

Oral Health: Bridging Somali Traditions and Western Practice

Recommendations for Technical Communicators

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Abstract

Language and cultural barriers often prevent immigrants from assimilating successfully in their new home. This is especially true of Somali immigrants in terms of their oral health needs. Oral health care is traditionally important to Somalis, yet they report poor oral health now that they are in Minnesota. To date, there has been a lack of effective communication between Somali immigrants and Western oral health practitioners. This paper attempts to show how technical communication strategies can effectively bridge this gap. To highlight the problem, this paper synthesizes published research on immigrant barriers to health care, traditional Somali oral health care beliefs, interviews with Somali immigrants, and interviews with dentists who work with immigrant populations. Also, Western attempts to craft immigrant-appropriate healthcare materials are examined. The author then applies technical communication best practices to offer recommendations on how to improve communications between Western oral health practitioners and their Somali immigrant patients. A communication program for each group is provided, along with avenues for future research.

Table of Contents

Introduction	3
Health Literacy	6
Language Barriers	7
Cultural Barriers	8
Cultural Literacy	9
The Aday	10
The Killer Teeth	13
Somali View of Dentists	16
Dentist Surveys	18
Reaching Dentists through Technical Communication	22
Somali Immigrant Surveys	24
Reaching Somalis through Technical Communication	26
Future Areas of Research	31
Conclusion	32
References	34

Introduction

As the number of Somali immigrants grows in the United States due to ongoing civil unrest in their home country, it is important to understand the heritage, both cultural and religious, that they bring with them. This is especially true in Minnesota, which has the largest concentration of Somalis in the country (Immigration Policy Center, 2009). Nearly 25,000 Somali have made Minnesota their home (Dunbar, 2010). Somalis have a strong Muslim faith, and its precepts inform much of their behavior regarding their health, including dental care. Western dental caregivers have to date not been very mindful of these traditions as they work with their Somali patients in an attempt to instill Western practices into their oral health regimens.

Somali people find dental care important for overall health. A survey done of recent immigrants showed that 64 percent of male respondents said dental care for their children was important or very important, and 55 percent of female respondents responded the same way (Obeng, 2007). Good oral hygiene is important to them because in many African cultures, men will not marry women with bad teeth: "Given the importance attached to marriage in traditional African societies and the stigma attached to being a spinster or bachelor, anything that potentially stands in the way of marriage is viewed with fear and contempt and is tabooed" (Obeng, 2007).

At the same time, the number of Somali immigrants who self-report their oral health as poor or fair is much greater than the general public at large (Okunseri, Hodges, & Born, 2008). This troubling statistic indicates that proper oral health instruction is not reaching the Somali

immigrant population, or it is not being understood correctly. Bridging this divide – helping Western oral health practitioners understand the culture of their Somali patients while promoting helpful Western techniques to Somali immigrants – is an issue where technical communication can assist.

By its very nature technical communication is ideal to address the needs of those seeking and those providing healthcare. Technical communication is defined as providing complex information in an easy-to-understand format to those needing to complete a task or goal. Communicators in this field are those who “research and create information about technical processes or products directed to a targeted audience through various forms of media” (Tech Whirl, n.d.).

As a complex field, the healthcare profession needs technical communication to achieve its aims. “Medical instructions help patients and care-providers manage a patient’s treatment, improving the health of the patient while reducing costs and risks associated with incorrect care” (Society for Technical Communication, n.d.).

For an example, consider a new drug or medical device that is ready to hit the market. Information about how to use the product properly is also needed before the product can be launched. In many cases, the designers of the product know all the scientific jargon involved with the product’s use, but are unable to translate that information into simplified language. Here is where technical communicators are needed. They take the complex scientific jargon and rework it so it is easily understandable by the people who will end up using the product. While

doing this “translation” work, the technical communicator also makes sure that the information stays accurate.

Translating the information also takes on a literal meaning in today’s global marketplace as the product is likely to be used all over the world. Technical communicators do not necessarily need to know dozens of languages, but they need to be aware that multiple translations of their work may be needed. Translating information for different countries is not only about the words. Cultural differences between countries need to be considered as well. For example, color choice of documentation or symbols used may have different meanings depending on the culture.

So in terms of Somali immigrant patients and Western oral health practitioners, how might technical communicators develop information that meets the needs and brings together these two disparate groups?

In this paper, I first examine the barriers that prevent immigrants from receiving proper oral health care. These barriers include poor health literacy and language and cultural differences. I will then introduce the concept of “cultural literacy,” as the term is important for technical communicators to understand because of three unique aspects of Somali oral health culture. These aspects include the *aday*, a tooth-cleaning stick; the ritual extraction of teeth in Somali youth; and the Somali view of dental practitioners themselves. I will describe these aspects in detail based on research done to date to show how they must be addressed and built into any technical communication documentation in order for it to be effective. Next, I provide interview results from a study done with dentists who work with immigrant patients and from

Somali immigrants reporting on the state of their oral health. These interviews show that dentists are not properly trained to meet the needs of immigrant patients, and Somali immigrants are not being served well at all in terms of their dental needs. I will provide recommendations on how to incorporate technical communication techniques to address these difficulties.

Health Literacy

Health literacy is defined as the ability to obtain, understand, and use information needed to make wise health choices (Kimbrough, 2007). In its earliest incarnation, health literacy was taken to mean only a person's ability to read and understand medical information and instructions. However, the definition has since broadened to encompass other social and individual factors. Besides having adequate skills in reading and writing, health literacy also entails proficiency in oral presentation, aural comprehension, and basic mathematical computations as well as to facilitate access to information, influence events, and exert a greater control over one's life (Shohet & Renaud, 2006).

In the United States today, health literacy is deficient. Nearly 30 million citizens have only the basic skills needed to understand health information and 47 million are worse off than that. "These findings mean that almost 80 million adults are unable, for example, to consult reference materials to determine which foods contain a particular vitamin or interpret a table about blood pressure, age, and physical activity" (Jones, Lee, & Rozier, 2007).

Those individuals with a low level of health literacy are nearly three times as likely to have a poorer health status and use of health resources as well as a greater mortality rate

(Jones, et al., 2007). And it is an expensive problem. The National Institutes for Health estimate that low health literacy rates cost between \$106 billion and \$238 billion per year. These figures represent seven to 17 percent of all personal health expenditures (Horowitz & Kleinman, 2008). “The problem of limited health literacy is perhaps best described as a functional mismatch between the skills of the individual and the demands placed on that individual by the health care system and its providers” (Horowitz & Kleinman, 2008, p. 336).

Oral health literacy is a subset of general health literacy. Similar to health literacy, the definition of oral health literacy is the ability to understand, interpret, and act on various types of health information to make good decisions about oral health. The need for quality oral health literacy increases year after year. “The growth in information technology and the rapid advances in dental scientific knowledge require that the public have an ever-increasing understanding of oral diseases to make good decisions about their oral health” (Jones, et al., 2007, p. 1199).

For immigrant populations, poor health literacy is even more acute. Two main reasons for this state of affairs are language and cultural barriers.

Language Barriers

Language differences are one of the major barriers in providing adequate health care to immigrant populations in the United States. Horror stories abound. In one instance, a Spanish woman was telling her neighbor that her daughter had fallen off her tricycle and hurt herself. The neighbor misunderstood the woman’s broken English and took it to mean that the

daughter was suffering from abuse. Social Services was called and the woman ended up signing away custody of her children without understanding what was going on (Flores, 2006).

These instances also have repercussions for the medical community. In another case, an 18-year-old Spanish man went to his girlfriend's home, said he was "intoxicado," and fell unconscious. The girlfriend relayed the word to the paramedics that arrived and they took it to mean "intoxicated," rather than the correct meaning of "nauseated." The man was treated for a drug overdose for 36 hours in the hospital before it was realized that the correct diagnosis was bleeding of the brain. The hospital later paid out \$71 million in a malpractice lawsuit (Flores, 2006).

It is clear that poor communication can lead to adverse health outcomes and severe litigation, as well as impaired doctor-patient trust. "Research in the medical field on doctor-patient communication suggests that effective communication can improve measures of health care, such as patient satisfaction, adherence to treatment, and disease outcomes" (Goldsmith, Slack-Smith, & Davies, 2005, p. 235).

Cultural Barriers

People's cultural beliefs affect everything they do, so it is no surprise that their views on health and health care needs also fall under their cultural lens. However, many doctors do not take this aspect into consideration and work under a one size fits all approach. This is a mistake. "It is critically important to identify and examine the relevant cultural issues that are likely to influence the ways consumers, particularly members of vulnerable populations, respond to communication about health and health care" (Kreps & Sparks, 2008, p. 329.).

Communication breakdowns can occur when the cause and effect of a disorder or a treatment regimen is at odds with patients' belief systems and the doctor is not aware of or is dismissive of them. "Stereotypes can also inhibit openness among patients and providers when they view their patients' differing cultural beliefs or values about illness and treatments as inferior to their own" (Kreps & Sparks, 2008, p. 329).

Research has shown that people tend to seek out health care providers who have similar cultural backgrounds as they do, because they assume they share the same set of values. This activity can be a troublesome proposition if these types of providers are not easy to find or even nonexistent. Oftentimes, then, the patient will forgo their health care needs or enlist a family member to provide care (Kreps & Sparks, 2008).

Cultural Literacy

According to Okunseri, Hodges, and Born (2008), "To prevent patient-doctor conflicts, providers should recognize that Somali immigrants have unique cultural needs, speak different languages, and religious beliefs which should be considered during treatment planning and informed consent processes" (p. 117). These unique cultural needs should be taken into consideration when creating technical communication material for dentists and their Somali patients. Besides looking to improve the health literacy of their patients, oral health practitioners need to inculcate "cultural literacy" into themselves and their practices. Technical communicators can help them do so, but they also need to be culturally literate as well.

Three cultural aspects of traditional Somali dental care require particular attention and seem to have been neglected or dismissed in healthcare studies of this population. They include

the aday or adayge, a Somali tooth cleaning stick; ilko-dacowo, a process of removing the lower cuspids in youth; and the Somali view of dental practitioners themselves.

The Aday

The main tool for cleaning teeth in Somalia is called the aday or adayge among other names (Figure 1).

It is a stick from a tree that commonly grows in the area.

The aday has a long tradition of being used in the Middle East as a teeth-cleaning device

and studies have found that it

works well in eliminating plaque and staving off other forms of periodontal disease (Hunter-Adams, Young, Laird, et al., 2013).



Figure 1

Source: <http://dentagama.com/news/miswak-toothbrush>

Besides being an effective dental tool, the aday has an important meaning in the Somali culture. It is a cultural object that has strong ties to traditionalism. Many Somalis have memories of going out in the mornings and pulling a fresh stick off of a favorite tree to serve as that day's aday. The act itself connected the Somalis with their natural environment.

The use of the stick also has a strong religious connotation. In the West, it is traditionally advised that people brush their teeth in the morning and night and after meals if possible. In

Somalia, the use of the aday is incorporated into the Muslim ritual of prayer five times a day. It has been said that the Prophet Muhammad asked for such a stick to clean his teeth when he was on his deathbed. Additionally, the public tends to keep the aday with them at all times – men carry it in their pockets and women keep it in their headscarves. It is not uncommon to see people chew on the stick throughout the day like a Western toothpick (Hunter-Adams, et al., 2013).

In addition to the aday, Somali people use charcoal – made from charred wood – as their equivalent of Western toothpaste. The charcoal serves as a natural whitener of teeth. However, its use is not as common as the aday; it is only used by those who need extra whitening help for their teeth, such as heavy coffee drinkers or smokers (Hunter-Adams, et al., 2013).

As Somali immigrants migrated to the West, they were introduced to toothbrushes and toothpaste. For many of them, this was the first time they had ever seen these products. At the Nairobi Transit Center, which is an African waypoint between their native country and their new home, Somalis and other immigrants were provided with a two-day session to orient them to Western culture. In what can be considered a stunning lack of cultural literacy, their centuries-old tradition of the aday was completely ignored: “Some...received toothbrushes and Colgate on the plane and were advised to use them ‘because this is what Americans do’” (Laird, Barnes, Hunter-Adams, et al., 2015, p. 341).

Once in the West, most Somali immigrants switched to using a toothbrush, but only because they were not able to acquire an aday. Packaged sticks are available in certain

locations in the United States, such as at some mosques, but they tend to be dry and do not possess the same qualities as a fresh and limber aday taken right off the tree.

However, some immigrants resisted and continue to use an aday, dry or not. Their reasoning is that it is an ingrained habit in their lives in addition to its use being a way of keeping their culture alive and relevant. Some have taken to using both an aday and a toothbrush. The toothbrush is used in the mornings and evenings, and the aday is carried and used throughout the day. More important, the aday is brought out during special religious observances, including throughout the holy month of Ramadan (Hunter-Adams, et al., 2013).

Those who continued to use the aday extolled its health benefits as well. Some said that the aday is better equipped for cleaning teeth or Western toothbrushes hurt their gums. According to an interview with some Somali immigrants after their initial experiences with a toothbrush and toothpaste, “one man described bleeding gums, an itchy face, and difficulty not swallowing the paste” (Hunter-Adams, et al., 2013, p. 1482).

Ignoring the importance of the aday to Somalis’ cultural and religious beliefs is a mistake. The approach of handing out toothbrushes and toothpaste and implying that they were the proper way to clean teeth was “based on an assumption of a lack of knowledge that must be remedied, as well as an assumption that possession of that knowledge will result in the desired behavior” (Zarcadoolas, Pleasant, & Greer, 2006, p. 244).

Technical communicators would be wise to consider the aday when creating oral health material for those of Somali origin. By incorporating the brushing stick into their brochures or other material, they would be showing appreciation of the Somalis’ religious and cultural beliefs

as well as building a relationship of trust. “The very act of not trying to dissuade people from the use of the stick brush could create a gateway through which to introduce Somali refugees to concepts and procedures of professional preventative dental care that may be unfamiliar to them” (Hunter-Adams, et al., 2013, p. 1484). Indeed, Somalis tend not to give much thought to preventative care, partly due to the effective properties of the aday.

The Killer Teeth

Effective cultural literacy also could play a part in stemming an unfortunate aspect of Somali dental care, the ritual extraction of otherwise healthy teeth. Also known as “Ilko dacowo,” this procedure is common in some regions of Somalia, as well as other parts of Africa, such as Kenya, Uganda, and Tanzania.

By removing the bottom cuspids, also known as the primary canines, in youth, it is hoped that this procedure will ward off several illnesses. These cuspids are called “killer teeth” and are assumed to cause such maladies as dehydration, fever, weight loss, and diarrhea. It is thought that this connection was made because at times when these teeth were breaking through the gums in babies and caused enough pain to warrant a visit to a local hospital, it also happened to be a peak time for malaria and gastroenteritis (da Fonseca & Hoge, 2007).

Needless to say, the connections between the teeth and other ailments does not exist, so medical doctors do not do the procedure. When it is done, the child is taken to a traditional healer, sometimes called a “tooth drawer” or “tooth extractor,” depending on the country. Using crude tools and no anesthesia, the healer removes the offending teeth. Most of the time,

the two teeth in the lower jaw are the ones removed, but sometimes the two upper canines are extracted as well.

Despite purporting to prevent the onset of many illnesses, the extraction procedure can create many health problems on its own. In examining people who have had their primary canines removed, oral health practitioners have found that neighboring teeth often suffered from defects to their enamel and vitality loss (Rodd & Davidson, 2008). Sometimes an adjacent tooth was missing altogether due to weakening of the jawbone or even from the healer inadvertently pulling the wrong tooth.

There have been even worse side effects. Removing the primary canine before it is naturally supposed to come out can lead to a malformed permanent tooth. Cases of odontomas, which is a type of dental tumor, have been reported in children who have had the procedure (Graham, Domoto, Lynch, et al., 2000). Also, there have been many deaths due to blood loss, sepsis, or tetanus (Rodd & Davidson, 2008). Additionally, if the healer is working on several individuals in a row without properly cleaning his or her tools, there is a chance of spreading bacteria and viruses, especially HIV, which is a growing concern in Africa. One other side effect is that children who do end up later suffering from gastroenteritis or another ailment that this procedure is supposed to prevent often will not seek treatment, since their ailment should not exist.

Even though this is a native ritual practice, studies have found that Somali immigrants have brought this practice with them. Oftentimes parents are reluctant to discuss the procedure with an oral health specialist because of a lack of trust (da Fonseca & Hoge, 2007).

The continued prevalence of this practice in the West is testimony that dentists have not been successful in addressing the needs of their Somali patients. Today's technical communicator needs to be aware that the practice exists and assist the dental community with developing culturally sensitive information about its hazards (Rodd & Davidson, 2008).

Although some governments in Africa have tried to discourage or outlaw the practice, it has been difficult to eradicate, especially as it is a source of income for many healers. One avenue that has been tried is to shift the procedure from the intrusive process of extraction to something less intrusive, such as rubbing herbs on the tooth. Somalis are already familiar with the use of herbs, as they have been traditionally rubbed on the site of the extracted tooth after the extraction procedure had been done. Some healers in Uganda have gone so far as to mix Western medicine into their herbal rub. They have even started to include medication to prevent diarrhea, which is what the tooth extraction was supposed to prevent in the first place (da Fonseca & Hoge, 2007).

Western oral health practitioners could go a long way in helping their patients if they adopted a similar system. If they tried to deny the efficacy of the procedure, they will most likely fail. "It is important not to be judgmental and inadvertently produce barriers that may limit the future uptake of dental services" (Rodd & Davidson, 2008, p. 295). Here, technical communicators need to educate dentists about this practice, explaining its significance, and how it would be most helpful for the dentist to embrace Somali culture by offering an herbal rub to infant patients. Groups that work with Somali immigrants, such as Lutheran Social Service of Minnesota and the Somali Health Coalition would be good allies in crafting materials

for dentists to learn more about this practice and how to incorporate its cultural value into their practices, such as by offering an herbal rub in lieu of tooth extraction. Even if the rub was no more effective than a placebo, its use shows that the dentist respects the Somalis' beliefs.

Somali Views of Dentists

Many Somalis feel that dental care is a personal matter left up to the individual. Poor dental health is generally thought to be a sign of laziness. In many African cultures, families are responsible for oral care rather than dentists or other health professionals (Obeng, 2007). So, when a person has to visit an oral health specialist, it is usually when a decayed tooth has become so painful to be unbearable. Tooth extraction is the usual result of these visits, so many Somalis associate dentists with pain and the removal of a tooth (Hunter-Adams, et al., 2013).

Many Somalis have never even been to the dentist or even needed one. That changed dramatically when Somali immigrants found themselves in the West. Because refined sugar is not typically found in the traditional Somali diet, cavities are rare in the home country. Somali cuisine tends to be high in calcium, which is generally considered to be integral in promoting robust teeth and gums. Actually, many Somalis reported their first-ever cavities after they had immigrated to the United States or another Western country and were introduced to the local diet of more sugar-processed foods (Obeng, 2007). This state of affairs can lead Western practitioners to the conclusion that Somalis have generally poor oral health when the situation is the exact opposite.

Since cavities are not common in their native countries, Somali immigrants are not that familiar with the concept of preventative care. For instance, many Somali mothers do not worry

about taking care of the teeth of their babies. Their reasoning is that these teeth were temporary and would eventually be replaced with strong, adult teeth (Obeng, 2007).

In the West, several ideas have been suggested to promote preventative dental care in the Somali community through its children at school. One suggestion was that “teachers should talk about the need to brush one’s teeth in the morning and before going to bed and also explain the need to floss one’s teeth. By so doing, the teachers will be able to inculcate proper ways of maintaining oral hygiene into the immigrant children” (Obeng, “Recommendations,” 2008, para. 3). Another suggestion was to bring dental care providers into the classroom to talk to the immigrant students about oral hygiene and the risks associated with ignoring the proper care of teeth. It was also suggested that parents could be invited to these sessions as well to “broaden their views on oral health” (Obeng, “Recommendations,” 2008, para. 4).

While the first suggestion has some merit, the second one is slightly misguided. This approach is yet another example of an approach where the views and needs of the constituents are not considered. Without buy-in from Somali community members, attempts to modify their oral health patterns will ultimately fail. What is needed is two-way communication where individuals can express their concerns and introduce the modes of oral health care in which they are familiar. Technical communicators have a seat right in the middle of this communication stream in order to establish an effective dialogue. “Oral health risk behaviors may not be modifiable by oral health educational interventions, if such interventions are not framed in a culturally informed and sensitive manner” (Garcia, Cadoret, & Henshaw, 2008, p. 322).

Dentist Surveys

Dentists have been surveyed several times to gauge how successful they are in providing oral health care to patients who are immigrants. In one such study, 120 dentists were surveyed regarding what languages they spoke, what languages they come in contact with, and which communication methods seem to work the best in their practices (Goldsmith, et al., 2005).

The results showed that 65 percent of the dentists were proficient in English only, and 35 percent knew at least one other language besides English. The percentage of patients who had trouble with the English language ranged from less than 10 percent to as high as 40. Interactions with these patients occurred weekly or monthly in most instances.

In terms of effective communication, the method found to be most beneficial to these dentists was the use of an informal interpreter. Sixty-four percent of the dentists surveyed ranked this method high or very high in terms of effectiveness. The next most effective technique was having a formal interpreter involved. This method was given a high or very high rating by 34 percent of the dentists.

Communication methods found to be least effective were the use of hand gestures or dictionaries. Nearly 30 percent of the respondents found these choices to be unsatisfactory or highly unsatisfactory.

Alternative forms of communication were also uncovered by the survey and used by the majority of the respondents. Seventy-nine percent of the dentists reported using diagrams,

models, intra-oral cameras, diagnostic imaging, and mirrors in order to better communicate with their English deficient patients.

The survey also asked the dentists to describe the most difficult topics to communicate to their patients regardless of the communication method used. The most difficult topic to convey, as mentioned by 28 percent of the respondents, was endodontics, the study and treatment of dental pulp. Endodontics is mostly involved in fixing cracked teeth and root canal surgery. Periodontics, which is concerned with gum disease and dental implants, was found hard to explain by 19 percent of the dentists surveyed. There also was difficulty in 18 percent of the dentists in explaining treatment planning, and 15 percent reported trouble learning about their patient's medical and dental history.

An even more troubling statistic was that 29 percent reported that the informed consent of the patient was compromised due to communication barriers and another seven percent indicated that it was potentially compromised. Respondents explained that they implied consent because the patients were not asking many questions about their procedure. Said one dentist, "I feel the patient would ask more questions if they could without going through an interpreter. Because of the language barrier, I believe the patient accepts the treatment without questioning" (Goldsmith, et al., 2005, p. 238).

In 15 percent of the responses, the dentists indicated that they referred their patient to another dentist because of their poor English skills. Finally, a majority – 78 percent – of the dentists said that the level of training they received in dental school for treating patients with limited English was poor or very poor.

Describing the use of informal interpreters, which are usually friends or family members of the patient who have better English skills, the dentists said their major advantages were convenience, as they were readily available, speed, and lack of expense. Dentists also felt using these interpreters was a good way to earn trust with the patient.

However, there were many disadvantages to these types of interpreters as well. Their ability was the number one concern. The dentists were not quite sure about their accuracy in translating what they wanted their patients to understand. Also, there were concerns about their knowledge of dental terminology as well as their actual proficiency in English.

An economic issue with using interpreters is that it adds time to the appointment, time that could be used to see other patients. The dentists did not normally charge any extra fees to their patients who chose to use interpreters.

Yet another problem with an informal interpreter is the privacy issues involved with discussing the patient's needs in front of someone else. Embarrassment could arise from the patient when discussing personal issues, including the costs related to the services being provided, and he or she might be reluctant to provide accurate details to the interpreter to relay to the dentist.

Finally, dentists were concerned with children being used as interpreters. In many cases the second generation of immigrants are more versed with the culture and language of the community and are better able to straddle the line between the new culture and the culture of their elders. So often times, the children find themselves speaking for their parents or older relatives. The trouble here is knowing if the child is able to understand complex and even not-

so-complex concepts in oral health care and dental terminology. Again, the issue of privacy was indicated here, especially concerning if the child is emotionally mature enough to be able to handle sensitive information about the patient.

For formal, or professional interpreters, dentists' positive appraisals were similar to those given to those working informally. Speed, accuracy, and the practitioner's confidence in the individual were also noted. On the negative side, the high cost of securing these individuals was seen as the worst aspect. The time it takes to arrange a visit from a professional interpreter was another negative. Having staff take time away from their regular duties to either bring in an interpreter or to serve as an interpreter themselves was also viewed as an economic loss to the practice.

Nearly 50 percent of the dentists had the means to get oral health printed materials in languages other than English. Eighty percent said that these publications were helpful in providing dental information to patients, but only if they were able to read. "Several respondents recognized that the pamphlets should not replace adequate verbal communication but may supplement communication, especially for post-operative instructions and education" (Goldsmith, et al., 2005, p. 238). Even though a majority of the respondents said they found value with printed materials, there were a great many who did not know where to access the literature.

When asked what their recommendations would be for both patients and fellow dentists, the respondents said that patients should seek out dentists who speak their own language and they should take more initiative for their own needs and secure their own

interpreters. This sounds like the dentists favor eschewing all responsibility to their patients, but they also indicated that “It is very much up to the dentist to ensure that information is provided to and understood by the patient” (Goldsmith, et al., 2005, p. 238).

Reaching Dentists through Technical Communication

Technical communicators can help to improve dentist-immigrant mutual understanding. They can offer their services as cultural intermediaries between oral health practitioners and Somali immigrants. I will show how technical communicators can use their skills to craft appropriate materials for dentists to better understand their Somali patients. For dentists, this task may be difficult at first, because, as shown, they operate from an inside-out cultural orientation and do not have specific training targeted at cultural matters. “There appear to be few such opportunities for continuing education in cultural competency aimed at practicing dentists and hygienists (Garcia, Cadoret, & Henshaw, 2008, p. 326). The American Dental Association offers hundreds of continuing education classes (American Dental Association, n.d.). In its Practice Management category, 41 classes are offered, including topics such as using social media to improve a practice or the benefits of an environmentally conscious office design. The number of classes for working with immigrants or patients with limited English skills? Zero. One class that has a segment on problem patients only focuses on children and the elderly.

Clearly, a class or classes on immigrant patients is sorely needed. Besides motives of learning about a new culture or being good neighbors, dentists are likely to be swayed by economic reasons as well – offering service to Somalis will swell their patient load.

To effectively educate oral health practitioners about the unique characteristics of Somali immigrants, a series of classes set up as webinars in partnership with the American Dental Association is recommended. Technical communicators will work with representatives of Somali outreach organizations to create and organize content. The classes would introduce various aspects of Somali oral health culture. The first class in the series will take time to introduce the Somali people and culture as a whole. It will also offer ideas on how to make the dental office more welcome to Somalis, in terms of décor and reading material.

The content of the class would be video and images of Somali immigrants, using either existing or newly shot footage, as well as verbal messaging tailored to a dentist's knowledge and education. Digital is integral in this endeavor because it allows the dentists to see and hear their potential new clients. They will be able to note their dress, their mannerisms, and their way of talking. Also, they will be able to hear Somali words central to dental care, and it will help them with their understanding and pronunciation.

As a goal of technical communications is to simplify information, they also can develop a series of symbols or pictograms that incorporate aspects of both Somali oral health culture and Western practice. These pictograms would serve as a communication short-hand for both dentists and Somalis. Pictograms have been demonstrated to enhance comprehension and recall. "If well-designed, pictograms have the advantage of being understood faster, remembered longer, and being more compact than the written word" (Mansoor & Dowse, 2003, p. 1004). The symbols would be explicated in the classes and suggestions would be made for how dentists could employ them in their practice.

A step in this direction which technical communicators can take is to emulate the work of migrantas, a collective of artists based in Germany. The collective is devoted to highlighting the thoughts and feelings of immigrants living in a new country. As it finds pictures a universal language, migrantas works with immigrant groups to give individuals a chance to share their migrant experience by way of simple drawings.

Analyzing these drawings, migrantas then identifies similar themes and distills them into pictograms

(Figure 2). “Their simple, universally understandable images stir emotions: people from different

backgrounds recognize themselves in the

representations, while others gain new insights or

modify their own perspectives. The results are better

recognition and visibility.” (Aaronf, 2010). Technical communicators can work with focus groups

of Somali immigrants to devise culturally appropriate pictograms. “Having greater insight into a

particular culture will undoubtedly enable us to avoid making unfounded assumptions about

what kind of information can successfully be conveyed through pictorial material” (Dowse and

Ehlers, 1998, p. 110).

Somali Immigrant Surveys

As more and more Somalis are settling in Minnesota in recent years, several studies

have been done in order to learn how to serve this population better, especially in terms of

health care. Many had distressing results. A survey done by the Minnesota Department of

Human Services of 4,902 Minnesota Health Care Program enrollees designed to examine racial



Figure2

Source: <http://migrantas.org>

barriers to health care asked Somali immigrants to rate the quality and availability of the interpreter services they have received (The Interpreter Services Work Group, 2008). Of those polled, nearly 50 percent reported that they had difficulties in getting an interpreter when needed. A second question asked them if an interpreter is beneficial in helping them understand what the doctor is saying, helps the doctor understand what they are saying, or even what is being done at the visit. To this question, 50 percent of adults provided negative feedback, and 35 percent of Somali parents said likewise.

Another study conducted in collaboration with the University of Minnesota Dental School and a community outreach service attempted to gauge the impression Somali immigrants had of their oral health in general (Okunseri, et al., 2008). The dental school established a “Somali dental clinic” and advertised it in multiple venues to attract nearby residents. In addition to providing a complete dental examination, practitioners also asked their Somali patients to complete a short survey about their oral health, as well as their health in general.

Fifty-three adults completed the survey with about 75 percent of them women. The results showed that 49 percent indicated they had poor or fair oral health. In terms of general health, 33 percent reported themselves at poor or fair. In comparison, a previous National Health and Nutrition Examination Survey found that only one-third of Americans 20 years of age or older considered their oral health as poor or fair.

A majority of the Somali group also reported access to dental care as poor or fair – 74 percent – and 83 percent said they did not have a regular place to go for their dental care needs. In fact, 36 percent said they had never been to a dentist before.

The results of the oral examination on the Somali patients bore out their self-reporting. For women, the average DMFT (a count of the number of decayed, missing, or filled teeth) was 10.3. For men, the average DMFT count was 7.1. Worse, the women on average had 6 decayed teeth, but only 1.7 of them were filled. Men averaged .8 filled teeth versus 3.2 that were decayed.

One other survey question produced significant findings. For language preference, 91 percent of the respondents said they prefer to speak in Somali, 90 percent preferred to write in Somali, and 87 percent indicated a preference to read in Somali. This finding has much significance for those seeking to deliver effective oral health care to Somali immigrants.

Reaching Somalis through Technical Communication

In order to determine the best methods of providing written materials to immigrant populations, researchers conducted a study comparing the needs of a new group – Somalis – to an established group – Hmong – in Minnesota (Martinson & Chu, 2003). Individuals in each population were part of a focus group to learn what they liked and did not like in printed materials tailored to them.

Both groups preferred materials that were bilingual – English and their native language. They also preferred clear layout with scant use of text, bullet lists, simple bold fonts, and

appropriate cultural imagery. Each group is relatively new to using printed materials as they both are primarily verbal cultures.

The Somali participants turned out to be more enthusiastic about the printed materials. As they were not used to seeing many publications written in their own language in their new homeland, they heartily embraced the attempt to reach them in their own language. The quality of the print pieces was secondary to the content.

For the Hmong population, quality was a significant concern. As they have been in Minnesota for quite a lot longer than the Somali population, they are more used to seeing items in their own language. As such, items that were poorly made stood out to them. When they were queried on how they might go about creating a print piece for themselves, they immediately talk about using high-quality paper and professional photographs. Their reasoning is clear: “The physical quality of the publication played an important role in indicating social location. The implied communication of the materials used was understood by the focus group as denoting a lower class of importance” (Martinson & Chu, 2003, p. 229).

This study provided an important glance into the mindset of immigrants differentiated by their time in their new surroundings. While both preferred seeing items in their own language, those who have been in the state longer have a greater sense of class identity and the role they play in society. This is not to say that newer immigrants should be plied with inferior quality communications. Rather, if extra steps are taken right away to provide them with high-quality publications – professional photography, sturdy paper, etc. – they will be

much more likely to embrace the information if they feel like they are being thought of as equal members of the community.

Brochures currently in use for Somali immigrants are sorely lacking in cultural understanding. A current booklet published by the Colorado Department of Public Health and Environment, *Cavity-Free at Three* (Figure 3), is available in 11 languages, including Somali (Colorado Department of Public Health and Environment, n.d.). While the language differs, the cultural content does not. The brochure is a guide for pregnant women to take care of their teeth and describes how a healthy diet also translates into healthy teeth for the unborn child. No mention is made of why healthy baby teeth is important. This fact may seem to be obvious to the writers of the booklet, but it is not obvious for Somalis, who traditionally do not see baby teeth as important. The booklet fails at being culturally literate.



Figure3

Source: <http://www.cavityfreeatthree.org/patient-education-resources>

Another booklet distributed by the Massachusetts Head Start Association, *Oral Health*

for Head Start Families, also is available in nearly a dozen languages (Massachusetts Head Start Association, n.d.). This booklet presents the case for the care of baby teeth right away – its first two pages are called “Baby Teeth are Important!” and numerous bullet points are offered to buttress the theme. However, the photographs accompanying the text remain the same in all translations (Figure 4). Some attempt is made at diversity – Asian and Hispanic people are portrayed, but no representation of a Somali is present. Again, the creators of the booklet paid little attention to the cultural needs of their audience. Without seeing themselves in the material, Somalis will not pay as much attention to the technical information provided in the text.



Figure 4

Source: <http://www.massheadstart.org/oral-health.php>

Similar to the work of migrantas, which has been successful, the Centers for Disease Control and Prevention (CDC) worked with immigrant groups to craft appropriate materials, but ended up taking it only halfway. In 2010, the CDC created four documents to educate immigrants about the seasonal flu (Centers for Disease Control and Prevention, n.d.). To successfully translate the text, the CDC held focus groups and educational sessions with various immigrant groups. The

documents were translated into 12

languages, including Somali, but again, the images remained the same. Throughout each document, the identifying character is a white male (Figure 5).

Technical communicators are in the unique position of being among the most capable in writing and designing effective brochures. Again, working with outreach organizations, but also with dentists, an educational package can be developed for the Somali population. Judging by

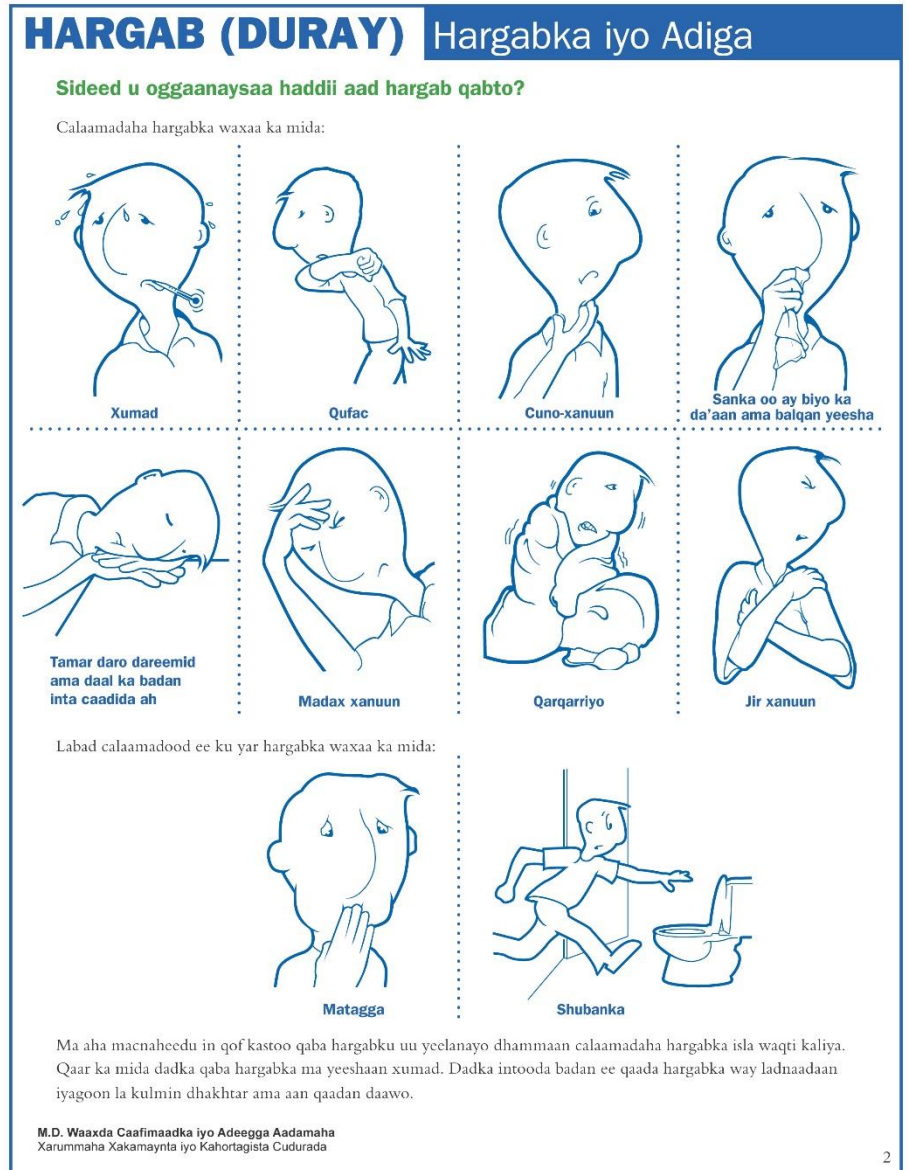


Figure 5

Source: <http://www.cdc.gov/immigrantrefugeehealth/resources/>

what Somali immigrants had the most positive response to, a set of brochures or other printed information will provide the best method to reach this population.

Communicators should write the brochures in both Somali and in English, to give newer immigrants another opportunity in learning the language of their new home. The content would introduce Western concepts of oral health care, but be culturally sensitive to Somali beliefs, in order to accelerate their acceptance of practices that may be strange to them. This is important because it is “very difficult for anyone to jump from one culture right into another due to the journey they have taken, often involving loss of family and a loss of ‘identity’ within the community, the family, or the workplace” (Morris, Popper, Rodwell, et al., 2009, p. 534).

The content of the brochures will be in simple language, with short bullet-point instructions. Additionally, the pictograms already discussed can be introduced here to continue the process of getting Somalis and Western dentists speaking the same language.

The brochures would be distributed at the community outreach organizations, at dentists’ offices, and provided to Somali children at school. A digital component or a website could be created to provide supplemental material if needed. Community outreach organizations would be the best partner to determine content needs and audience of a web-based platform.

Future Areas of Research

To take the information I presented in this paper to the next level, technical communicators can craft materials outlined in the recommendations and introduce them to

groups of dentists and Somali immigrants. With before and after interviews of each population, researchers can identify the strengths and weaknesses of the recommendations to create even stronger material. When successful, the techniques used in creating these materials can be expanded to other areas of Somali healthcare that may be lacking or even into other immigrant populations with certain healthcare deficits. Also, this paper was limited to already-practicing dentists. Future research can look into dental school curricula to learn how working with immigrant populations is or is not discussed in the classroom, and the strengths and weaknesses that are found there.

Conclusion

To date, Western oral health practitioners have not been proactive in attracting new Somali immigrants through their doors, resulting in poorer oral health for Somalis. Language barriers aside, the major obstacles seem to be a lack of health literacy on the part of Somalis when it comes to Western oral health care and the Western health care professionals' unwillingness to incorporate Somali traditions into their practice. If these two elements can come together through the guidance of technical communicators, a mutual trusting relationship can grow and flourish. "Culture, and by extension cultural literacy as a component of health literacy, is clearly part of a successful equation to improve health care, promote healthy decisions, and prevent unhealthy behaviors" (Zarcadoolas, et al., 2006, p. 244).

In order to effectively bridge the gap between Somali oral health care and the practices of Western medicine, technical communicators have the biggest role to play. And the reward is enormous: "They will help people to live more satisfactorily using health information to

improve their understanding about their bodies, social behavior, and potentialities” and “they will assist health educators to recognize their own limitations and challenges in offering simple, effective solutions to the complexities of educating people about health, well-being, and quality of life” (Zanchetta & Poureslami, 2006, p. S29). Effective results also will solidify Somalis’ relationships with Western oral health practitioners and be a large step in integrating them into the greater community.

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