How communication currently works within culturally-specific communities

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Identified Community Leaders	Community leaders are less frequently used means for obtaining local news, but can serve as messengers and provide info back to the response organization. Community leaders include Pastors, Community Center Directors, Mental Health Agency Directors, Substance Abuse Counselors.	Respected persons are influential because of intelligence, age, sex, integrity or combination of such traits and may include spiritual leaders, teachers, those with high educational level, those knowledgeable of oral traditions, seniors/elders, former high ranking gov't or military officials, successful business owners, community council leaders, etc. Respected persons play strong but secondary role (after word-of-mouth) in disseminating info throughout community. Many African MAAs are made up of elder men, but very few are over 65 (age range is 18-50 and most are under 40). Thus Respected Persons also include those who have done well with acculturation, diplomacy and mediation skills, and are trusted advocates; may not be bicultural nor fluent in English but can interpret info for community. Can also be religious person or one whose community work is respected (e.g., Griots are West African poet, praise singer, and wandering musician considered repository of oral tradition).	Information sources are within community rather than outside organizations (e.g., County).	Gatekeepers include: Hispanic/Latino ministry leaders, teachers and program managers.	Native American organizations (e.g., NARA) could play important role in translating information provided by mass media.	Inform key community members.	Respected Persons in SE Asian communities may not necessarily interact with Western society, may not be bicultural nor fluent in English. Examples of Respected Persons include: Cambodian = monks, teachers, seniors/elders; Hmong = clan leader, teachers, spiritual leader, pastor; Lao = monks, senior/elder, teachers, community leaders, former high ranking gov't or military officials; Mien = clan or community leader, seniors/elders, shaman/pastor, high ranking former gov't or military officials; Vietnamese = monks, teachers, Catholic priests/pastors, elders/seniors.

How communication currently works within culturally-specific communities

	African Americans (AAHC)	**African immigrants and refugees (ACCO)**	**Chinese, Korean (AHSC)**	**Hispanic population (Latino Collaborative)**	**Native Americans (NARA)**	**Russian-speaking population (EMO/ROSS)**	**Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)**
Word-of-mouth	Family member or friend, followed by co-worker, then church, are usual sources of local news. High value on relationships.	Word-of-mouth is most effective when done through one-on-one contact in person, face-to-face in a group or telephone/cell phone from trusted sources. Word-of-mouth is way African communities build trust and is most effective tool used by community messengers in working with communities and all their subgroups and at all levels. Most effective to combine word-of-mouth networks with text-based literature, visual-based info and spoken announcements in dominant language and English. Especially for recent refugees, in-person contact preferred and more necessary as phones not as common (messengers act as communication bridges between cultural and majority communities).	Family and friends.	Latino-serving organizations, many of which are small and grassroots, have strong connections to Latino communities in the region. In addition many mainstream organizations have culturally-specific programs within that can share info and serve as resource during emergency.	Telephone and in-person conversation: initial steps of dispersing info in event of PH emergency is a telephone tree to contact primary and secondary contacts followed by face-to-face contacts with members of Native American community groups. Home phone = 55.9%; In person contact = 35.7%; Email = 22.4%; work phone = 21.7%.	Family and friends.	Best to do one-on-one contact in person, face-to-face in group or telephone/cell phone/phone-tree. These methods are also effective in building trust and working with subgroups at all levels. Barrier: considerable community reluctance in giving contact names and info until necessary comfort level with gov't achieved.

How communication currently works within culturally-specific communities

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Specific Media	For local news source, 71% use TV, 51% read The Oregonian, 44% use internet, 39% read Skanner or Observer, 39% listen to radio, and 10% indicated 'other'.	Community-based newspaper, radio, TV and internet news sources from home countries that reflect African community news. No major local African newspaper or radio that all communities rely on. International/national TV and newspapers are reliable source for avian/pan flu incidents and large-scale emergencies. Many go between TV and radio. Many newer African refugees don't have cable TV. Community-based internet news sources more widely used by those with daily access. Middle-aged adults from newer refugee communities may not be as computer savvy as children due to literacy rates, no time to learn or no access to computer with efficient internet. More successful community members watch satellite-beamed stations from home countries. As become more fluent in English, local newspapers used more. Use direct mail and formal letters (show of respect), but some turning to email as preferred form of "letter-writing". Direct mail should be followed-up by in-person meetings for effectiveness.	Local TV and radio are primary resources for families with at least one English speaker. Many get delayed local news via TV on a Chinese speaking channel. Depend on Asian language newspapers, but delay because many printed weekly. Asian language media is primarily printed, not broadcast. Asian community somewhat isolated from conventional communication networks. May need to bridge language gap especially if translated materials are in places not frequented by non-English-speaking Asians. Many Asian language materials on internet sites require some English proficiency to access.	Daily, 64% listen to Spanish-language radio (46% listen to KGDD 1520, 17% to 1450 La Grande, 15% to KWBY 940 La Pantera). 19% listen to English-language radio (29% listen to KXJM 95.5, 17% to Z100 100.3, 11% to KLDZ 103.5, 8% to1330 K-Praise). 8.5% read Spanish-language newspaper (75% read El Latino de Hoy, 25% read The Hispanic News). Of 15% who read English-language newspaper, 96% listed The Oregonian. 47% watch Spanish-language TV (66.7% watch Univision, 27% Telemundo and 4% Azteca; national stations are out-of-state and need local info scrolling to direct to local stations). English-language TV watched by 32% (29% watch KGW (NBC), 28% KPTV (FOX), 10.5% KOPB (PBS) and 11% KOIN (CBS)). Only 8.5% use internet daily.	General information from TV = 72.4%; newspaper = 45.4%; Direct Personal contact = 28.3%. Get local news from local TV = 77.7%; local newspaper = 56.7%; family member or friend = 51%. During Avian or Pan Flu, majority have access to and will rely on local TV = 54.6%; local newspaper = 44.7%; local radio = 34.2%. English is primary language for 98.6%.	TV is main source for all RSP, then direct contact and newspaper. For church-affiliated, newspapers are second (Russian newspapers preferred), then pastors, family members, and friends. In non-church group, second preferred source is family and friends, then newspapers and Internet tie for third. Most popular TV channels are local, then Russian channel (not much local news because broadcast from NY or CA). In emergency, would watch local news even if don't understand English; recommend having 2-3 minute report on local news in different languages; scrolling captions hard for elderly to read.	Prefer community-based newspapers, radio, TV (especially for large-scale emergency info), and internet news sources. Many will toggle between radio, local and cable TV, and community-based internet news over course of the day. Only Vietnamese have local radio, newspaper, and a dedicated community cable station specific to their community. Local community based websites and newspapers are recommended for detailed and long-term emergency prep information, training opportunities and instructions.

How communication currently works within culturally-specific communities

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Community Centers		Community gathering places and events, community networks and respected persons play strong but secondary role (after word-of-mouth) in dissemination to community. Many expect to be able to walk or travel to community gathering centers and meet fellow community members face-to-face regardless if telephones/cell phones were available. Many had past care-giving and illness experiences with disease outbreaks such as cholera, malaria, and other contagious diseases in refugee camps which tempers overall concerns regarding avian/pandemic flu and levels of quarantine seriousness.	As information source, community centers ranked second. Next highest was Hospital/clinic, followed by internet. Others sources mentioned: radio, church, newspaper, school, family, police station, Chinese market, library, residence management office, fire station, government office, bank, phone calls, post office, mail.	Local health departments (specific programs such as Women, Infant and Children (WIC), clinics), welfare office, educational institutions (e.g., their children's schools, community colleges that offer ESL classes, etc.) and other social and health service organizations ranked as first or second place that respondents access information and help. Health departments lead in prevention efforts and sharing culturally and linguistically appropriate information.			Community centers, Mutual Aid Associations, networks, associations, and respected persons play strong role in disseminating, confirming, and translating info throughout community. When phones not available, rely on community gathering places to give and receive info. Many expect to be able to walk or travel to these centers in emergencies if phones not available and even if phones ARE available (need to consider ramifications of this when social distancing is needed).

How communication currently works within culturally-specific communities

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Places of Worship	Community is affiliative and feels comfortable gathering as congregation at church. Chose family and friends, followed closely by people at their church/place of worship, to be with in emergency. Church culture reaches diverse segment of African American community and historically, working with African American churches requires trust/familiarity. AAHC partners with faith community and has rapport with churches and its leaders. Emergency sessions at churches via church leaders/AAHC to prepare community.	Mutual Aid Associations often serve tri-community role as religious institutions, community councils, and/or secular organizations (e.g., dance or music groups). Many community centers revolve around religious practices (e.g., Mosques or Islamic Centers, Christian churches, and Spiritual Leaders' places of ritual service). Estimated 6-10,000 Muslims, 11 mosques or Islamic Centers in greater Portland region, with seven being Sunni of varying ethnic backgrounds. Many Northern and Eastern Africans residing in Clackamas, Multnomah, and Washington counties are predominately Muslim and their Mosques and/or Islamic Centers are also community gathering places for giving/receivng social information. Non-Islamic African population is majority Christian. Spiritual Leaders practice traditional rituals in homes.	Churches may be a source of information for some, but not a primary source for many.	Churches identified included local Catholic, Jehovah Witness halls, and evangelical congregations. Existing community-based organizations were mentioned as trusted places used by the Latino community.		Pentecostal, Evangelical Christians and Baptists are strongly affiliated with churches; most likely to respond to opinion and religious limitations of these denominations. Most Russian churches are in SE and NE Portland; SE and NE (not so much SW) residents are affiliated with churches, because many churches forbid driving to services. In emergencies, pastors are key to providing information, support, shelter, food, clothes, etc.	Churches are main Mien dissemination centers; half Christian and half Taoists who follow spiritual leader. Most Cambodians are Buddhist; others Protestant. Hmong are divided between Animism and Protestant Christianity. Most Lowland Lao are Buddhist (one primary church). First wave of Vietnamese tend to be Catholic or Protestant, later waves Buddhist. Community centers such as Buddhist temples, Christian churches, and spiritual leaders' homes used for religious practice, sometimes double as Mutual Aid Associations and places that help facilitate delivery of information. SE Asian refugees tended to adopt religious practices of sponsoring organizations or families. However, they also continue to practice and pass to future generations various traditional spiritual practices (e.g., healing practices/beliefs, ancestor-based rituals, etc.).

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Local Businesses, Grocery Stores		Community-based businesses also important places to give and receive info. Currently, no African ethnic-specific locally-based business directories or internet services. Key community businesses are restaurants and African food and/or Halal markets.		Rural and urban communities both identified local community businesses: laundromats, grocer stores' bulletin boards, etc, as key places in which they get info. Rural communities identified specific businesses: Wal-Mart, Winco, etc., as frequented often and where they seek info. Use Latino-serving businesses. Many respondents identified local businesses such as grocery stores, discount stores, etc., as places where they congregate, meet others, garner and share info through community boards posted at stores. Crucial to engage these businesses early as they will eventually be selling prevention materials. Suggestion: contact Hispanic Chamber of Commerce in Portland Oregon.			Community-based businesses and mainstream major businesses (i.e., Purdy Brush Comopany, Intel, Anodizing Company) where community members work are important places to disseminate emergency info. 15 Vietnamese restaurants are active as community gathering places.

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Other access to emergency information?		Most trusted non-community entities are county health depts and community clinics.	Translated materials, citizen information workshops, emergency information phone line, free emergency and disaster kits, trained Chinese and Korean volunteers, mailed information.	Watch local English stations but want Spanish language information at bottom of scroll screen. For prevention efforts, prefer current local Spanish language and culturally-specific programming, including cable programming as Cita con Nelly (Conversation with Nelly), talk show format and based in Portland that welcomes local speakers as guests. Encourage prevention education via public TV. Several Spanish language newspapers in this region include: Latino de Hoy; El Hispanic News; Spanish Yellow Pages (NOTE: some use emergency pages in Spanish Yellow Pages to call fire and police); Local newsletters and postings.	Clinic or Local Health Department, hospital emergency room, personal doctor, and family member or friend.		Internet websites and email sites connect communities across the nation and to home countries (note: education and income levels and religious beliefs influence internet use). National Laotian website gives global Laotian-related news. Diversity of Vietnamese population is reflected in diversity of websites, blogs, Vietnamese and Vietnamese/English-based sites. Main Cambodian website is in English and Cambodian and is local site used to transmit/receive news/info and promote/preserve Cambodian culture. Hmong access Hmong websites/blogs, many based in St. Paul, Minnesota. Main Mien website is English-based global site.

How communication currently works within culturally-specific communities

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Cultures' involvement in community-based orgs	African American communities work with their community-based organizations to strategically organize and mobilize emergency communication plans, allocate needed resources for the future, and promote opportunities and occasions to interact and work with county health departments in order to reduce communication and service gaps. More health workers, trained to meet needs of communities and located at area health departments, multi-ethnic agencies and community centers are needed.	Cultures' participate in Mutual Aid Associations (MAAs) that have been developed to either take place or be public version of more traditional community council of elders; best place to begin delivering information to local African communities because MAAs often provide social service assistance, mobilize communities, represent and advocate for community. MAAs revolve around political, tribal, or religious groupings and can get messages out quickly and effectively.	Most Chinese and Koreans have some direct or indirect involvement in one or more culturally-specific community-based organizations (i.e., live with someone who is involved) .	Many Latino families depend on Latino-serving community-based organizations to provide needed services.			Cultures participate in Mutual Aid Associations that have been developed to be public version of more traditional community councils of elders.

How communication currently works within culturally-specific communities

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CBO as bridge between cultures and emergency agencies	The response to the African American Health Coalition was very natural and unforced because of years of relationship-building, trust-building and delivery of programs that are culturally sensitive and targeted. With adequate time and funding, AAHC can work to ensure that the community is prepared for any emergency by simply using opportunities already in place through existing programs.	Few leaders/respected persons and transcontinental associations can transcend cultural/ethnic/religious communities and speak to entire African community. Don't generalize group; African community considerably more varied than most other populations. Suggestion: have African community liaison to assist city/county leaders in continuous planning for emergency preparedness, have regular leadership training to promote greater civic participation by African communities and stronger pan-African community leadership (emergency preparedness is ongoing, not one-time, process).	CBOs are connected to vulnerable and high-risk individuals in their communities. Partner with CBOs who have already established trust in their communities to dramatically increase information’s potential to reach communities.	Using Latino-serving community-based organizations to communicate emergency messages is efficient, because the Latino community already trusts the messenger. Culturally-appropriate strategies are used (e.g., food and refreshments are provided along with educational information, safety tubes donated by American Red Cross, etc.).	NARA works with Health Department to develop culturally-specific education materials and assist individuals with developing emergency preparedness plans for home. Protocol in emergencies: Health Director (HD) of NARA Indian Health Clinic (NIHC) gets call from County Health Department (CHD); HD calls Contact Lists and relays instructions from CHD; NIHC outreach staff/hlth educators meet with Elders Groups and other community organizations to give recommended response/accurate information/answer questions; NIHC staff appears on KBOO's Native American Hour radio program to present accurate information, debunk myths, answer questions from listeners; brochures given to all patients who visit NIHC.		Use IRCO as primary/immediate contact for disseminating emergency information to refugee/immigrant communities in Clackamas, Multnomah and Washington counties. IRCO’s staff includes community influentials: IRCO Main, Asian Family Center, Mid-county Senior Office, Cherry Blossom Senior Center and Skill Training Center for youth and adults. Can do periodic checks of key community-based organizations (Mutual Aid Associations); maintain/update contact lists on behalf of public health agencies; use existing community communication networks and facilitators instead of creating new ones; follow-up on community gatherings to update communities on emergency preparedness activities and opportunities; do culturally-competent education/training as part of overall communications plan.

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Financial Constraints	Yes	Ghana: Focus emergency planning on low-income, refugee communities. Oromo (Ethiopia): concerned that should include growing African community in Washington County. All African communities can benefit from more emergency preparedness training. The diversity of African members/groups includes income (economic burdens give little time or motivation for emergency preparedness) and education gaps, necessitating different messaging styles and content for each type of community being reached.		Yes	Native American community in the Portland Metro Area needs: assistance with developing Emergency Preparedness Plans; access to supplies, e.g., breathing masks, disinfectant wipes and other infection prevention supplies located in areas near their home at schools, churches or other community centers; food boxes for families that are not able to leave their house for extended period; containers for water storage; assistance with caring for vulnerable Elders that may be living in home.	Limited finances, no savings or other financial resources.	Make EP kits available at little or no cost.

Special considerations for successful communication in an emergency

	African Americans (AAHC)	**African immigrants and refugees (ACCO)**	**Chinese, Korean (AHSC)**	**Hispanic population (Latino Collaborative)**	**Native Americans (NARA)**	**Russian-speaking population (EMO/ROSS)**	**Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)**
Lack of sick leave at work				33% would not go to work. Of those going to work, 47% didn't want to lose jobs, 38% said they're paid hourly and didn't want to lose hours, 12% said they don't get personal/sick days off.		Usually have no option of flex hours, sick leave, vacations.	
Immigration Issues	Disaster preparedness is sensitive subject because many African refugees (see ACCO) have previously experienced trauma. They are impressed when government takes time to prepare them for disasters that have not yet taken place.	Government has negative stance on immigration and Islam. Education and training need to be sensitive to community-experienced trauma and available to communities as part of overall communications plan.	Immigration process allows family members to sponsor each other's immigration to the U.S.	55% would attend public event to receive a vaccination. Of those that wouldn't, 49.5% said they would be afraid of getting sick from another person, 24% said afraid due to undocumented status, 20% said afraid to get sick from vaccine. 70% would be present to receive food and water. Of those that would not, 4% said afraid to get sick from another person, 44% said afraid due to their undocumented status.		Majority are not US citizens; stresses of resettlement.	Increased immigrant bashing and blaming in US. Community outreach should include information on area public health agencies and services in general. Do annual community assessments on community level of trust of public health and other emergency responder/preparedness agencies.

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Distrust of government	Noncompliance because mistrust government from past experiences with governments in Africa (see ACCO). Discrimination might result in being last to be assisted in disaster. Appreciated that government is bringing up this topic, but wondered if survey was just an exercise—or if it will really be implemented -- again demonstrating deep-rooted mistrust.	Africans are annoyed with American ignorance, especially as it influences how they are treated by government agencies and police/emergency workers. Primary concerns are access to emergency training and planning resources, especially vaccines, and help rebuilding community infrastructure. Those receiving social services want to know who will provide vaccines for them. Low survey return rate because leadership reluctant to collaborate with often less-than-accountable government plus cynicism about benefits to African communities. Would like more "after emergency" planning and data collection. Past experiences of non-delivery of results back to community or tangible community impacts; also want to know in timely manner how information given will be used. Public health approach of using proxy leadership to work with African communities may miss key community opinions and concerns.	Many elderly, disabled, retired and unemployed Asian Americans depend on government for assistance but they may also have more barriers to accessing information put out by government.	Issues of immigration and fear of deportation are high. Rumors that INS will be called keep many from asking for help. Engaging community organizations early in emergency response process will increase comfort of communities to seek/accept help. However, despite fears of immigration problems, in emergency they would call police or fire department and would listen to them for instruction. It is critical that police, fire and rescue personnel have some basic capacity to give instructions in Spanish.	Almost 1/3 cite distrust of government as barrier in seeking assistance. Mistrust of government agencies and fears of experimental vaccines could restrict participation in vaccination campaigns. Others may live in the present and not fear future events, thus inhibiting early recognition and sense of urgency needed to mount a timely response to crisis. Discerning valid information from mix of exaggeration and myths circulating can prevent effective action for some.	Memory of Soviet Union's governmental persecution of pastors, religious, churches. Pastors guarded about government using churches. Will take time to develop trust.	Past US history of scape-goating non-Caucasian, non-English-speaking communities. Past personal experiences where information led to death and/or refugee status. Cultural privacy (especially health privacy, so culture not blamed, ostracized, or held responsible); contact list antithetical to culturally prescribed ways of communicating. More relationship-building (presence at community gatherings) needed by government agencies. Current Vietnamese List is of places that emergency preparation materials and info can be disseminated. Belief that contact held responsible for any/all actions/activities during emergency.

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Other reasons for mistrust	Trust-building efforts needed, especially since African American community has high distrust of government. Government should partner with trusted members and organizations in community.	US history of dealing negatively with non-Caucasian/non-English-speaking communities during national emergencies and crises. Concern over current high level of Islamic and immigrant bashing and lack of outreach from government to alleviate community unease. Communities place high value on privacy and self-sufficiency issues and may withhold health information if could result in community being blamed, ostracized, etc. Community influentials willing to use skills, fill job opportunities, help in emergency pre-planning and implementation (for community ownership, skill-building). Learn how, whom and where to communicate with populations, done in ways that alleviate fears of discrimination and/or viewing them as "terrorists".		Latinos, especially immigrants, don't always feel that coming forward to government authorities during crisis, whether natural or man-made, is in their best interest. If government and private relief agencies fail to convince nation's largest minority that they are not safe sources of preventive care/treatment or credible information, government's ability to keep the country safe and healthy is undermined.			Some community leaders/influentials said that if they had been brought into planning loop for project they would have suggested better methods or alternatives to the contact list request. Community influentials willing to use skills, fill job opportunities, to help in pre-planning and implementation (community ownership). " When we are only asked for information and never asked who we want to give our information to and how we want it to be used, when we are not shown what was done with our information, when we never get a follow-up response, of course our trust in them is low."

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Other reasons for withholding information		Bias against giving out personal contact information even for good cause because: past experiences where such information led to death and/or refugee status; no relationship with those who would use information and thus no trust that it would be used wisely and correctly; belief that list would be used to "round up" community members as terrorists or other unwanted group if community did not "perform well" for Western health agencies; belief that contact would be held responsible for any/all actions/activities during an emergency and be deported; contact list antithetical to culturally prescribed ways of communicating. Some community leaders/influentials understood Western reasoning behind wanting contact info; however, many stated that if brought into planning loop for project they would have suggested better methods or alternatives to contact list request.					Many have strong ties to home countries and return at least once/twice a year. Have concerns that their community would be blamed for avian flu outbreak (since originated in Southeast Asia).

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Conflicting advice from trusted sources	Noncompliance because of conflicting advice from trusted sources).	Know who is considered health care practitioner in communities (e.g., shaman, healer, nurse, EMT, immediate family female caregiver, etc.). Many expect to combine traditional healing practices with Western treatments. Past experiences show many refugees that aftermath of emergencies involve greatest family upheaval, mental and physical toll, financial expense, and constant movement to escape effects of emergency. Low perception of risk with avian/pan flu when compared to past traumas. Direct involvement in emergency planning AND training should be community-based.	Many elderly, disabled, retired and unemployed Asian Americans depend on family, friends, and social contacts for health education (family and group-oriented due to language and cultural barriers).		More than 1/4 identified conflicting advice from trusted sources as barrier in seeking assistance.	Concern: how to get updates, know where to get resources if language barrier.	Use combination of word-of-mouth networks, text-based literature and visual-based info (e.g., DVDs, pictorial or iconographic format brochures, spoken announcements in native language and English. Most EP efforts focus on expectations before and during an emergency, more important to refugees to be prepared for life after emergency since involves greatest financial, mental, and physical expense as well as constant movement to escape effects of emergency. Need holistic emergency preparedness.

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Fear of experimental vaccinations, medications	African Americans fear government-run medical testing without their knowledge as a reason they would not follow directions (i.e., fears of racism, poverty and mistrust in government would probably influence community members' reactions to public emergency). Would be interesting to survey individuals and determine if lack of response in aftermath of Katrina and Rita influenced responses to this survey.	Fear of access denial to cures because do not speak English or discriminated against because of religious beliefs, skin color, wearing of traditional and religious-mandated dress, etc. Western health practitioners, agencies, and related government officials should take time to develop personal relationship with community influentials before emergency.			Mistrust of government agencies and fears of experimental vaccines could restrict participation in vaccination campaigns. Some individuals who live in present and do not fear future events may not recognize sense of urgency for timely response. Discerning valid information from mix of exaggeration and myths can prevent effective action for some.	Fear they will be forgotten in panic of public health emergency.	

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Transport challenges	Noncompliance because of transportation challenges. Most refugee women do not have transportation (nor funds for childcare -- childcare and incentives also had to be given to interpreters and those who helped to bring the women).		54% said yes; 46% said no. About half would use household vehicle and other half would evacuate using public transport or go on foot.	53% said would evacuate home in emergency if public official requested. Of those not evacuating home, 25% had no transportation, 22% had nowhere to go. 64% would avoid taking public transportation, and of those that couldn't, 22% had no other means of transportation. In addition, 44% say they would take refuge at a shelter. Of those that wouldn't, 43% had to pick up all their family members first, 28% had to buy food first, 16% had to work, and 11% had to go to church.		Lack of transportation, especially for those elderly who live apart from children's family and church community.	Majority settled in urban centers of Clackamas, Multnomah and Washington counties. Transportation not problem as long as buses running.

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Interpretation and translation needs	Surveys done according to language groupings and interpreters help people feel comfortable with those they already know and trust. Due to increasing disconnect that many parents feel with children who are becoming more “Americanized”; there is concern that children will shrug off information from parents. In addition, they are nervous about emergency communications because many parents rely on children to communicate for them in English under normal circumstances.	Limited English. Need clear written and spoken messages, suitable to particular ethnic groups, religious beliefs and practices. Some have low-literacy due to past social standing and/or educational access. Many fluent in 2+ languages but not necessarily of Indo-European origin. Some older generations are fluent in obsolete European colonial languages, thus many in younger generation (<25) may not understand tribal/ethnic language of parents; speak to them in dominant language (e.g., national or widely spoken trade). Interpreters and translators, visual-based media materials the norm, not exception. Public health agencies should use messengers with proven skill in native language AND cultural knowledge. Primary language translations requested in Multnomah, Clackamas and Washington counties are: Somali, Arabic, French, Somali Maay, and Amharic.	Language would be barrier to accessing health services, even for those with high English proficiency. Mandarin and Cantonese Chinese are identical in print, but very different spoken languages.	Monolingual Spanish speakers with varying levels of formal education. Facilitator/translator was present to answer questions from participants filling out the survey. Surveys were in Spanish and efforts were made to increase usability by considering potential for low-education attainment participants. Focus groups were facilitated in Spanish, tape-recorded, transcribed into Spanish and analyzed to identify salient themes and descriptive findings. 87% preferred information in Spanish during emergency while 13% expressed no preference between Spanish and English.	98.6% use English as primary language (no major access barriers to public info announcements on tv and radio).	Wouldn’t understand instructions.	Many subgroups, thus communicating with these diverse populations will be challenge. Many have language and literacy barriers. Certain languages written differently depending on age group being addressed. Interpreters and translators should be readily provided and visual-based media materials should be norm, not exception. Public health agencies should use messengers with proven capability of communicating in native language AND have cultural knowledge.Primary language translations requested in MC, Clackamas and Washington counties (in order of demand): Vietnamese, Cambodian, Lao, Hmong, and Mien. In rural counties, Hmong more in demand than Lao.

Special considerations for successful communication in an emergency

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Framing the message		Messages need to reflect numerous ethnically, linguistically and culturally diverse subgroups. Make message specific to African ethnic audience (be culturally-rooted message). Be simple, concise, but complete and informative. Consider using community spokesperson or griot to relay msg. Use ethnic language and low literacy materials. Use both ethnic language and English when and where apprpriate. Use English for younger generations and educated persons. Include and/or use visuals (pictures/icons) wherever feasible. Incorporate checklists for instrucations and give examples in text and visuals. Avoid needless repetition.		Use less text, more illustrations, clear message about health and safety, and comic book style for translated brochures for Hispanic population. 87% preferred information in Spanish during emergency while 13% expressed no preference between Spanish and English.			Language, literacy, and cultural differences are major barriers to effective communication. Be simple, concise, complete, informative. Use ethnic language, low-literacy material. Use both ethnic language and English when and where appropriate. Use English for younger generations and educated persons. Include and/or use visuals (pictures/icons) when feasible. Incorporate checklists for instructions and give examples in both text/visual forms. Avoid needless repetition. Use ethnically-matched role models, culturally-matched examples, culturally-rooted value messages.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Identity		"African" refers to people from a continent, not specific cultures. Africans are confused with American categories of "Black" or "African American". North Africans generally define selves as Middle Eastern or Arabic and specifically by country of origin or tribal group. Those from West and Central Africa defined by country of origin and/or tribal/ethnic group, not necessarily as Black or African American except as political or social gesture. Youth are having difficulties in balancing self-perceptions. Eastern and Southern African similar to West and Central Africans, but if seen as Caucasian or East Indian, frustrated that cannot acknowledge African origin.					

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese
In a public health emergency, will first contact			Family members		55% cited NARA	Family and friends	
In a public health emergency, second contact			Relatives in the Portland area		51% cited County Health Dept (Clinic or Hospital = 49%); 19% cited other Native American orgs such as NAYA, NICWA, NIVA, North Portland Elders. (note: may not approach non-Native agencies in emergencies).	911 (for information, not help)	

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How will they access care?		Socio-cultural and religious differences in health beliefs, healing solutions and concepts of disease and how it's spread are potential barriers to responding to and/or using Western practitioners and health agencies before, during and immediately after a health emergency.	Barriers to accessing healthcare: Language: 32% yes; 40% N/A; 29% no Insurance: 44% yes; 20% N/A; 36% no Financial situation: 42% yes; 20% N/A; 38% no Immigration Status: 29% yes, 18% N/A; 53% no	Where they would go to receive medical attention during an emergency: 48% said hospital, 24% Health Department and 8% doctor's office. Of those that said they would go to the hospital, 4% listed St. Vincent Hospital, 4% Tuality Hospital, 3.5% Virginia Garcia and 3% Kaiser Permanente. NOTE: Individual county's hospital rose when data disaggregated.	49.4% identified Primary Health Care Provider, 46.8% identified Emergency Room/Urgent Care and 41.7% chose to call 911	Urgent care/ER (estimated 60% have no health insurance), then 911, then primary health care provider	Who in community is trusted health care practitioner (i.e., shaman, healer, nurse, EMT, grandmother, aunt, or mother, etc.)? May also combine Western with traditional healing practices during health emergency. Fear that they will be denied access to cures because they don't speak English or will be blamed for outbreak.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese
Compliance with public official's instructions?	Fear of separation from family, followed closely by fear of perceived danger to family are major considerations influencing noncompliant behavior. Other reasons for noncompliance are: financial, followed by mistrust in government, conflicting advice from trusted sources, and transportation issues.	Distrust, fears and privacy issues of refugees are compounded by lack of good support system and unfamiliarity with American method of addressing problems (e.g., need repetition of information and hands-on tools). Financial and language constraints. Preparation means having survival skills, accessing preventative services such as vaccinations or information (vaccines unavailable in home countries or refugee camps, so access to vaccines is strong concern).	93% said they would be willing to comply; many had family in other countries where government regulation was integral. Chinese or naturopathic medicine may be primary health resource and may affect compliance.	To protect selves/others from communicable disease: 19% willing to avoid contact with family members (81% not willing), 23.5% willing to avoid friends (76.5% not willing), 24% willing to avoid work colleagues (76% not willing), and 33% willing to avoid strangers (67% not willing). To self-limit mobility, 15.5% said willing to avoid stores, (84.5% not willing), 17% willing to avoid work (83% not willing), 20% willing to avoid school (80% not willing), 19% willing to avoid social events (81% not willing), and 24% willing to avoid restaurants (80% not willing). For self-care sanitation measures, 59.5% would wash hands several times/day (41.5% would not) to avoid communicable disease and 38% would only wash hands after sneezing or coughing.	59% said they will do what is recommended, 39.1% said they will try to follow instructions, and 8.3% were Not Sure. Appreciate seriousness of emergency, but will initially contact established/trusted relationships (greater influence than level of specific medical expertise). Immediate response if heard that Avian Flu is in area: Stay home = 78.9%; Go to a friend or family member's home = 24.3% (note: many have close relationships with extended family and/or adults living in their home); return to reservation or tribal housing = 6.4%	65% said yes, 3% said no, remaining either didn't know or said it would "depend". Want to see family members even if told to stay home or would look for family members in spite of evacuation, etc.	Those who distrust public officials will need a community influential to tell them they should comply with official instructions. Cultural differences in health beliefs, healing solutions, and concepts of disease and its transmission may affect compliance.

	African Americans (AAHC)	**African immigrants and refugees (ACCO)**	**Chinese, Korean (AHSC)**	**Hispanic population (Latino Collaborative)**	**Native Americans (NARA)**	**Russian-speaking population (EMO/ROSS)**	**Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese**
Gather at particular community place?	Overwhelming majority of community members, indicated that they would meet at church as primary gathering place. Community centers and hospitals are secondary gathering places, after churches.	Mutual Aid Associations and community events such as festivals, events, plays, dances, "graphic" literature (all groups), first tee golf events with local authority figures, etc.	Religious associations are important to those completing survey in Chinese or Korean.		Church for 38.1% of respondents, 34.0% chose a Native American Agency such as NARA, NAYA or UISIHE and 21.1% chose their neighborhood school.	Church and work for church-affiliated; others remain at home and watch TV. All go to grocery stores (important information channel in public health emergency). To buy groceries, most likely go to store close to home, then WinCo, then Russian stores and Fred Meyer.	Festivals/events, plays, dances, comic book literature (younger groups), language-based magazines and books (older generation), first tee golf events with local authority figures (joining with African groups), etc.
Heard anything about Avian/bird flu?					yes = 83.7%; no = 16.3%. First thing that comes to mind about how Avian Flu is spread: being in contact with infected birds = 59.3%, unwashed hands = 37.5%, and eating infected birds = 28.1%		

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Have family emergency plans	Top two themes: family concerns and need for safe shelter. Getting family together, staying together and ensuring everyone's safety were consistently mentioned. Others mentioned they would stay in their house if possible; go somewhere safe; go to a pre-arranged meeting point; go to nearest emergency shelter; or leave town/evacuate. Although less mentioned , some would listen for information and directions on radio or TV, while others said they did not know what they would do. 50% African American community not/somewhat prepared; only 5% think very prepared.	Few have family emergency plan in Western sense, but knew which community centers they could meet at or how to learn fate of family members. Financial constraints and lack of language accessibility given as main reasons for not having emergency kits and supplies and/or developing family emergency plans or finding out about school emergency plans.	Only 1/3 have household emergency plan (but small group discussions show this to mean "very broadly defined idea", often not sufficient e.g., no outdoor meeting place; no list of alternative exits, etc.).	Your apartment complex? - 70% no. Your house? 51% no.	"Does your family know what to do in case of a public emergency such as a pandemic flu?" 59.2% responded Not Sure, 29.3% Yes, and 18% No. General lack of knowledge about what Emergency Preparedness Plan should include, whether for home, school or workplace. Education on how to develop emergency preparedness plan for home and how to learn about what is in place at school or work is needed to provide those important first steps in responding to emergency. Not having plan would contribute to confusion and panic and an inability to organize a successful response.	Only 34%.	Low level of emergency prep, because perception of risk is low compared to past traumas; very few have family plan. Cites financial constraints, lack of language ability, and cultural belief that words have power and speaking about a negative like an emergency will cause it to happen. Refugees also have difficulty planning for an emergency in a country they emigrated to because it is "safe".

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Have emergency kits	Asked what they have in emergency kits, 46% said they did not have emergency kit. How best to prepare the community: find resources for community members to purchase emergency items. Many suggest offering such items on reduced or free basis to enable community to be better prepared.	Low level of emergency preparedness in terms of on-hand supplies. Financial and language constraints are main reasons for not having emergency kits and supplies and/or developing family emergency plans or finding out about school emergency plans. Have actual example of culturally appropriate kits available at community gathering centers, in native language for added visual aid, at little or no cost.	43% = yes; 57% = no (But many don't realize how unprepared they really are. Some assume an emergency 72-hour kit is simply recommended articles scattered in different locations throughout house. Danger of this is they will not make effort to make legitimate emergency kit, or even find out what real emergency kit is.)	From 16% of respondents: Do you have emergency materials (water, flashlight etc) at your house? - 42% yes; 27% no because I haven't thought of it; 20% no because I don't have money.	59% = No, 32.2% = Yes, and 9.2% = Not Sure. Native American Community in Portland Metro Area needs assistance with: developing Emergency Preparedness Plans; access to supplies such as breathing masks, disinfectant wipes and other infection prevention supplies located in areas near home, at schools, churches or other community centers; food boxes for families that are not able to leave their house for extended period; containers for water storage; assistance with caring for vulnerable Elders that may be living in home.	Only 38% have kits.	Very few. Cites financial constraints, lack of language ability, and cultural belief that words have power and speaking about a negative like an emergency will cause it to happen.
Have workplace emergency plan, know what it is		Few knew whether workplace had emergency plan due to language constraints.		36% said no.	Majority reported that workplace did not have emergency preparedness plan or they were not sure. When asked if they knew what the workplace plan was, only 23.1% said yes.	Only 29% said yes.	Very few knew what work plan is.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Child's school or childcare site has emergency plan, know what it is	Critical lack of knowledge surrounding emergency plans of local schools. Many asked to describe children's school emergency plan listed limited or partial answer, such as "get under the desk" or "I don't know". Since family's safety is major concern, media campaign should give complete information about local schools' plans.	Few knew whether child's school had emergency plan due to language constraints.		53% said no. Most Latinos are young and have school-aged children. Most schools have emergency plans but parents not aware of these plans. Understanding school process is critical to parents. Schools can channel prevention information and emergency instructions via parent meetings at migrant education, Headstart, etc.	Majority reported that school did not have an emergency preparedness plan or they were not sure. When asked if they knew what the school plan was, only 32.7% said yes.	Only 20%	Very few knew if school had or what school plan is. Cites financial constraints, lack of language ability, and cultural belief that words have power and speaking about negative like an emergency will cause it to happen.
Family member's nursing home has emergency plan, know what it is							
Have medical provider, know how to contact in an emergency		Some have working knowledge of how to keep safe and healthy during avian or pan flu based on past experience with contagious diseases.			73.7% = Yes, 20.4% = No, and 5.9% = Not Sure.		Believe that being prepared not as important as having access to vaccines to survive avian/pan flu incident.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Know basic first aid			42% = yes; 58% = no		77.3% = Yes, 14.3% = No, 8.4% = Not Sure. Significant number know basic first aid, so can help each other in emergencies.	Only 34% said they could provide first aid.	Believe that being prepared not as important as having access to vaccines to survive avian/pan flu incident.
Know how to access safe water during emergency?			49% = yes; 51% = no	Emergency materials (water, flashlight, etc.) at your house: 42% = yes; 27% = no because haven't thought of it; 20% = no because don't have money.	Need containers for water storage as well as access.		
Have out-of-state emergency contact?			43% = yes; 57% = no				
Survive in home without outside help for 3 days?			64% = yes; 36% = no		Need assistance with caring for vulnerable Elders that may be living in the home.		

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Survive on own for 3 days if had to leave your home	Majority need education, training, information and a plan (e.g., community gatherings and planning meetings, community drills, a community plan/system in place for disasters, first aid classes, and awareness training/announcements.) Need more resources and funds to assist in community disaster planning, disaster kits and resources to purchase emergency items.	Many have skills to create shelters, produce food and obtain money for surviving aftermath of an emergency.	62% = yes; 38% = no.				

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Recom-mendations	County, city and state need to engage/build confidence with community on broad basis by expanding dialogue and supporting community plans for public emergencies. Create newsletter with general emergency info, community plans, how to prepare, where to get training, local organizations that provide assistance, etc. Offer CPR, trainings and drills for the community. Gather more information from communities and involve them in solutions. Create and establish better relationships with police, hospitals and others who are instrumental in emergency situations.	Unify to develop emergency resources, build trust by learning about African cultures, and including them in efforts. African Mutual Aid Associations are learning to be non-profit, want stronger leadership and intra-community collaborations so trainings and planning programs should contribute to leadership's growth and capacity-building. Promote/Support/Train Leaders to be messengers and give information back to response organization. More research. Prioritize rural residents, mentally ill, homebound, children. More minority health planners, administrators, and policy makers and funds for growing refugee/immigrant populations.		Use community input to enrich translated (into Spanish, other native languages) materials and tailor community education. Train at grassroots level and offer trainings on weekends or weekday evenings. Create family emergency plans during home visits. Develop basic supply kits to complement training/education. Use regional Spanish radio stations (increasing in number and popularity); some have community-focused prevention/health programming. Involve police/fire so community feels comfortable with them. Teach/practice different levels/kinds of emergencies: earthquakes, tsunamis, etc.; how to prepare for each and what skills are universal. Affordable housing for Latinos and other minority populations are good settings to practice drills.	In a pan flu, additional staff may be needed to answer phone calls at the clinic and field questions from patients and the general community during extended evening hours. An Advise Nurse could be available during and after normal clinic hours to provide information and emotional support. Community education and individual consultation to develop Family Emergency Preparedness plans would be a proactive measure before an emergency occurs. A variety of culturally-specific education materials could be developed, printed and distributed in the community.		Build unified effort around resources and collaborations with agencies and organizations to reduce duplication and waste, increase numbers of interpreters and community health workers, etc.

Special considerations that might affect community's ability to respond appropriately in an emergency

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese
Cultural		Believe that planning for emergencies is ineffective against inescapable destiny. Also strong reticence to talk of emergencies in refugee communities due to need to feel "safe" in their new home. Level of preparation tied to religious belief of afterlife plus belief that preparation is not as important as knowing how to live in aftermath.	Hospital or Health Center may be external to community and not a primary health resource for a family that uses Chinese or naturopathic medicine. For many elderly, disabled, retired, and unemployed Asian Americans, family, friends, and social contacts (resources within community) play larger role in health education.			The Russian-speaking population usually forms multifamily communities with church at center (walking distance). Evangelical Christians have large families (8-10 children). Non-church affiliated groups are isolated, communicate mostly with family, often learn English quicker and have stable employment if young (elderly don't learn English easily and are more vulnerable and have employment and transportation needs).	Social relationships in SE Asian communities are hierarchical. In families, usually based on birth order and sex. Outside families, rank determined by combination of factors such as age, sex, status, education, wealth, mediation skills, etc. Many believe that any benefit received becomes a reciprocal obligation and that merit is gained/lost through actions. Hmong and Mien are intensively clannish and put high trust in clan leaders to lead and make decisions for all. Hmong clan (21 in Region 1) members are considered to be brothers and sisters.
Financial	Financial constraints.	Financial constraints.			32.7% identifed financial constraints as barrier to seeking assistance. 54.4% identified lack of money as affecting ability to prepare for an emergency.	Limited finances, no savings or other financial resources.	Financial constraints.

Special considerations that might affect community's ability to respond appropriately in an emergency

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese
Income from jobs						No paycheck means poverty, unless one is a senior who receives income from social assistance.	
Lack of storage space					34.2% cited lack of space to store things as affecting ability to prepare for emergency.		

Special considerations that might affect community's ability to respond appropriately in an emergency

	African Americans (AAHC)	**African immigrants and refugees (ACCO)**	**Chinese, Korean (AHSC)**	**Hispanic population (Latino Collaborative)**	**Native Americans (NARA)**	**Russian-speaking population (EMO/ROSS)**	**Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese**
Lack of awareness; Know where to get emergency information	51% would listen to friends or family members, followed by police (50%), public official (47%) and primary healthcare provider (30%). Family and friends topping the list isn't surprising, given that word-of-mouth is powerful communication tool in community. Interesting note: community identified police as second choice despite repeated confirmations that they distrust police (e.g., some are afraid police would shoot them). Is police second choice because they lack choices for help and support?	Differing definitions/meanings of "prepared" and how "prepared" is translated into major African languages are due to cultural/linguistic differences. Offer periodic, non-alarmist, culturally appropriate workshops and community outreach programs: practical information in short format (i.e., 20-minute DVD, easy-to-read visually-based brochure, etc.); as part of a community meeting; include meal, provide childcare, etc. Longer trainings for key community members.	52% = yes; 48% = no. Most would get information from family members.		24.8% do not know how to develop an emergency preparedness plan.		Very few currently know how to keep safe and healthy during an avian or pan flu incident. Offer periodic, non-alarmist, culturally appropriate workshops and community outreach programs: practical information in short format (i.e., 20-minute DVD, easy-to-read visually-based brochure, etc.); as part of a community meeting; include meal, provide childcare, etc. Longer trainings for key community members.

Special considerations that might affect community's ability to respond appropriately in an emergency

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese
Other Barriers	Lack of a organized and widespread community education and media campaign to prepare African American community. Need to disseminate emergency information, well-designed and culturally appealing brochures, community safety plans and resources via churches, TV and Oregonian newspaper and other widely-read community media (e.g., Skanner and Observer).	African refugee group includes many diverse subgroups, each with their own culture, language, etc. Many travel home at least once every 2-5 years; strong ties to home countries. Each community has special populations (e.g., elderly and those with mental and emotional health issues, illiterate, children under five years old) that have even more limited access to info centers.			Intersecting issues of race and poverty in the US, a mistrust of government, and a strong concern about family (that might impede compliance with quarantine and other social measures).		Past refugee and immigrant experiences can trigger additional mental and emotional responses that result in additional barriers to receiving emergency preparedness training and/or information. Each community has special populations (e.g., elderly and those with mental and emotional health issues) that have even more limited access to information centers.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Short duration of project		Short duration of project necessitated that information gathered be used as preliminary guide to more in-depth work with targeted populations. Information was gathered from small though knowledgeable and credible group of key community leaders and members. Special subgroups (e.g., mentally ill, disabled, homebound, sub-ethnic/religious groups) not actively assessed although seniors and youth were sought.	625 surveys collected in 1-1/2 months, but could have clarified some survey responses if had more time.	Windshield tour through four counties (Clatsop, Columbia, Tillamook and Washington) because Latino CBOs involved in project did not have programmatic activity in these counties prior to this project and needed to quickly establish new relationships. Meetings with key informants in remaining two counties (Multnomah and Clackamas) were scheduled following windshield tour. The six counties in HRSA Region 1 were too much to cover in the short length of the project to be more than superficial.		Due to time constraint, the assessment sampled EMO/ROSS's social service clients and was not reflective of the size and distribution of the wider Russian-speaking population in HRSA Region 1.	Dynamic populations; surveys are snapshot of populations at one point in time. Generalizations should be continuously verified due to varying levels of acculturation and integration.

	African Americans (AAHC)	African immigrants and refugees (ACCO)	Chinese, Korean (AHSC)	Hispanic population (Latino Collaborative)	Native Americans (NARA)	Russian-speaking population (EMO/ROSS)	Southeast Asian: Cambodian, Hmong, Lao, Mien, Vietnamese (IRCO)
Population assessed	115 African Americans or African immigrants or refugees: 26% men and 74% women; 27% 31-40 yrs. old, 24% 0-18, 22% 41-50, 12% 19-30, and 12% 50-64; 46% married, 40% single, 12% divorced, 2% widowed; 58% live in NE and 21% live in N Portland, bringing total percentage living in N/NE Portland to 79% .	2005 American Community Census Survey ranks Oregon 42nd in number of Black/African Americans. Of Oregon's total population, "Black/African Americans" total 1.6% of population or 58,309. IRCO focused survey work in Clackamas, Multnomah and Washington Counties because of high concentration of target groups; census data not available for African ethnic groups at county level. Local community expert sources gave population numbers as 17,000 for entire African community.	Nearly 100% of English surveys were completed by individuals bilingual in Chinese or Korean. In Oregon, there are over 20,000 Chinese and over 12,000 Koreans.	Latino population in Oregon has doubled in last 10 years with 42% of population living in tri-county Portland Metro area. This growth mirrors that of Latinos across country and reflects population of fairly new immigrants from many Latin American countries, especially rural Mexico. Percentage of Latinos/Hispanics in Region 1 counties varies from 2.5% to 11.5 percent. Survey participants had lived in Oregon for varying lengths of time: 11% less than one year; 37% 1-5 years; 28% 6-10 years; and 23% more than 10 years. 93% of survey participants were between 19-45 years old: 24% 19-25; 46% 26-35; 23% 36-45.	Married couples and parents more connected with social support systems, e.g., extended family, schools and social service agencies. Single 60%; Married 28.3%; Divorced 11.7%; One to Five Children 28%. Adults in home: One 27.8%; Two 20.1%; Three 12.5%; Four 12.5%; Five 8.3%; Six 18.1%; Age 50+ 37.4%; Disabled 6.4%; Caring for a disabled person in the home 7.0%.	Average age = 51.4 (average age in population is significantly lower); isolated, most difficult to reach, vulnerable.	Oregon and Washington have 5th largest population of Asians in U.S. Unfortunately, US census only delineates Chinese, Filipino, Korean, Japanese and Vietnamese so national data is inclusive of all Asian groups; Asians are 5-6% of total pop. Population counts of Cambodian, Hmong, Lao, and Mien are from local community expert sources; in general, households average 5 people. Vietnamese (one of largest Asian groups in Oregon) have census count of nearly 19,000 (probably an under-count due to reluctance in completing census forms).

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Population not assessed		Special subgroups (e.g., mentally ill, disabled, homebound, sub-ethnic/religious groups) not actively assessed.	Chinese and Koreans outside of Multnomah and Washington counties were not assessed.	Implementation plan was created in consultation with key informants. Used existing groups rather than new recruitment for convenience and to maximize ease of educational follow-up with participants. Existing groups also better positioned to provide organized response and support to communication efforts during emergency. Majority of survey and focus group participants were affiliated with community colleges, churches and programs run by social/health agencies.		Employed middle-aged men who often make decisions were not assessed.	Very few in rural counties of Clatsop, Columbia and Tillamook, so only assessed urban populations in Clackamas, Multnomah, and Washington counties.
Education needed		Do not pay much attention to written surveys and emergency preparedness materials. Some, because of experiences that led to becoming refugees, are unable to mentally and/or emotionally handle planning for emergency in the place they think of as “safe.” Others, because of acculturation issues, have more immediate concerns and survival goals.	Emergency information printed or broadcast in Chinese and Korean and offering emergency kits would help make them feel more prepared. Disaster training and preparedness seminars would also help.	Outlying counties (Clatsop, Columbia, Tillamook and Washington) need to pick up where Latino Collaborative's efforts left off due to time constraints. Develop additional educational materials and conduct more comprehensive educational outreach in Multnomah County.		1) Do not call 911 for information, only to help those in serious need/danger. 2) Increase awareness on how to provide first aid	Cultural differences in what “prepared” means to various communities. Education and training should be community-based. Include community members in planning and actual training.

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What can government or community do to help people access emergency and disaster information?		Many African refugees self-medicate to deal with past horrific traumas. Creating “safe places” are more difficult when asked about level of emergency preparedness in the place they are think of as “safe.” Adding a mental health component to periodic and culturally-appropriate training and community outreach programs is key to refugees seeing the value in being prepared for emergencies. Surveyed communities know how little they are prepared but attribute it to lack of access to any culturally appropriate emergency training.	Government can provide emergency information through TV, community centers or radio, either via a 24-hour information station or similar. Other suggestions: translate materials, host citizen information workshops, establish information phone line, offer free emergency/disaster kits, enlist Chinese and Korean volunteers, send information by mail.	Involve community leaders to agree to be available as contacts in their community in case of emergency (set up protocols for confidentiality during non-emergency periods). Enlist institutions (e.g., Latino serving churches, community based organizations, English as a Second Language (ESL) classes at local community college, etc.) to get involved in distributing emergency information and education to their communties.			Provide: Emergency Preparedness “sample” kits to community members for little/no cost; simple, concise text in targeted community language; DVD/Video-based information guides and examples; visually-based sources for low-literate; culturally-relevant examples and information; presentations that incorporate culturally-specific modes of messaging; annual test of community emergency contacts list.