first names** with younger people, and **title and first name** with people over 35 or 40
- **Hand shaking** is common across genders, although not with more traditional Muslim women. If in doubt ask first, or use the customary verbal greeting
- Kissing on the cheeks, between and across genders occurs with people who know each other and is considered a polite and friendly greeting
- The **right hand** is used for shaking or passing items, or both hands, but never the left
- A slight **bow** shows respect
- **Eye contact** is usually direct but tends not to be prolonged
- **Pointing** is considered rude
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the **practitioner being on time for appointment** is very important in Ethiopian culture, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

[1] *There seems to be confusion, dissent and sometimes contradiction in the literature amongst terms and spellings regarding the ethnicities Tigre and Tigray. The Consular of the Ethiopian Consulate in Australia provided the following clarity: The peoples from the Ethiopian region of Tigray are called the Tigray/Tigrai and speak Tigrigna. In Eritrea there is a very small ethnic tribe referred to as the Tigre who speak Tigrynia (sometimes spelled Tigrigna). In essence the languages are very similar, although the ethnicities are distinct. He reported however, that there are very few Tigres who have resettled in New Zealand (and Australia) so that most of the people who speak Tigrigna will likely be people from Tigray in Ethiopia. 'Tigrean'/Tigrayan is essentially an adjective, but is often used to refer to people from Tigray in Ethiopia.*

2. FAMILY VALUES

- Extended families are traditionally the norm although they tend to be smaller in resettled countries
- There is less segregation between genders in Ethiopian Muslim families than in some other Islamic cultures
- In traditional families males are heads of households and make decisions in relation to the outside world. However this is changing rapidly in countries of resettlement
- Elders are given enormous respect
- Disputes are generally settled by community leaders, or elders
- Boys and girls receive the same education, and literacy amongst women is higher than in some other Islamic cultures
- Marriages can be arranged or be of the individual's choice although family will need to approve of the match
- In some more rural areas marriage can take place at 14 or 15 and men can have more than one wife (Muslims). Laws in countries of resettlement alter these norms
- Although part of a collective culture, Ethiopians value independence and are expected to stand up for their rights and needs. These however, do not override family or community needs

3. HEALTH CARE BELIEFS AND PRACTICES

For more detailed information refer to Jackson (2006) Ch. 6, and Kemp and Rasbridge (2004) pp 160-163.

3.1 Factors seen to influence health

1. **Western biomedical concept** of disease causation and disease communicability is accepted as explanation for some illnesses and is more likely to be understood by those living in the west. Other attributions of ill health may be preferred or may co-exist along with western concepts.
2. **Equilibrium/balance**
   Generally Ethiopians/Eritreans believe that a balance between internal and external worlds (including the supernatural) is essential for wellness. Imbalance results in illness. Emotional wellbeing is thought to play an important role in physical health, and harmonious relationships are also seen to influence health significantly.
   Humeral concepts of 'hot' and 'cold' also apply in understanding certain physical ailments.
3. **Spiritual/supernatural**
   Beliefs in spiritual and supernatural causation are well established. Mental illness is attributed, by those who subscribe to supernatural beliefs, to evil spirits by both Christians and Muslims. (For others, mental illness is understood in more 'Western' terms). The following are the most common beliefs:
   - '***Zar***' spirit possession is common. Long-term possession can cause mental illness, especially amongst newer refugees or immigrants. *Zar* possession is believed to be higher amongst women in the home country and more common amongst men in the country of resettlement.
   - Belief in the '***evil eye***' (called *Buda)* is common. It is believed that an individual can put a curse on others by looking at them. This mostly affects children

- Illness may be punishment from God for sins committed or as a result of anger from spirits (e.g. HIV/AIDS is believed by many to be punishment, hence the stigma)
- ***Sorcery*** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together

3.2 Traditional and current treatment practices

1. **Western medicine**
   This is more commonly practiced in urban areas. Most Ethiopians accept western interventions although they may also continue with traditional treatments concurrently.
2. **Traditional/complimentary practices**
   - The use of **herbal medicine** is a highly and widely developed practice in Ethiopia and Eritrea. Kemp and Rasbridge (2004) report that there are 21 types of specialized traditional healers in these countries practising a number of traditions including herbalism.
   - **Cupping** is used to treat *wind* conditions. This may leave scars which should not be assumed to result from abuse (probably not practised in New Zealand)
   - **Moxibustion** is practised by the Eritreans, and possibly other ethnicities (probably not practised in New Zealand)
3. **Magico-religious articles** and **spiritual healing** may be used by some:
   - Intercessory **prayer** is used to heal both physical and mental illness, and especially spirit possession
   - **Amulets** (*kitab)* are worn by some

3.3 Important factors for Health Practitioners to know when treating Ethiopian and Eritrean clients:

1. As many Ethiopians and Eritreans who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below).

2. Given the ethnic conflicts in both countries, as well as the disputes that continue between the groups in New Zealand, it is imperative that interpreters from the same ethnicity as the client are involved. Interpreters from the same country speaking the same language but belonging to a different ethnic group will NOT be trusted and information is highly likely to be withheld during the clinical session.

3. Women do not take the husband's name after marriage and records need to accommodate this preference.

4. Both men and women prefer same sex practitioners and interpreters, and particularly for gynaecological issues and childbirth.

5. Female Genital Cutting (**FGC**), Types I and II, is common throughout both countries and is practised by people from all 3 religious groups. In Eritrea Type III is also practised. It is believed by local residents that it is not practised by resettled people in New Zealand. Respectful handling of the issue is crucial with assistance and/or education as needed. This is part of the culture and is

expected and accepted as such by many women. Practitioners need to familiarize themselves with the needs and sequelae.

6. Clients respect health practitioners highly and will tend to take a passive and dependent role in illness. Back home families are involved in treatment decisions, however in New Zealand there are often few or sometimes no family members to take this role and the practitioner is expected to advise and support.

7. In Ethiopia medications and injections are usually received for every illness. When these are not prescribed in New Zealand, clear explanations about the reasons would be helpful, particularly with newly arrived clients who might otherwise believe that they are not being helped. In addition compliance is likely to be enhanced if some traditional practices can be encorporated within the current treatment plan when possible.

8. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

9. Ethiopians and Eritreans tend to be stoic in the face of adversity and in pain endurance and will often refuse pain control.

10. A **culture specific syndrome**, '*moygnbagegn'* is a traditional disease with symptoms of fainting, fever, headache, stiff neck and abdominal cramps. It is treated by blood letting and believed by some Ethiopians to be exacerbated by western medicine. The similarity of some of the symptoms to meningitis makes is important that this order is correctly identified. In the absence of a practitioner some people may make incisions over the brachial vein in the forearm and many hold scars from this practice (see Jackson 2006, p. 91).

11. Because of the emphasis on the role of mental health in physical health, news of poor prognosis or terminal illness is usually not delivered to the client, but to a (male) family member. Informed consent issues may need to be dealt with in such cases, and this is likely to be a new procedure for most Ethiopians/Eritreans and will need explanation.

12. It is believed by some that blood lost cannot be replaced from the body and so venous blood drawing and blood transfusion create anxiety and fear. Explanations would be necessary.

13. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit. Visits should always be scheduled
    - It is appropriate to remove shoes before entering the home
    - It is customary to address the male adult or elders of the household first
    - Food or drink will usually be offered and it is expected that the hospitality will be accepted
    - Modest dress is appropriate
    - Be aware that no food or drink is consumed from sunrise to sunset during Ramadan (in Muslim homes)

3.4 Stigmas

Mental Illness in Ethiopia is stigmatized and families prefer to manage the person themselves. If a family seeks help from a mental health practitioner it is considered a sign of a member having a major mental illness. Jackson (2006) reports that in 2000 there were 11 psychiatrists in a country of then 55 million.

Although suicide is considered a sin by Muslims and orthodox Christians, it is not stigmatized in the community.

3.5 Diet and Nutrition

Engera (pronounced en-jer-a) is the staple. It is a sour-like fermented pancake that is used with "wot", a stew made with spices, meats and pulses, such as lentils, beans and split peas. The bread eaten by Oromo people is called *'bedeena'* and made similarly. Coptic Christians do not consume meat or dairy products for more than half of the year and Muslims require *halaal* foods and do not eat pork. Oromos do not eat pork. Families would provide traditional breads and stew or soups for hospitalized clients who are unable to eat western foods.

3.6 Death and dying

- Many Ethiopians contribute financially to a 'burial society' on a monthly basis. After a death in the family, the society takes care of all procedures and expenses and for 3 days the family has only to mourn
- Burial takes place on the same day as the death unless the death occurs after 4.00pm in which case the body will be buried the following day (Muslims)
- Immediate family should be informed by **an elder** in the family (or close friend or community member if there is no family in the country of resettlement). It is important that the medical examiner consults an elder or community member in order to identify the best person to deliver the news to the family or person concerned. This is an act of respect and would be appreciated in this culture
- In the case of suicide, the body will not receive a service in the church or mosque. However it is acceptable if the family wishes to treat the death as a non-suicide and there is no stigma in the community if the family does not inform the religious practitioner that the death was a suicide
- Neither autopsy nor organ donation is prohibited by the religion or culture, but individual families will have their own preferences
- The deceased should be cleansed and clothed by someone of the same gender
- Burial in a cemetery is required, not cremation

4. HEALTH RISKS (as listed by Kemp and Rasbridge, 2004)

- Amebiasis
- Anthrax
- Boutonneuse fever (African tick fever, Marseilles fever, tick typhus)
- Cholera
- Crimean-Congo hemorrhagic fever
- Dracunculiasis (Guinea worm disease)
- Echinococcosis (hydatid disease)
- Filariasis (Bancroftian and Malayan filariasis, loiasis or loa loa, onchocerciasis (all of the later found in tropical Africa, but potential exists)
- Hemorrhagic fevers (HFs): Lassa HF, Marburg and Ebola HFs, Crimean-Congo HF, chikungunya fever, dengue fever and dengue HF, and Rift Valley fever)
- Hepatitis B (9% carriage rate)
- Hookworm
- Leishmaniasis
- Leprosy
- Malaria

- Malnutrition
- Measles
- Plague
- Poliomyelitis
- Relapsing fevers (louse-borne relapsing fever (LBRF) primarily in highlands of Ethiopia; tick-borne (TBRF) has a wider distribution
- Rift Valley fever
- Schistosomiasis or bilharzia
- STDs including HIV/AIDS, cervical cancer, chancroid, gonorrhea, granuloma inguinale, lymhogranuloma venereum, syphilis
- Sickle cell disease or sickle cell hemoglobulinopathies
- Strongylodiasis
- Trachoma
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzias; intestine-dwelling; and lung-dwelling
- Tuberculosis
- Typhus
- Yaws (frambesia)
- Post-traumatic stress disorder

Kemp and Rasbridge state however that few Ethiopians and Eritreans arrive in the west with dramatic health problems. HIV/AIDS is 10% in Ethiopia and 2.9% in Eritrea. The most common problems include hepatitis, TB, intestinal parasites, measles, long-term effects of malnutrition, and war trauma.

5. WOMEN'S HEALTH

For Ethiopian and Eritrean women who have resettled as **refugees** a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general. The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some women re-locate alone as a result of family losses, separations and displacements.

Female Genital Cutting (**FGC**) occurs extensively in both countries (90-95%) (see 3.2.5 above and Youth Health below). Over 70% of girls undergo FGC before 12. Although in Ethiopia Types I and II are most common, Type III is practised around the regions bordering Somalia and Sudan. FGC tends to be a more common practice in some Muslim cultures, however, since statistics reflect such high percentages, it is assumed that it is also practiced by Christians in these two countries. It is reported by local community residents that educational programmes in Ethiopia are widespread and that the practice is diminishing.

- **Traditional fertility practices**
  - Family planning is not widely practised in the home countries but is well accepted by those people living in the west
  - Breast-feeding is the most common form of contraception. However, after resettlement, fertility rates are reported to be higher (in the U.S.) because of women needing to return to work and stop breast feeding early
- **Pregnancy**

  Amongst traditional people, this is believed to be a time of vulnerability for the mother and that the fetus is at risk for harm from evil spirits and sorcery

- **Labour and Delivery**
  - Men are traditionally not involved in the process. A female friend or family member will be informed when a mother commences labour
  - Traditionally deliveries are assisted by midwives/traditional birth assistants, or a female family member
  - Resettled women prefer female health practitioners
  - In order to avoid what is seen as hasty decisions by western doctors to perform caesarian sections, some mothers may delay going to the hospital for delivery until the last minute
- **Postnatal care**
  - Oromo people feed the infant on water only for 24 hours followed by butter which is used as a laxative to expel meconium before starting breast feeding. Eritreans use water with a little sugar during the first 24 hours
  - Some women practice a brief symbolic rejection of the newborn for the discomfort and pain caused during pregnancy and delivery
  - After delivery the mother stays home for 2-6 weeks (when possible)
  - Family or friends will assist with cooking and housework to enable her to recover her strength. This is sometimes not possible after resettlement
  - Breast-feeding is the norm and can last up to 3 years (sometimes for a shorter period after resettlement). However other foods can be introduced at about 4 months
- **Religious Ceremonies Related to Birth**
  - Orthodox Christians will baptize a baby boy on the 40th day after birth, and girls on the 80th day. Evangelical or Pentecostal Christians will baptize babies when the family is ready.

6. YOUTH HEALTH

- **Newborn & Child Health**
  - Circumcision for boys is mandatory
  - Circumcision is practiced on 90-95% of girls
  - Within the Oromo tradition female circumcision is preferred but not mandatory
- **Adolescent Health**
  - Most resettled adolescents will be faced with:
    - role changes at home
    - pressures from peers to integrate more quickly than they or their families may be comfortable with
    - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
  - In addition to resettlement issues, some children and adolescents may be carrying trauma from pre-settlement experiences and conditions. It is noteworthy that children often present with poor school performance, lack of motivation or concentration, 'bad' behaviour, and physical complaints as symptoms of post-traumatic stress, depression, anxiety and other mental health conditions
  - Some Islamic traditions and the difficulty in explaining these because of language barriers, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, time schedule for prayers, *halaal* food etc.)

- Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the **FGC**
- Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women

7. SPECIAL EVENTS

Ramadan
Ethiopian New Year, September 11
Ethiopian Christmas, January 7

8. SPIRITUALITY

The reported percentages of religious practitioners belonging to different religious groups differ amongst sources, however in general it seems that **Muslims** (Sunni) and **Ethiopian Coptic Church** share similar numbers of practitioners in both countries.

Some Oromo follow an **indigenous religion** whose God is *Waka (Waaqa).* For many Oromo this religion has been encorporated into other religions. Christians within the Oromo ethnicity tend to be Catholic or Adventist rather than Orthodox as the latter is associated with the dominant Amhara.

In Addition to Islam and Orthodox Christianity, some Eritreans are animists whose God is Anna. Roman Catholics and Protestants are also represented in small numbers in Eritrea.

Photos: www.care.org.newsroom and www.refugeesinternational.org

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Useful Resources

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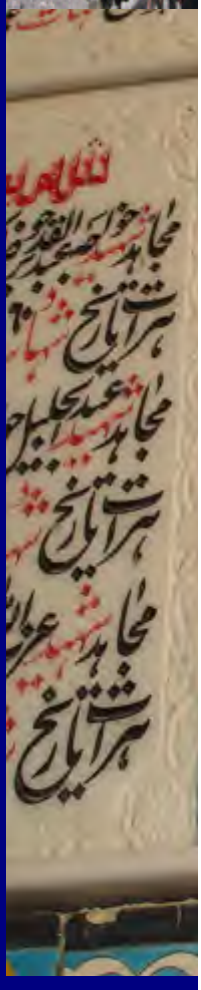
AFGHAN CULTURE



Afghanistan is part of the 'Eastern Mediterranean region' recently defined as such by the WHO. As a crossroads for Central Asia, Iran and India, Afghanistan is a weave of many cultural influences spanning many centuries. It was once the highly prosperous and flourishing hub of Central Asia but has since been plundered and ravaged by the many wars and power mongers leaving it devastated and in factional, political and economic strife.

Afghanistan takes its modern identity from the Durrani Empire founded in the mid 1700's. Since then it has survived 3 Anglo-Afghan wars during its monarchy, and 10 years of civil war after the Soviet invasion in 1979. The United States, China and Saudi Arabia funded and fuelled a war in opposition to the Soviet with the result that more than 6 million Afghans were displaced as refugees, mostly in Pakistan and Iran. (Afghans represent the largest group of refugees in the world). After the Soviets withdrew in 1989 widespread factional fighting led to more people fleeing, especially professionals. The fundamentalist Taleban regime took control in 1996 and created another wave of millions of Afghans fleeing the tyranny, oppression and horrors resulting from the imposition of the fanatical laws. Many of the last wave of refugees were Tajiks and other minorities including Hazaras. The country was further depleted of resources, poverty was rife and the drug trade particularly in opium, remained a major source of revenue.

Although refugees have begun returning 'home' since the fall of the Taleban, some continue to leave Afghanistan, either to join their displaced families or because of continued discrimination against minority ethnicities, or due to the dire prevailing conditions. Life is harsh with continued violence and lack of resources, services and food.

New Zealand has Afghan communities established in Auckland, Christchurch and Wellington.

Photographs provided by Gary Poole and Arif Saied

1. COMMUNICATION

Greetings video clip

Hello greeting	*Salaam aleikum* 'peace be upon you' (Muslims)
Goodbye greeting	*Khuda Hafiz* 'God be with you' (Muslims)

Main languages

Dari and **Pashto** (Pashtu) are the main languages spoken in Afghanistan. Dari is the Afghan form of Farsi (Persian, based on Arabic script) which is spoken in neighboring Iran. Farsi speaking interpreters can be used for Dari speaking clients when necessary. However there are enough differences in the languages for misinterpretations to occur and the practitioner needs to be aware that a discussion of some concepts may need clarification between client and interpreter.

Pashtuns (generally Sunni Muslims) form the largest ethnic group. The Dari speaking Tajik constitute 25% of the population and are associated with sedentary farming and urban dwelling, the Turkic (Uzbek and Turkmen) who live north and south of the Hindu Kush constitute about 11% and speak Farsi and an ancient form of Turkish, and the Hazara, most of whom speak Dari live centrally and represent about 1.1 million people. There are 15 other ethnic groups living in Afghanistan.

Although the religion is principally Muslim, and the language script is based on Arabic forms, Afghans are not ethnically Arabic.

Gestures and interaction

- It is appropriate to **shake hands** with men, though not usually with Muslim women. Physical contact with women should be restricted to necessary physical examinations as propriety is highly valued and also required
- Same gender practitioners and interpreters are preferred, and are usually imperative for gynaecological examinations
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Health practitioners are considered to have a high status and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions
- Prolonged **eye contact** is avoided between men and women, and between people considered to have a different status. A person with lower status may lower their eyes, or heads to avoid eye contact. Second generation Afghans may be more relaxed about eye contact
- **Saying 'no'** directly is not courteous in Afghani culture so an affirmative response from a client may not necessarily mean agreement or acceptance (clients will also appreciate a more indirect way of saying 'no' from the health practitioner)
- Western custom of **asking direct questions** is considered impolite and can result in reticence to engage. Asking general questions about the wellbeing of the client (and importantly, family) will assist with establishing rapport and for the client to volunteer information for further questioning
- Showing an **interest** in the culture and practices will likely enhance compliance and the relationship with the practitioner

2. FAMILY VALUES

- Religion plays an extremely prominent role in family life
- The family is sacrosanct
- Traditionally fathers and sons are heads of household and decision makers in all respects (although in some resettled families women may have more say in family affairs)
- The chastity of unmarried women is of great concern to the family
- Resettled families strive to maintain ties with relatives in their homelands and will often arrange marriages to this end
- There is profound respect for elders and those in authority
- Individuals are oriented towards the good of the whole family and mutual dependence is required over independence
- Privacy about family matters is imperative and so confidentiality issues will need to be well established
- The freedom and difference of family values in the West places significant stress on families who resettle as refugees, and school, health and social services can often be seen as undermining parental and male authority. Sensitivity from practitioners to the challenges faced in adapting to a new culture will be appreciated

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

1. Balance

Similarly to many other cultures included in this resource, it is believed that health is based on keeping the body elements in 'balance' and that certain kinds of diet, lifestyle, treatments and external factors can influence this. Maintaining the balance of the 'humours' is essential for good health and entails keeping a balance between the 'warm' (*garm)*, 'cold' (*sard)*, and 'wet' and 'dry' states of the body

2. Spiritual/religious

Punishment for misdeeds or for not adhering to the principles of Islam can bring illness. Unlike some of the practitioners of Buddhism who tend to take a fatalistic view, Afghans see themselves as responsible to seek treatment.

3. Supernatural

Evil spirits known as '***Jinn***' in Islam can cause some illnesses, (often associated with mental health problems) (See Jackon, K. (2006) Ch. 2 for more information about supernatural beliefs in Islam)

4. Western concept of disease causation

This is commonly accepted and may co-exist along with any of the other attributions of illness

3.2 Common Traditional treatments and practices

- **Magico-religious articles** such as amulets, charms and strings, are worn to ward off evil spirits. The amulets (that look like a piece of string) contain verses from the Qur'an and are believed to guard against the 'evil eye'. Permission to remove these articles for medical interventions needs to be gained from clients beforehand

- **Traditional medicine** (known as *attary* in Dari) comprising herbal remedies taken as powders or tea are commonly used and some of these are available in the West, especially in Middle Eastern stores. *Attary* specialists have knowledge about prescribing for particular ailments, although Kemp and Rasbridge (2004) suggest that there are few of these specialists, if any, amongst resettled populations. They also highlight that raw opium in a wrapped form (*bast*) is commonly used in folk medicine and is used to treat extreme pain, stimulate the appetite and increase sexual stamina
- Allopathic practitioners are commonly consulted. However, many **Western medicines**, including antibiotics are available over-the-counter and it is common for Afghanis to self-medicate with these

3.3 Important factors for Health Practitioners to know when treating Afghan clients:

1. As many Afghan who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below)

2. The addition of 'Inshallah' ('God Willing') to statements is frequently made when expressing hope for good outcomes or for the future. It is useful for practitioners to use this phrase too as it will assist with good rapport and show an understanding of the importance of religion in the client's life.

3. In Afghanistan a referral to a specialist is not required. Clients will often 'doctor shop' and may expect to do so in New Zealand. As mentioned above, they can also buy their own medications over the counter back home. As a result clients resettled in New Zealand may need to be informed about health practice here.

4. Children should NOT be used as interpreters as it often results in information being withheld due to privacy and status issues. When it is absolutely necessary, give authority to parents by asking if the child can interpret for them.

5. When Afghan people first resettle they usually expect a tangible intervention (prescription, injections etc.). If this is not offered at consultations clients may seek treatment elsewhere, or try their own. So rationale behind treatment plans may need more explanation than with western clients. After a period of resettlement however, the local traditions are understood and accepted.

6. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

7. Some mental health issues (particularly depression, '*afsordagi'*) may present as somatic complaints. If the mental health component is addressed, often the somatic problem will resolve.

8. Terminal illness should be divulged to the family, NOT the client. It is customarily believed that the client's response to the news encourages deterioration of the condition. Client will need to give informed consent for medical information and issues to be discussed with a designated family

member. This is expected practice.

9. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Always remove shoes when entering the home
    - If food or drink is offered, it is acceptable to either decline politely, or to accept. However, if food has been especially prepared it would be considered rude to refuse. (Be aware that no food or drink will be consumed by the family in between sunrise to sunset during the Ramadan period)
    - Afghanis regard their privacy highly and would appreciate assurances of confidentiality
    - Modest dress is appropriate

3.4 Stigmas

Mental illness is considered a stigma and some clients may withhold related symptoms or emphasize physical ones. It is also difficult for men to acknowledge problems that may be seen as 'weakness'. Refugees who suffer from the long-term after-effects of torture may present with physical symptoms that need further exploring. For information on mental health issues see *Jackson (2006)*, *Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities*.

3.5 Diet and Nutrition

Afghan food is largely based on cereals like wheat, barley, rice and maize as well as lamb, chicken and beef, but no pork for Muslims. Curds and spices are common in cooking. *Nan-i-Afghani* is the national bread. The addition of this in a hospital diet would be appreciated. The bread is available in most stores stocking Middle Eastern or Indian foods. Families would be happy to provide this for members who are hospitalized.

3.6 Death and dying

Muslims

- When death approaches, a Muslim will recite "There is no god but Allah, and Muhammad is His Messenger"
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, not cremation
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife, and wrapped in a white shroud
- The body is laid out in specific ways and prayers recited before it is taken to the cemetery
- A ceremony and meals commemorating the deceased are held in the home for 3 days after death. The family is visited by community, friends and relatives, and their support is paramount during this time. Men will attend the mosque but have meals at the home.

4. HEALTH RISKS

Wikipedia (updated 12 September 2006) cites the following high risks for Afghans:

- Food or waterborne diseases:
    - bacterial and protozoal diarrhea
    - hepatitis A
    - typhoid fever
- Vectorborne diseases:

    - malaria is a high risk countrywide below 2,000 meters from March through November
- Animal contact diseases: rabies (2005)
- Nutritional deficiencies
- Tuberculosis

In additon, Kemp and Rasbridge (2004) list the following risks for refugees and immigrants from Afghanistan:

- Amebiasis
- Anthrax
- Boutonneuse fever
- Brucellosis or undulant fever
- Cholera
- Crimean-Congo hemorrhagic fever
- Cysticercosis (tapeworm)
- Dracumculiasis (Guinea worm disease)
- Echinococcosis (hydatid disease)
- Gardia
- Hookworm
- Leishmaniasis
- Measles
- Plague
- Schistosomiasis (bilharzia)
- Toxocariasis
- Trachoma
- Trematodes
- Trichinosis (trichinella)
- Tuberculosis
- Typhus
- Post-traumatic stress disorder

5. WOMEN'S HEALTH

During the Taleban regime, women were prevented from leaving their homes to seek medical treatment. Although access is no longer denied, the continuing problems of inadequate services, extreme poverty, lack of resources including drinkable water, poor sanitation, lack of health education, and often lack of food result in exceptionally high health risks for both women and children. In 2003 Afghanistan was reported to have the fourth-worst health profile in the world. Some Afghans resettling in New Zealand will have suffered such conditions and may arrive in need of significant health care and health education.

Rape and Sexual abuse is extremely common amongst **refugee** women in general, and Afghans are no exception. Due to the lower social status of women in Afghanistan few disclose, but those who do so report atrocities and assault within and outside marriage. Many women have been assaulted by soldiers during war situations, during flight and in the refugee camps or countries of first asylum. The witnessing of violence and assault also leave women feeling vulnerable or traumatized. It is important to explore a possible history of sexual assault although this needs to be done when trust has been established as privacy and chastity is so highly valued.

- **Pregnancy**
    - Maternal health remains highly inadequate with the mortality ratio at an alarming rate of 1,600 maternal deaths per 100,000 live births
    - Iodine deficiency is common in women, resulting in low birth weight, deafness and cretinism among newborns
    - Pregnant mothers arriving in New Zealand may need assistance with nutrition education and also dietary supplementation

- **Labour and Delivery**
  - Births are usually assisted by a midwife (a *dais)*, particularly in more rural areas
  - Gender matching with practitioners for examinations and births is necessary
- **Postnatal care**
  - Early weaning, poor complementary feeding and breast-feeding practices, and lack of nutrient-dense complementary foods are factors leading to the high prevalence of chronic malnutrition amongst newborns in Afghanistan. Young children presenting for treatment in New Zealand after resettlement may have endured such histories.

6. YOUTH HEALTH

- **Newborn, Child and Adolescent Health**
  - According to UNICEF, Afghanistan ranks as the fourth-worst country in the world in terms of under-five mortality, with one in four children not surviving beyond their fifth birthdays. The infant mortality rate is at 165 per 1,000 live births
  - The major causes of child mortality include diarrhoea, acute respiratory infection, malaria and micronutrient deficiencies
  - Many young children and adolescents have been subjected to violence themselves or have been witness to the atrocities leveled at their families and communities during the war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children. Sometimes children do not tell their parents in order to avoid added stress on the family, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal or learning difficulties as well as various somatic presentations. Practitioners and teachers need to be alerted to possible pre-location conditions
  - Most resettled children will be faced with role changes in the home, pressures from peers to integrate more quickly than they or their families may be comfortable with, and with the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
  - Some Islamic traditions that differ from western ones, and the difficulty in explaining these in a new language, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, prayer time schedules, the requirement for *halaal* food etc.)

7. SPECIAL EVENTS

Norouz, the Afghan New Year, is usually held on 21 March

Ramadan	(fasting month)
Eid al-Fitr	(celebration after fasting)
Eid Al-Adha	(important holiday for making pilgrimages to Mecca)
Moulid	(celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan)

8. RELIGION/SPIRITUALITY

Muslims constitute the majority of Afghans (about 99 percent). About 80% of the population is Sunni, and about 19% is Shiite Muslim. There are an estimated 3,000 Afghan Christians. The *mullah* is the (male) religious leader or teacher. The Qur'an is the holy book. Tajiks tend to interpret the Islamic practices less strictly than the Pashtuns, and there is some variance in the adherence to rituals and religious laws amongst the diverse ethnicities.

A few Muslims practice **Sufism**, a mystical form of Islam.

There are a few Hindus and Seiks in Afghanistan but they tend to migrate to India rather than New Zealand.

References and Resources

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3. Maqsood, R.W. *Thoughts on Modesty. Islam for Today*. Retrieved July 2006. Available at: www.islamfortoday.com/ruquaiyyah05.htm

4. No author. *Culture of Afghanistan*. Retrieved September 2006. Available at: http://en.wikipedia.org/wiki/Culture_of_Afghanistan

5. No author. *Ethinic Groups of Afghanistan*. WebMedia iNteractive. 1997 – 2002. Retrieved September 2006.

6. No author. *U.S.-Afghan Health Partnership.* Retrieved September 2006. Available at: http://www.voanews.com/uspolicy/archive/2005-01/a-2005-01-03-2-1.cfm

7. Saeid, A., Community Manager RASNZ. (January 2007). P*ersonal consultations on Afghan culture and practice in general, and on practice amongst resettled community members in New Zealand*. Auckland.

Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. RMS Refugee Resettlement can provide information on resettlement issues and contacts for community leaders. Contact the Auckland Co-ordinator on +64 9 621 0013.

3. A number of health fact sheets can be found in **Dari** and **Pashtu** for download in pdf. at: http://www.healthtranslations.vic.gov.au/

Iraqi Culture

Al-Tanf Camp 'store'

Al-Mustansiriyah University

Gate of Ishtar

Iraq has been besieged by incessant war, internal strife and tyranny since Saddam Hussein came to power in 1979: the Iran-Iraq war from 1980-1988, the *Anfal* (campaign to eliminate Kurdish culture), the Gulf War of 1990, and recently the U.S led war of 2003 which ousted Saddam Hussein and his Sunni-dominated Baath party. The interim Iraqi-led government, (which continues at the time of writing this resource, 2006) is beleaguered by political, religious and ethnic faction, and daily violence and bloodshed continue with no real certainty of resolution. Political dissidents, Shiite Muslims, Kurds and Assyrian Christians who opposed Saddam's regime, were among the persecuted and these groups continue to be targeted. Currently thousands of people flee daily, an estimated 2,000 into Syria and about 1,000 into Jordan.

During the wars millions of Iraqis (including Kurds from *'Iraqi Kurdistan'* in Northern Iraq) have fled, initially into the refugee camps in Saudi Arabia (Al Artawea and Rafha), into Iran, the US-occupied zone along the Iraq-Kuwait border, and more recently into Syrian and Jordanian refugee camps. Many Kurds fled to Turkey where they were forcibly settled in camps. Life has been harsh and conditions very poor in some of the camps and also in resettlement locations where conditions have become overcrowded. In 1994 the US resettled large numbers of refugees from Rafha, and some Kurds from Turkey. Some were accepted by other countries including New Zealand.

Most Iraqi refugees arrived in New Zealand during the 1990s and were relocated in Auckland, with smaller groups in Wellington and Hamilton. The communities in these cities are well established and continue to grow as people from the 'at risk' groups (defined by the UNHCR) continue to arrive as well as through family re-unification programmes. Some Iraqis have resettled here as migrants.

Photos: www.refugeesinternational.org

1. COMMUNICATION

Greetings video clip

Muslims (Arabic)

Hello greeting	*Salaam aleikum*	'Peace be upon you' (Muslims)
Goodbye greeting	*Ma'a alsalam*	'God be with you' (Muslims)

Assyrians and Chaldeans (Aramaic)

Hello	*Shlamalugh (*masc.*), Shlamalagh (*fem.*)*	
Goodbye	*Push pshena*	*(*Stay in peace*)*

Main languages

The main language spoken in Iraq is **Arabic**. Most people are Arabs (about 75 – 80%) and about 15% Kurdish. There are small numbers of other ethnicities including Assyrians, Chaldean and Armenians (all Christians), Turkomans and some Iranian based ethnicities. Some less educated Kurdish people do not speak Arabic but a dialect (usually Sorani or Kurmani). Literacy in Arabic in Iraq is reported to be around 58%.

Assyrian and Chaldeans would very much appreciate being greeted in their own language although they would not be offended if greeting in Arabic (see above).

Gestures and interaction

- **Hand shaking** occurs between same sex members only (Muslims). Physical contact with women should be restricted to necessary physical examinations as propriety is highly valued and also required (it is usually acceptable to shake hands with Assyrian and Khurdish women unless they are elderly)
- It is customary to greet males first (Muslims)
- The **right hand placed on the heart** after hand shaking or greeting is a gesture of sincerity
- **Pointing a finger** is considered rude, and either the right hand or **both hands** are used to pass objects, NOT the left alone
- Showing **respect,** especially for elders, is appreciated (the practitioner being on time for appointment, greeting them in their traditional way, greeting elders first)
- Health practitioners are considered to have a high status and clients will not ask **questions** as it is considered disrespectful. Clients will expect that practitioners know this and will wait for practitioners to invite them to ask questions
- Avoiding direct **eye contact** is considered respectful, especially between men and women, and between people considered to have different status. A person with lower status may lower their eyes, or heads to avoid eye contact. Second generation Iraqis may be more relaxed about eye contact.
- **Eye contact** is more acceptable with Christian Iraqis
- **Saying 'no'** directly is not courteous in Iraqi culture so an affirmative response from a client may not necessarily mean agreement or acceptance. Alternatively the client may answer with "I don't know" rather than saying no. (Clients will also appreciate a more indirect way of saying 'no' from the health practitioner)
- **A negative response** is indicated by a nod of the head and a click of the tongue and is easily misunderstood by westerners as an affirmative gesture

- The Western custom of **asking direct questions** is considered impolite and can result in reticence to engage. Asking general questions about the wellbeing of the client (and importantly, family) will assist with establishing rapport and for the client to volunteer information for further questioning
- **Shaking the head from side to side** indicates a misunderstanding, not necessarily disagreement
- Showing an **interest** in the culture and practices will likely enhance compliance and the relationship with the practitioner

2. FAMILY VALUES

Arabic Iraqis

- Allegiance to the extended family and tribe is paramount
- Traditionally men manage household finances and women are more responsible for childrearing. These roles may change after resettlement, depending on education and period since arrival
- Arranged marriages are common and customarily girls are wedded as young as 12 or 13 in rural areas. Laws in resettlement countries curtail this practice. For people with formal education, marriage age is higher at 15 - 20.
- Marriage to first-cousins is valued, particularly in New Zealand as backgrounds of other families are often unknown and futures therefore insecure
- Marriage is sacred and serves as a bond between families
- Married women live in the husband's extended households
- Households are usually segregated according to gender
- Women are usually subservient to men although Iraqi women have higher status than in most other Islamic cultures (particularly amongst the Sunni where there are many educated and professional women)
- Children are cherished and indulged although strictly punished for misbehaviour

Kurdish Iraqis

- All above applies
- Social organization is principally clan oriented
- Males and parents are afforded great respect
- Marriage must be sanctioned by the family
- Khurdish women have higher status than other Islamic cultures and do not have to wear a veil
- Khurdish women retain their own name after marriage while the children carry their father's name

Christian Iraqis

- All above applies
- Assyrian women do not wear a veil

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health

1. **Western** biomedical concept of disease causation
   This belief is well established although other attributions of ill health may co-exist along with western concepts
2. **Spiritual/religious**
   - Punishment from God for sins committed
   - God's will (for some Iraqis life is believed to be pre-destined)
3. **Supernatural**

- *Evil spirits* known as '***jinn***' in Islam can cause some illnesses, (often associated with mental health problems) (See Jackon, K. (2006) Ch. 2 for more information about supernatural beliefs in Islam)
- The '***evil eye***' (*ayin harsha* in Arabic*)* present in some individuals, can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackon, K. (2006) Ch. 2)
- **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together (not for Christians)

3.2 Common Traditional treatments and practices

1. **Western medicine**
   This has been well established since the 10th century and is highly valued and commonly practised in Iraqi culture
2. **Traditional/complimentary practices**
   There are variations across tribes and geographical areas but many herbs, henna dye, food items and rituals are used to treat common ailments (see Kemp and Rasbridge (2004, Ch. 21) for a list of examples
3. **Magico-religious articles** and **religious rituals** may be used. Articles such as amulets and the blue-glazed faience eye is common in the Eastern Mediterranean

3.3 Important factors for Health Practitioners to know when treating Iraqi clients:

1. As Iraqi who enter New Zealand have arrived as **refugees**, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below)
2. Same gender practitioners and interpreters are preferred by both men and women, but are imperative for gynaecological examinations. A nurse will be preferred if only a male gynaecologist is available.
3. Iraqi clients usually seek professional biomedical help early when feeling unwell.
4. The identified client is customarily accompanied by at least one family member who will often assist in answering questions. Treatment plans need to be discussed with family members as well.
5. Women retain their own name after marriage while the children carry their father's name. Records need to accommodate this practice.
6. Trust may need to be established before clients will feel able to share enough information for a proper diagnosis.
7. When Iraqi people first resettle they usually expect a tangible intervention (prescription, injections etc.). If this is not offered at consultations clients may seek treatment elsewhere, or try their own. So rationale behind treatment plans may need more explanation than with western clients. After a period of resettlement however, the local traditions are understood and accepted.
8. If medicine is prescribed, practitioners need to enquire about the use of herbal medicines to assess for potential drug interactions.
9. Clients may refuse medication during Ramadan, or need to alter doses.
10. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

11. Reasons for laboratory testing need to be clearly explained.
12. Doctors may need to take the time to explain the nurse's role to the client as this role in a GP practice is not common in Iraq.
13. Dietary needs should be established if a client is to be hospitalized.
14. For older and more conservative Iraqi Muslims, western concepts of preventative medicine may conflict with beliefs that life has been pre-determined by God and should not be altered.
15. Any woman who has just undergone purification for daily prayer may not be touched.
16. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit
    - It is necessary to remove shoes before entering the home
    - If food or drink is offered, it is acceptable to decline politely. However, accepting would be appreciated as offering food is a gift of hospitality and it encourages openness and trust
    - Iraqis regard their privacy highly and would appreciate assurances of absolute confidentiality at all times, but especially in dealing with mental health, fertility issues and terminal illness such as cancer.
    - Modest dress is appropriate
    - Be aware that no food or drink is consumed during sunrise to sunset during Ramadan

3.4 Stigmas

- Mental Health problems are seen as a stigma for Christian Iraqis
- Suicide is forbidden by the Qur'an for Muslims so families with a suicide incident would feel stigmatized
- Suicide is also not acceptable for Christians and a funeral service will not be conducted by the priest

3.5 Diet and Nutrition

Both Sunnis and Shiites observe '*halaal*' laws. This involves eating *halaal* meat (meat that is blessed at slaughter by another Muslim in a prescribed way), and no alcohol or pork is consumed. (This does not apply to Assyrian Christian clients).
Meats, vegetables, rice and spices form the basis of the diet with flat bread '*samoons'* part of most meals. Saffron, rose water and mint are typical flavourings. Nuts and raisins are another hallmark of Iraqi food.

For different reasons clients may not request special foods whilst in hospital and therefore may not eat much that is provided while hospitalized. Families are usually happy to supplement foods for family members. '*Halaal*' meats needs to be provided for hospitalized Muslim clients.

3.6 Death and dying

Muslims

- Life-support measures are acceptable to most Iraqis
- Clients who are near death need to be turned to face Mecca
- An opportunity to confess sins is customary
- When death approaches, a male Muslim will recite verses from the Qur'an
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, cremation is not permitted
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife. They body is wrapped in a white

cloth, not placed in a casket. The deceased should not be touched by non-Muslims, where possible, after death
- The body is laid out in prescribed ways and prayers recited before it is taken to the cemetery
- Women do not usually attend burials although it is becoming more common in resettled countries when they will remain at some distance from the graveside until the men have departed
- Expression of grief varies sub-culturally. Sunnis are more restrained, and Shiites are expected to express their grief openly and intensely
- Mourning ceremonies last 3 days followed by a further 40 where other ceremonies and celebrations are not attended by mourners
- It is customary for family members to remain attached to the deceased and to honour the relationship in different ways

Christians (adherence depends on region orthodoxy)
- A priest is called to administer the bukhra (holy bread) near death
- Family members accompany the client at the last moments where possible
- Traditionally Assyrians also bury their deceased within 24 hours
- The body is placed in a casket which is buried (cremation is prohibited)
- Traditionally a ceremony takes place in the home and then at the church
- Grief is openly expressed by men and women
- An important mourning ceremony is conducted on the 3rd day following the death

Kurdish
- Protocol and rituals are similar to Muslims in general (above). However women usually attend the burial and ceremony. After the funeral the family will stay home at least 3 days to 7 days to accept visitors

4. HEALTH RISKS (as reported by Kemp and Rasbridge, 2004)
- Boutonneuse fever
- Brucellosis or undulant fever
- Cholera
- Crimean-Congo hemorrhagic fever
- Cysticercosis (tapeworm)
- Dracumculiasis (Guinea worm disease)
- Familial Mediterranean fever (Mediterranean area, primarily among persons of Sephardic Jewish, Armenian, and Arab ancestry)
- Giardia
- Helminthiasis (ascariasis,echinococcosis/hyatid disease, schistosomiasis)
- Hepatitis B (13% carriage rate)
- Hookworm
- Leishmaniasis
- Malaria
- Plague
- Sickle cell disease or sickle cell hemoglobulinopathies (occurs primarily in people of African lineage but to a lesser degree in Arabs)
- Thalassemias
- Toxocariasis
- Trachoma
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzias; intestine-dwelling; and lung-dwelling: paragonimiasis
- Trichinosis (trichinella)
- Tuberculosis

- Typhus
- Post-traumatic stress disorder
- Nutritional deficits

5. WOMEN'S HEALTH

For Iraqi women who have resettled as **refugees** a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general. The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built.

In general, refugee women (and men) need to be treated with extra sensitivity and care since they may suffer many of the conditions related to the tragedies and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some Iraqis re-locate alone without spouse or family support due to displacement and separation from families.

- **Traditional fertility practices**
  - Birth control is not common as this is considered an interference with God's will (similarly for abortion)
  - Re-settled women however, are beginning to use oral contraception, depo-provera, IUDs, and tubal ligation
  - Mid-wives play an important role in pre-natal care, childbirth and post-delivery care although resettled women are increasingly preferring female doctors
- **Pregnancy**
  - Women are usually relieved of regular household work by other household members and treated with extra care. Women who have re-located without family may need extra emotional support, particularly for first pregnancy
- **Labour and Delivery**
  - Deliveries traditionally took place at home with a midwife, particularly in rural areas. However this practice is changing both in Iraq and in countries of resettlement; women are more often choosing hospital births. Practitioners will need to explore preferences with clients
  - Childbirth is considered a female issue and men are usually not permitted to attend the birth. Women relatives and friends support the mother
  - There is a preference for breastfeeding
- **Post-natal care**
  - For Kurds there is a ritual post-partum bath after 40 days to relieve the mother of bad spirits

6. YOUTH HEALTH

- **Newborn & Child Health**
  - It is customary for Iraqi Muslims and Assyrian Christians to circumcise newborn boys within the first few days. This is followed by a feast
  - Kurds usually circumcise within the first 2 months
  - Traditionally it is preferred that females have their ears pierced at 1 week

- **Adolescent Health**
  - Most resettled adolescents will be faced with:
    - role changes at home
    - pressures from peers to integrate more quickly than they or their families may be comfortable with
    - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
    - Many young refugee children and adolescents have been subjected to violence or have been witness to the atrocities leveled at their families and communities during war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children adequately. Sometimes children do not tell their parents in order to avoid added stress on the family, out of respect, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal, learning difficulties, poor concentration and motivation as well as with various somatic complaints. These presentations may mask post-traumatic stress, depression, anxiety and other mental health conditions. Practitioners and teachers need to be alert to the possibilities of pre-relocation trauma
  - Some Islamic traditions and the difficulty in explaining these to teachers and peers in a new language, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, time schedule for prayers, requirements of *halaal* food etc.)

7. SPECIAL EVENTS

- **Ramadan**
- **Id al-Fitr** (celebration after fasting)
- **Id Arafa** (important holiday for making pilgrimages to Saudi Arabia)
- **Moulid** (celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan). This may not be practiced by Sunni Muslims

Kurds celebrate **New Year (Newroz)** on March 21, which marks the independence of Kurds. They also observe Ramadan and the other Muslim ceremonies although the strictness of adherence to the rules on fasting varies according to their orthodoxy.

Christians celebrate **Christmas, New Year, Easter**, and various Saint's days.

8. RELIGION/SPIRITUALITY

Islam

Most Iraqis are Shiite Muslims with about 40% Sunni Muslims. Shiites tend to be more orthodox and strict in food, religious and social practices. Women (especially older women and widows) usually wear full 'hijab' (purdah) where the entire body and face is covered. They are usually segregated from men both at home and in society. The political elite, military and merchant classes tend to be Sunni.

Kurds are usually Sunni Muslims and are not expected to be veiled.

Christianity

Assyrian Iraqis belong to the **Assyrian Church of the East**. In Auckland, Iraqi Christians attend three main churches: the Chaldean Church, the Syrian Orthodox Church, and the Holy Apostolic Catholic Assyrian Church of the East.

References and Resources

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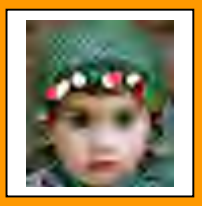
10. Yoab, B. (2006). *Assyrian Rituals of Life-Cycle Events*. Retrieved November 2006. Available at: www.aina.org/articles/yoab.htm

Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. RMS Refugee Resettlement can provide information on resettlement issues and contacts for community leaders. Contact the Auckland Co-ordinator on +64 9 621 0013.

3. A number of health fact sheets can be found in **Arabic** and **Assyrian** for download in pdf. at: http://www.healthtranslations.vic.gov.au/



IRANIAN CULTURE

Iran was known as Persia until 1935 when the Shah requested of the international community that it be called by its native name, Iran. It was subsequently referred to as both although most of its peoples will refer to themselves as Iranians rather than Persians. It is a country with a history (like most others) of invasions and occupations including by the Arabs, Turks, Mongols, British and Russians, and its traditions are ethnically and religiously diverse and rich. In 1979 Ayotollah Ruhollah Musavi Khomeini led the Islamic revolution, ousting the Shah and founding the Islamic Republic of Iran. His unpopularity with the U.S and the West provided Saddam Hussein of Iraq an opportunity to invade Iran and the bloody Iran-Iraq war ensued until 1988 when Khomeini finally accepted a truce mediated by the United Nations. Iran lost nearly a million civilians and military personnel and many people were displaced internally, fled or immigrated.

Since education was highly valued during the time of the Shah, many students studied in the West and those who migrated there, before and after the revolution, remained abroad and have been able to enjoy good prospects. However since the new regime, there has been oppression of women, violence and violations against religious minorities (especially the Baha'is) and political dissidents are imprisoned, tortured or executed. Asylum seekers and refugees arriving in countries of resettlement, including New Zealand leave often without means, are separated from family and their heritage and may have suffered severe hardship before leaving. Some Iranians migrate out of choice to escape the current dictatorship and for freedom of lifestyle.

Photos from www.persianmirror.com, www. en.wikipedia.org/wiki/History_of_Iran

1. COMMUNICATION

Greetings video clip

Hello	*Salaam*
Goodbye	*Khoda hafez*

Main languages

Farsi (Persian) is the national language of Iran. It is a non-Arabic language but is written in Arabic script and includes some extra characters not found in Arabic. Most Iranians will speak Farsi as it is the only language taught in schools, however some people may also speak Arabic, or one of the following: Turkish, Armenian, Kurdish, Luri and Baluchi. There are a number of minority ethnicities in Iran.

Gestures and interaction

- It is appropriate to **shake hands** with men and with many Iranian women however, if a women is wearing a hijab (headdress) it is best to allow her to initiate the handshake, otherwise a verbal greeting and smile will be best
- **'Mr'.** and '**Mrs'**. and surname is appropriate
- **Eye contact** may be shorter than usual for New Zealanders out of respect
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance
- Health practitioners are usually highly regarded and older or more traditional clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

2. FAMILY VALUES

Many Iranian immigrants in New Zealand are more westernized and secularized than some of the other migrant groups (who are presented in this resource) and so adherence to traditional roles may vary considerably from one individual and family to another

- Religion plays an important part in family life (95% of Iranians are Muslim)
- Family ties are more important than political or social alignments
- Filial duty is highly regarded
- Traditionally fathers and sons manage outside relations for the family while women usually manage the household
- There is great respect for elders and those in authority
- Marriage in Iran is more often by mutual choice. It is not unusual for marriage to be within the kin group (first or second cousins)
- Individuals are oriented towards the good of the whole family and mutual dependence is required over independence
- Divorce is permitted in Iran although this is more difficult for the woman than the man to initiate and achieve

3. HEALTH CARE BELIEFS AND PRACTICES

3.1 Factors seen to influence health:

1. Western biomedical concept of disease causation

This is commonly accepted and may co-exist along with any of the other attributions of illness

2. Balance

- Similarly to many other cultures included in this resource, it is believed that health is based on keeping the body elements in 'balance' and that certain kinds of lifestyle, treatments and external factors can influence this, with diet having significant bearing on one's state. Of particular importance is the notion of 'hot' and 'cold' which does not imply temperature, but is elemental in nature. Excess of either state can cause related illnesses, which can be treated through the use of the opposite foods to achieve balance. Individuals are hot, cold or neutral in nature.

3. Spiritual/religious

- Punishment from God for sins committed
- God's will (*tagdir*)

4. Supernatural (these beliefs are less subscribed to by the younger generations, particularly in resettled countries)

- **Evil spirits** known as '***Jinn***' in Islam can cause some illnesses, (often associated with mental health problems), and '*Zar'* spirit possession is seen as a cause for poor mental health (See Jackon, K. (2006) Ch. 2 for more information about supernatural beliefs in Islam)
- The '***evil eye***' (*ayin harsha* in Arabic*)* present in some individuals, can put a curse on others by looking at them. This mostly affects children and is associated with physical illness, in particular epilepsy (See Jackon, K. (2006 Ch. 2).

5. Cultural beliefs

- '*Wind'* as a possible cause for rheumatism is culturally accepted
- '*Lack of blood in the head*' is often seen as cause for headaches

3.2 Traditional and current treatment practices

1. **Western medicine**
   This practice is very well established and practiced, often in conjunction with traditional medicine.
2. **Traditional medicine**
   The use of herbal and natural cures is a tradition extending over centuries in Iran, and is part of an holistic approach incorporating physical and psychological factors. Traditional specialists (*'hakim')* administer herbal potions, do bone-setting, **cupping** (*badkesh),* leech therapy as well as massage therapy with plant oils. Both physical and psychological symptoms may be treated. (See Kemp and Rasbridge, 2004, Ch. 20 for a list of common herbal treatments, and Jackson, 2006, Ch. 7 for detailed information on psychological descriptors and presentations).
3. **Magico-religious articles** and **religious rituals** may be used. Articles such as amulets and the blue-glazed faience eye is common in the Eastern Mediterranean. '*Esfand*', is a seed burned to ward off the evil eye and possibly bad spirits. A *do-aa-nevis* (prayer-writer) will scribe verses of the Koran or prayers which clients attach to themselves as protections against spirits.

3.3 Important factors for Health Practitioners to know when treating Iranian clients:

1. There is great variance in adherence to traditional practices amongst resettled Iranians. Younger resettled Iranians are generally familiar with western medicine and health systems and use traditional practices less frequently than the older generations. However, it is crucial to assess the degree of acculturation on an individual basis.

2. In spite of considerable reform regarding women's position in Iran, resettled men face intrafamilial stress with role changes and perceived loss of status in New Zealand.

3. Tentative diagnoses, reliance on diagnostic tests and no provision of medicines can be interpreted as signs of incompetence as compared with the more aggressive practice in Iran. Explanations about treatment decisions, especially when no medications are advised, may deter clients from 'doctor shopping'.

4. If medicine is prescribed practitioners need to enquire about the use of herbal medicines to assess for potential drug interactions.

5. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

6. Modesty is culturally prescribed, particularly during pregnancy.

7. It is traditional in many Iranian families that terminal illness diagnoses and prognoses are discussed with the male head of the family and **concealed** from the client. The process of Informed Consent may be new to many families and this process will need to be explained. It is best to ask the client who they would like to be included in medical decisions. If the client does not want to make any decisions for themselves, they will need to have a Durable Power of Attorney signed.

8. When doing HOME VISITS:
    - Give a clear introduction of roles and purpose of visit
    - Check whether it is appropriate to remove shoes before entering the home
    - If food or drink is offered, it is acceptable to either decline politely, or to accept (be aware that no food or drink will be consumed by the family in between sunrise to sunset during the Ramadan period)
    - Modest dress is appropriate, particularly during Ramadan
    - It is respectful to address the male family member first when visiting traditional families

3.4 Stigmas
Severe mental disturbance (distress or 'craziness/madness') is stigmatized. Suicide in a family would be highly stigmatized as this is forbidden by the Qu'ran for all Muslims.

3.5 Diet and Nutrition
The staples of Iranian diet are rice with meat, chicken or fish, fruits, vegetables and herbs. Hospitalized clients may not request different food and therefore may not eat much that is provided while in hospital. Families are usually happy to supplement foods for members (in fact feeding is seen as the responsibility of the family). '*Halal*' meats needs to be provided for hospitalized Muslim clients.

For more traditional clients, factors and foods affecting the *humoral balance* (see 3.1 (2) above) need to be considered. Clients will advise about this, but it would be appreciated if these needs are recognized and incorporated into treatment where possible.

3.6 Death and dying
Muslims
- When death approaches, a Muslim will recite "There is no god but Allah, and Muhammad is His Messenger"
- Do Not Resuscitate (DNR) orders are usually elected
- In Iran, after death the body is taken to the morgue within a few hours. Prayers are continuously recited at home and relative and friends will visit the family for up to 10 days after the burial
- Burial in a cemetery is required, not cremation
- After death the male body is washed by a male relative or professional, a *morde shour*' (dead body washer), and a female by a female relative or '*morde shour*'
- The body is laid out in specific ways, clothed in a shroud (white cloth) and taken to be buried immediately thereafter
- Public expression of grief is required by Shiite Muslims (especially from the women). This may be seen as dramatic compared with western standards

4. HEALTH RISKS
These are listed by Kemp and Rasbridge (2004) as health risks for new Iranian immigrants or refugees to the USA and some of these may apply to those immigrating to New Zealand. However, local community members state that many of these diseases no longer occur in Iran and may be listed because of Iran's inclusion under Middle Eastern groupings:

- Amebiasis
- Anthrax
- Boutonneuse fever
- Brucellosis or undulant fever
- Cholera
- Crimean-Congo hemorrhagic fever
- Cysticercosis (tapeworm)
- Dracumculiasis (Guinea worm disease)
- Familial Mediterranean feer (Mediterranean area, primarily among persons of Sephardic Jewish, Armenian, and Arab ancestry)
- Giardia
- Helminthiasis (ascariasis,echinococcosis/hyatid disease, schistosomiasis)
- Hepatitis
- Hookworm
- Leishmaniasis
- Malaria
- Plague

- Sickle cell disease or sickle cell hemoglobulinopathies (occurs primarily in people of African lineage but also to a lesser degree among people from the Mediterranean area and amongst Arabs)
- Thalassemias
- Toxocariasis
- Trachoma
- Trematodes (liver-dwelling: clonorchiasis and opisthorchiasis; blood-dwelling: schistosomiasis or bilharzias; intestine-dwelling; and lung-dwelling: paragonimiasis
- Tuberculosis
- Typhus

5. WOMEN'S HEALTH

- **Traditional fertility practices**
  - Contraception is generally accepted and practised in Iran
- **Pregnancy**
  - Traditionally, pregnancy provides women with status and self-esteem and giving birth to males accords higher levels of social acceptance
- **Labour and Delivery**
  - In Iran most women have their own obstetricians, give birth in hospitals and it is reported that elective Caesarian sections are common
  - Fathers are not usually involved, or likely to attend at the birth. This may be different with younger and more assimilated immigrants
- **Postnatal care**
  - Traditional Iranians may observe diet regimes that maintain humoral balance during the first 40 days
  - Breast feeding is practiced for up to a year with solids introduced at 4 – 6 months

6. YOUTH HEALTH

- **Newborn & Child Health**
  - Males are circumcised within the first few days (except for Christians)

7. Special Events

Ramadan (fasting month)
Eid al-Fitr (celebration after fasting)
Eid Al-Adha (important holiday for making pilgrimages to Mecca)
Moulid (celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan)

8. SPIRITUALITY

About 90% of Iranians are Shiite **Muslims**. There are some Sunni Muslims. Adherence to religious practice varies considerably with the younger, more educated and professional Iranians tending to be less strict.
There are small numbers of **Christians**.

Other faiths include **Zoroastrians** and **Baha'is**. Baha'is tend to be the most oppressed by the Shiite majority. They are regarded as infidels because unlike the Muslims who believe that Mohammed is the final prophet and cannot be succeeded, the Baha'is believe that all major religions hold a place in the spiritual evolution of humans and therefore do not see Mohammed as necessarily the final prophet. The practice of the Bahai faith is prohibited under the current regime although torture and executions are less frequent since international pressure has been raised in recent years.

References and Resources

1. Jackson, K. (2006). *Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities*. New Zealand: Rampart

2. Kemp, C., Rasbridge, L. (2004). *Refugee and Immigrant Health. A handbook for Health Professionals*. Cambridge: University Press.

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6. Zoreh Karimi, Iranian community member and Interpreter, and Neda Tolouee, Community Facilitator at RASNZ. (February 2007). *Personal consultation on Iranian culture and practices, in general and in New Zealand.* Auckland.

Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on related clinical cultural issues, and contacts for community leaders/facilitators. They can be contacted at + 64 9 270 0870.

2. A number of health fact sheets can be found in Farsi for download in pdf. at: http://www.healthtranslations.vic.gov.au/

SECTION IV - Additional Resources

(For working with **Asian** clients in general)

For **Asian Language assistance**

In Auckland:

1. 24 hour 7 day week medical translation services are accessible by health providers working in secondary care via:
    - WDHB: Waitemata Auckland Translation & Interpreting Service (managed by Asian Health Support Service).
      Phone: (09) 442 3211
      Fax: 486 8307
      See www.asianhealthservices.co.nz
    - ADHB Auckland Public Health Interpreting Service - go to internal intranet website for listing of interpreters
    - CMDHB Interpreting Service
      Phone: (09) 276 0014
      Fax: 276 0198

2. WDHB's Asian Health Support Service also provides:
    - Interpreter services to assist with their consultation process with non-English speaking patients at:
        - GPs belonging to Healthwest PHO (West Auckland)
        - Harbour PHO (North Shore)
        - Tamaki Healthcare PHO (Central Auckland)
    - Asian cultural advice to health providers/practitioners
    - Training for health practitioners: on Cultural Perspectives in Asian Patient Care and how to work effectively with interpreters
    - Translation of pamphlets and resources in Chinese and Korean
    - Asian inpatient and outpatient support services through their volunteers programme
    - iCare health information line (call centre) for non-English speaking Chinese and Korean patients/ community members (9am to 4.30pm Monday to Friday)
    - Service information and translated resources on website: www.asianhealthservices.co.nz

3. Auckland Regional Public Health provides resources on website: www.asianhealth.govt.nz

4. In Australia, the NSW Multicultural Health Communication Service acts as a clearing-house for all health-related multilingual resources. Resources may be accessed online (http://www.mhcs.health.nsw.gov.au/). Resources are classified under 33 different categories and available in 43 different languages. The website is updated every month and resources are downloadable in pdf format.

Asian Classification Categories

Asian Classification Categories	
Asian NFD	Fijian Indian
South East Asian NFD	Gujarati
Filipino	Tamil
Cambodian	Punjabi
Vietnamese	Sikh
Burmese	Anglo Indian
Indonesian	Indian NEC
Laotian	Sri Lankan NFD
Malay	Sinhalese
Thai	Sri Lankan Tamil
Southeast Asian NEC	Sri Lankan NEC
Chinese NFD	Japanese
Hong Kong Chinese	Korean
Cambodian Chinese	Afghani
Malaysian Chinese	Bangladesh
Singaporean Chinese	Nepalese
Vietnamese Chinese	Pakistani
Taiwanese	Tibetan
Chinese NEC	Eurasian
Indian NFD	NFD = Not further defined
Bengali	NEC = Not elsewhere defined
Commonly spoken Asian languages/dialects in New Zealand	
Country	**Language/Dialects**
Chinese from	
Mainland China	Mandarin (O)
Taiwan	Mandarin (O) Taiwanese (D)
Shanghai	Mandarin Shanghainese (D)
Hong Kong	Mandarin (O) Cantonese (D)
Other major Chinese languages/dialects spoken in North Asian and South East Asian countries include	Mandarin (L) Cantonese (D) Foochow (D) Hakka (D) Hokkien (D) Teochew (D)
Indians from	
India (national Language) (second most spoken language in India after Hindi)	Hindi (O) Telugu (L)
Bangladesh	Bangla (Bengali) – (L)
Fiji	Fijian Hindi (L)
Pakistani	Urdu (L)

	Gujarati (L)
Punjab	Punjabi (L)
Sri Lankan	Tamil (L)
Other Asian countries	
Afghanistan	Pushtu (Pashto) (O)
Burma	Burmese (O) Karen (D)
Cambodia	Cambodian (Khmer)
Indonesia	Indonesian (O)
Japan	Japanese (O)
Korea	Korean (O)
Laos	Lao /Laotian (O)
Malaysian	Bahasa Malaysia (O)
Philippine	Tagalog (O) Pampango (D)
Malaysian	Bahasa Malaysia (O)
Thailand	Thai (O)
Vietnam	Vietnamese (kinh) (O)

O= official language

L = Major language commonly spoken in NZ

D = Major dialect commonly spoken in NZ

Festival and New Year celebration dates for cultures in this resource

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
China	New Year In Jan or Feb(different dates each year) 15 days, ends with Lantern Festival											
Korea	'Seollal' New Year, in Jan or Feb (different dates each year), 2 days											
India									Ramadan (9th month Islam lunar calendar) different each year - starts anywhere from Sept to Nov, 1 month	Diwali 'Festival of Lights', 5 days (different dates each year)		
Vietnam	'Tet' (new year) in Jan or Feb (different dates each year), 3 days											
Cambodia				'Water Fest.' +- 13-16								
Laos				'Water Fest.' +- 13-16								
Burma				'Water Fest.' +- 13-16								

ORDER FORM FOR CROSS-CULTURAL RESOURCES

Asian Health Support Services (WDHB) has two resources available for health practitioners working with culturally and linguistically clients and interpreters:

CCR1 iCare™ Cross-Cultural Resource Kit which includes the Booklet and a CD-Rom covering information 17 Asian, Eastern Mediterranean and African cultures © WDHB and RAS NZ

CCR2 Cross-Cultural Resource for Interpreters and Health Practitioners working together in mental health Part I © NDSA

For more information how to order or get a copy of the above resources, please contact:

Administration Office
Asian Health Support Services (WDHB)
Private Bag 93503, Takapuna, Auckland, New Zealand

P: 09 4868314
F: 09 486 8307
E: Elena.wong@waitematadhb.govt.nz
E: Sue.lim@waitematadhb.govt.nz

You may also email suggestions for areas you would like added to this resource to the above addresses: