THIRD EDITION

Cultural Awareness in Nursing and Health Care

An Introductory Text

Karen Holland

Routledge
Taylor & Francis Group

CULTURAL AWARENESS IN NURSING AND HEALTH CARE

This introductory textbook relates theory to practice and enhances students' learning and understanding of cultural issues that impact on patient care and their own practice as nurses, while considering wider social and political issues.

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- Mental health and culture;
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CULTURAL AWARENESS IN NURSING AND HEALTH CARE

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by Karen Holland

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Preface

This preface begins with sadness because my co-author, friend and colleague died on 6th January 2014. She was just 53 years old. As soon as she knew she was going to die we sat down together in a nice restaurant and considered our options with writing the third edition of this book, and who should now write her chapters. This was accompanied by some tears but also humour as Christine and I worked diligently over our lunch, turning from work to reflection on where we began with the ideas for a book of this kind, along with Christine's recollections during her doctorate study of what hairdressers and others believe mental health to be. Some interesting perceptions.

The history of the book as seen in the first edition stems from developing and teaching a transcultural nursing and healthcare module but without enough resources that focused on United Kingdom health and social care. We used ideas from our lecture notes (based on personal experience, and mainly US textbooks) together with personal narratives of our students from different cultures to help us on that first book. We were so grateful to ARNOLD, the first publisher we had, for taking a risk on what was then a relatively unknown area in UK books. Four of us were also fortunate to receive an award from the university's teaching and learning scheme to support us in developing additional material for students undertaking a Cultural Awareness Module using problem-based learning. This was an incredible leap forward for all of us in learning about different cultures, in particular from our own students. It was a wonderful development opportunity.

It was the beginning of our journey to support students and practitioners, mainly in nursing at the time, but we know from collaborative work we have both undertaken that the book has been used by others working within multicultural environments. I have special memories, for example, of working with the senior chaplain at a large teaching hospital supporting the development of their standards for cultural care. The book was their main resource at the time.

We built the contents of the book in various ways into our curriculum and we were especially pleased to be able to offer Cultural Awareness in Health Care as an option module in the 2010 curriculum following the Nursing and Midwifery Council review of the NMC standards for preregistration nursing (NMC, 2010). The book became a core text for us as well, and the university was able to offer the book as an e-book for students in any programme.

So to the book, how did we agree on a way forward? We both met with colleagues of Christine and I who had each volunteered to write a chapter on their own or together. It was a very difficult time for us and also for Christine but she and I worked on all the chapters and highlighted new things we now needed to add to them. The time after her death was very sad indeed but we had signed a contract to write the book and I slowly started the next stage of the journey on my own in terms of editing the book, but with fantastic and committed individuals who believed as we did in the importance of enhancing the knowledge base around cultural issues in their broadest sense.

Some of our book reviewers wanted more of a focus on race and ethnicity as a book but we have remained true to our original premise and ideas while ensuring that there is more integration

of these important issues throughout the chapters. I did, however, rewrite Chapter 13 based on reviewer feedback and I am very grateful for their insight and comments that have influenced the content.

The book, however, remains true to our belief that to support students and practitioners to care for patients and work with colleagues from different cultures, we begin by raising awareness of the overarching issues that we encounter in our daily practice and professional lives. The title therefore remains *Cultural Awareness in Nursing and Health Care*.

Chapter 1 remains as before where we explore the concepts of culture, race and ethnicity as they apply to health care and nursing. We have added new evidence throughout and especially from Australia and New Zealand.

The New Zealand Cultural Safety Standards are important and especially the definition of what is meant by cultural safety. Their definition of culture encompasses such areas as 'age or generation; gender; sexual orientation, occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief' (Nursing Council of New Zealand, 2011). It needs to be read in its entirety to fully appreciate its meaning for Maori health in nursing education and practice and resonates well with the chapters in this book.

Chapter 2 is now the chapter about cultural care: knowledge and skills for implementing in practice. This is a chapter where again we refer to the Cultural Safety in New Zealand and have added further evidence on nursing models and frameworks that can support patient and family care. There are seven in all and we have updated the evidence as appropriate as well as adding a new Model of Cultural Competence in this edition, namely the Campinha–Bacote Model of Cultural Competence. We have added a number of websites that have been tested as appropriate to obtain additional information on topics in this chapter. This can also be seen throughout the other chapters as an additional resource for the reader.

Chapter 3 focuses on the way care is affected by the religious beliefs and practices of patients and both their professional and lay carers. This chapter focuses mainly on religious beliefs but the importance of considering the spiritual beliefs of patients is also considered.

Chapter 4 focuses on the health and illness beliefs of people and how they impact on the way care is planned and delivered. It is linked directly to the content of **Chapter 5**, which then focuses on actual healthcare systems working together in practice, whilst taking into account the challenges health professionals face when trying to attain the best care for the person with different health beliefs. In both chapters there are case studies to explore care delivery issues and exercises for the reader to explore his or her own beliefs about health and illness.

As noted in the second edition, **Chapter 6** examines how nurses can ensure that the care they give to women from different cultures takes into account their personal needs and beliefs as well as being responsive to their role within those cultures. The addition of new website links to support the case studies and exercises in this chapter brings added value to the chapter due to their international range.

Chapter 7 focuses on men's health and has an added value through the inclusion of findings from a doctoral study by Muwafaq Al-Momani from Jordan. The study focuses on men's health problems related to erectile dysfunction and the way in which men seek help from health professionals. The chapter also considers the issue of men in nursing and a study by O'Connor (2015, p. 194) determines that we need to 'examine the relationship of nursing to gendered

concepts'. Other reported studies also look at this important issue of gender and vocationalism in the rationale for men choosing nursing as a career.

Chapter 8 has been revised and now takes a more detailed look at various health problems that may occur due to either genetic or cultural practices with regard to diet. There is an enhanced focus on the child and the young person, especially on issues such as menstruation and the wearing of different clothes and adornments.

Chapter 9 focuses on the older person and has also been revised but retains many of the exercises and a major case study that explores the nurses' actions when caring for an elderly Polish woman living in a warden-controlled home who has been admitted to the hospital. A personal narrative by one of the authors adds to our understanding of migration back to one's home country after living in the United Kingdom. A term 'cultural bereavement' is introduced for those groups of people 'who have experienced a permanent and traumatic loss of their familiar land and culture'. The issues around health and illness of older people from different cultures are managed by health and social care services.

Chapter 10 explores mental illness and its impact on the lives of people from different cultures. Issues such as 'culture-bound' syndromes and transcultural psychiatry are discussed as is the importance of communication across a variety of scenarios, including working with interpreters. Intercultural communication and discrimination of people from different cultures who have mental illness are also addressed.

Chapter 11 discusses many issues we are facing across the world in relation to migrants, refugees and asylum seekers. The different definitions attached to these terms will determine the kind of care that people are given, not just in health but in their new life and country, in general. The narratives and case studies throughout the chapter provide some insight into the issues impacting people's health and there are strong links to Chapter 10 concerning mental health issues facing these three groups of people as well as additional content regarding women's health and children and young people.

Chapter 12 address the issues facing those who face death, are dying and those experiencing grief because of their loss and how they manage it. This chapter links with Chapter 3 on religious beliefs and spirituality. There are examples from three main cultures which explore nursing practice and caring for the dying and bereaved.

Chapter 13 is a completely new chapter, although there are certain issues discussed from the second edition. The chapter focuses now on the workforce itself and the issues facing 'nursing and healthcare colleagues making every attempt to deliver culturally appropriate care in a constantly changing society'.

The main focus is on the health and social care services in the United Kingdom to illustrate the key issues facing multicultural teams caring for multicultural and diverse communities. The addition of new websites and YouTube examples on intercultural communication offers added value to ensuring the understanding of the importance of the different cultural beliefs and practices in the delivery of patient care.

In the appendices, we have retained the summary of religious beliefs and practices as they impact on individual care. They are not intended to be viewed as a 'recipe book' but as drawing together many of the issues identified throughout this text. We have also received positive feedback from people on how useful they were as brief guides to use in practice.

We also decided to retain the overview we had in the second edition which recognised that, in still taking a broader multicultural and not multiracial standpoint, we could be accused of not reflecting the importance of race in any meaningful way. However, this book makes reference to race as an important concept within care, as we recognise its importance as a key component of the nurse–patient relationship, patient–patient relationship and nurse–nurse relationship.

We also acknowledge that the way in which literature uses the phrases 'black and minority ethnic' and 'white' to define cultural groups could in fact indirectly exclude individuals in society who normally consider themselves to be 'white' but who are also members of a minority ethnic group (e.g. members of the Polish or Gypsy Traveller communities).

To ensure continuity and clarity of terminology, the word *patient* is used in the majority of the text. However, the word *client* is used in relation to mental health care, consistent with the literature in this area. For convenience, where the pronoun is necessary we have used 'she' to refer to the nurse, but this is not to disregard the fact that many nurses are men, as discussed in Chapter 7.

Each chapter concludes with a list of further reading which will enhance the reader's understanding of the issues discussed, as well as a list of relevant websites for additional resources. Throughout the book we have endeavoured to ensure that the text is referenced to supporting literature, reflecting our recognition and belief that practice needs to be evidence-based. However, this has not always been possible due to the dearth of material in nursing literature that reflects the issues we have chosen to discuss, in particular, research studies related to nursing practice and cultural issues. The whole text is a reflection of our own ideas, values and interpretations of events, and not those of the publishers. We have made every attempt to ensure that these have been represented and dealt with sensitively.

Karen Holland and
Christine Hogg

Acknowledgements

As with the first and second editions, we wish to offer our thanks to a number of people who have given us their support throughout the writing of this book.

I begin, however, by thanking all those who have both read and purchased copies of our first two editions and for all the helpful feedback we have received over the past 15 years since its publication. This has been gratefully received and used to update the book as much as possible. We are aware that many of those who have read chapters applicable to their work have been enabled to change their practice as a result. This has made us believe that another edition was necessary in order to enhance, whenever possible, the evidence-base for their practice.

My personal thanks first go to Debbie, Elizabeth, Shelly, Naomi, Moira and Angela who agreed with Christine to continue the work she began on her chapters. They have been brilliant and have really engaged with the task of updating and rewriting chapters to bring them up to date. I cannot thank them enough for stepping in and helping us both at such a distressful time. Thanks also to Muwafaq and Prem for their personal experience contributions and sharing with our readers.

At Hodder Arnold we wish to thank Naomi Wilkinson (Commissioning Editor) for commissioning this third edition and for her support for the new chapters, and Grace McInnes (Senior Editor, Health & Social Care) at Routledge for her ongoing patience and caring approach when all of us as authors of this book were grieving for a dear friend and colleague but who were committed to ensure that the work Christine and I began would be continued. Latterly, we have had the support of Carolina Antunes (Editorial Assistant) to whom I am very grateful for being kept to strict deadlines in order to get this book to final publication. Additional thanks go to Linda Leggio (Production Editor) and her team for the overall support with this stage of the book, and finally to Arun from NovaTechset for his amazing patience and management of the editing and proof-checking process for this book.

My other acknowledgements must go to Christine's family, all of whom were supportive of us writing this book initially and continued to support our endeavor in pursuing her special area of interest and beliefs. My personal acknowledgement goes to my husband, Terry, who knows how much this book meant to both Christine and I and when she died gave me both emotional and practical support in dealing with my own grief initially and then focusing me on editing this book.

Foreword

Cultural awareness is about connecting with people. This book open doors as to how we as nurses and health care providers work with people in multicultural environments – who have religious beliefs, languages and backgrounds different to those of the health care provider.

As nurses, we meet and engage with people from all walks of life and cultures in our practice. Health care can be compromised if the health care provider is not able to appreciate and respect the patient's background, language, religious beliefs and culture. Nursing is a complex ever-changing profession and there are numerous influences on the quality of care that the nurses provide. High-quality patient care has been the aim of nursing curricula since the time of Florence Nightingale. It was her belief that the practice of nursing should not be limited by gender, spiritual beliefs or values, and I have no doubt that in today's world she would also have added culture.

The authors are passionate about creating bridges between nurses and health care professionals and persons of different cultures for whom they care. They have explored cultural traditions from across the world and contextualised these for local health care; the book will, however, also be a good resource for international readers. The theoretical basis of the book is clearly articulated and the evidenced-based approach enables the student to further explore aspects of particular interest.

This new edition of the book takes into account our rapidly changing, multicultural society. Challenges of culturally sensitive and competent health care, in a society in which our patients come from many different ethnic, language, cultural and religious backgrounds, require that nurses have not only the knowledge, but the skills and attitudes to competently care for their patients. The information in this book has been carefully chosen, and is enhanced by the practical examples and references to updated policy and legislation. Each chapter sets the scene for the content, identifies key learning points and includes case studies and reflective exercises which encourage the reader to reflect on his/her own experiences and translate the concepts into practice.

What is particularly unique about this book is the journey that the reader travels as he/she explores each of the chapters. We journey through the developmental stages of life, consider the particular cultural communication and care needs of vulnerable groups, and are encouraged to reflect on our own values, cultures and beliefs, and practice as we do so.

Whether a nursing student, experienced nurse or from another health discipline, this book will be a resource for promoting culturally sensitive communication between health care provider and patient, and facilitate decisions regarding planning and implementation of quality care.

The ability to 'cross the bridge' of cultural and other differences in communicating with and caring for our patients, and in so doing making a real connection is surely one of the great privileges of being a nurse. This book provides the resource for nurses to be able to do just that.

On a personal note, it has been a special privilege to be asked to write this foreword. I met both authors some years ago at a NET (Networking in Healthcare Education) conference, have valued them as colleagues, and visited and stayed with Christine and her family. The commitment of the

co-author and her colleagues to complete this project is an acknowledgement of the significance of her work. Her passion and work lives on in this new edition.

Pat Mayers (D.Phil)
Emeritus Associate Professor, Division of Nursing and Midwifery,
University of Cape Town

Contributors

Shelly Allen
University of Salford
Manchester, United Kingdom

Muwafaq Al-Momani
Al-Hussein Bin Talal University
Ma'an, Jordan

Elizabeth Collier
University of Salford
Manchester, United Kingdom

Prem Conhye
Greater Manchester Mental Health NHS Foundation Trust
Manchester, United Kingdom

Angela Darvill
University of Huddersfield
Huddersfield, United Kingdom

Debbie Fallon
University of Manchester
Manchester, United Kingdom

Karen Holland
School of Nursing
University of Salford
Manchester, United Kingdom

Moira McLoughlin
University of Salford
Manchester, United Kingdom

Naomi Sharples
Edge Hill University
Ormskirk, United Kingdom

CHAPTER 1

Culture, race and ethnicity: Exploring the concepts

Karen Holland

INTRODUCTION

This chapter aims to explore and discuss the concepts of culture, race and ethnicity. These three concepts are found being discussed in various ways in the media, government and health policies and in the literature generally. Consideration of their individual meaning as well as their application and interpretation within nursing and healthcare practice will then enable the reader to understand some of the underpinning issues throughout the book.

This chapter will focus on the following issues:

- Cultural care in context
- The meaning of culture
- The meaning of race
- The meaning of ethnicity
- Culture, race and ethnicity in nursing and health care

CULTURAL CARE IN CONTEXT

Nurses have been advised in the past that the needs of different cultural groups were not being catered to (Chevannes, 1997; La Var, 1998), and that there was a need to ensure that healthcare practitioners are suitably prepared to cater to these needs (Gerrish et al., 1996). However, as noted in the first edition of this book in 2000, there remains very little specific guidance offered by the statutory and professional bodies on how to make these recommendations a reality within healthcare practice and nurse education. The publication of the English National Board research report (Iganski et al., 1998) on the recruitment of minority ethnic groups into nursing, midwifery, and health visiting was an example of the evidence clearly indicating a need for a national policy. The Department of Health in the United Kingdom began this cultural change in health care by ensuring that National Health Service (NHS) Trusts adhered to Patients' Charter standards with regard to privacy, dignity, and religious and cultural beliefs (Department of Health, 1992), and in 2009 published guidance for NHS organizations on how to manage the issue of belief and

religion in order 'to implement and comply with the requirements of legislation on religion or belief enacted recently', and also provided general practical guidance around the issues that fall out of that for the NHS (Department of Health, 2009).

However, despite the increase in information and research concerned with ensuring that the culture and religious beliefs of patients and clients are considered in health care and nursing, there remains a distinct lack of evidence on what is available to help us to achieve this. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992 Code of Professional Practice set out for nurses, midwives and health visitors how they were expected to relate to the general public in the course of their work. It stated the need to:

> **Recognize and respect the uniqueness and dignity of each patient and client and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor[.]**
>
> *(UKCC, 1992)*

The updated Nursing and Midwifery Council (NMC) professional code (*The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives*, 2008), however, no longer made this an explicit issue as in 1992 but an implied one, where ensuring that the specific needs of individuals is met is an accepted part of ensuring that nurses 'make the care of people your first concern, treating them as individuals and respecting their dignity'. For example, it states that as nurses we 'must not discriminate in any way against those in your care'.

The new Code (NMC, 2015) can be downloaded at (https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf). Here is an example from the revised Code, which can be seen to reflect the need for understanding cultural diversity and equality of care:

Section: Practice effectively

> ***7 Communicate clearly***
>
> **To achieve this, you must:**
>
> **7.1 Use terms that people in your care, colleagues and the public can understand**
> **7.2 Take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs**
> **7.3 Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs**
> **7.4 Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum, and**
> **7.5 Be able to communicate clearly and effectively in English. (p. 8)**

This remains a holistic approach that ensures that nurses care for people as individuals irrespective of their culture, which is essential in today's multicultural UK society. However, to ensure that student nurses become not only culturally aware but demonstrate knowledge about different cultural groups so as not to discriminate requires a much more focused Standard as per the UKCC (1992) one.

The new NMC (2010) Standards for Pre-Registration Nursing also offer a broad approach for student nurses to achieve in practice:

> **Generic Standard for Competence: Domain 3: Nursing practice and decision-making**
>
> **All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.**
>
> *(NMC, 2010, p. 44)*

It is left up to curriculum development teams including practitioners, students and service users to interpret this competence statement, which as can be seen includes understanding culture and how it impacts on health and illness.

Reflective exercise

Consider the NMC (2010) statement above and plan at least two Learning Outcomes or Goals for your next practice placement on how you are going to ensure that you can identify how culture (as well as the other concepts defined) impacts on health and illness and how you intend to demonstrate this for your mentor in clinical practice.

The Australian Code of Professional Conduct (2008), unlike its UK counterpart, has retained a more explicit Conduct statement: 'Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues' (4) and offers four explanatory statements as to how this is visualized (see Box 1.1).

Box 1.1 Conduct statement 4: Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues

Explanation

1. In planning and providing effective nursing care, nurses uphold the standards of culturally informed and competent care. This includes according due respect and consideration to the cultural knowledge, values, beliefs, personal wishes and decisions of the persons being cared for as well as those of their partners, family members and other members of their nominated social network. Nurses acknowledge the changing nature of families and recognize families can be constituted in a variety of ways.
2. Nurses promote and protect the interests of people receiving treatment and care. This includes taking appropriate action to ensure that the safety and quality of their care is not compromised because of harmful prejudicial attitudes about race, culture, ethnicity, gender, sexuality, age, religion, spirituality, political, social or health status, lifestyle or other human factors.

continued

Box 1.1 Conduct statement 4: Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues (continued)

3. Nurses refrain from expressing racist, sexist, homophobic, ageist and other prejudicial and discriminatory attitudes and behaviours toward colleagues, co-workers, persons in their care and their partners, family and friends. Nurses take appropriate action when observing any such prejudicial and discriminatory attitudes and behaviours, whether by staff, people receiving treatment and care or visitors, in nursing and related areas of health and aged care.

4. In making professional judgements in relation to a person's interests and rights, nurses do not contravene the law or breach the human rights of any person, including those deemed stateless such as refugees, asylum seekers and detainees.

From *Code of Professional Conduct for Nurses in Australia* (Australian Nursing & Midwifery Council 2008: Rebranded in 2013 but Code is unchanged)

From this we can see very clearly what those involved in the education of student nurses would be able to promote in the undergraduate curricula and this incorporates a clear statement in Point 4 around the vulnerable group that we have now included in Chapter 11.

A major report published in New South Wales, Australia, was a National Review of Nursing Education, with one element focusing specifically on multicultural nursing education (Eisenbruch, 2001). The conclusion from the review was that, at least in Australia, 'nursing has embedded within it a notion of multiculturalism which is both new and old'. Omeri and Raymond (2009) discuss how some of the population changes since 2001, however, have created new challenges for nurses and healthcare services generally so that new ways of supporting culturally diverse populations have to be developed. Cultural competency frameworks for care delivery (see Chapter 2) is one such development.

The Australian government also worked with the health professions (National Health and Medical Research Council, 2006) to produce a guide to ensuring cultural competence: Cultural competency in health: A guide for policy, partnerships and participation (access this at: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/hp19.pdf).

In the United Kingdom this approach to multiprofessional cultural competency is not as clear, and Lauder et al. (2008) in their report on the evaluation of pre-registration nursing and midwifery programmes in Scotland found that there was generally an exposure to cultural issues rather than any development of competency and, again, this was variable across the education providers. This raised the issue of how students were both prepared for, and experienced, meeting the needs of a multicultural community in any one of the four UK countries, namely England, Scotland, Wales and Northern Ireland.

New Zealand nurses, however, have a very different experience to these countries because multicultural nursing care is not only part of general health care of the community but there is also a specific set of standards called the Cultural Safety competencies which they have to achieve and then adhere to as qualified nurses. These can be accessed at the Nursing Council of New Zealand website, along with other linked policies: http://nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses.

EXERCISE

Consider your own learning experiences either as a student nurse or a healthcare professional and, focusing on one encounter with someone from a different culture to yours, decide what you would have liked to know about their culture which would have helped you to manage their care differently. Use the definition of cultural safety in Box 1.2 for an overarching topic; for example, an issue relating to gender or sexual orientation. When you have undertaken that task, read one of the chapters or appendices that can offer an insight into that specific culture.

Box 1.2 Cultural safety definition from Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011)

Cultural safety

Cultural safety relates to the experience of the recipient of nursing service and extends beyond cultural awareness and cultural sensitivity. It provides consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. It also enables them to participate in changing any negatively perceived or experienced service. The Council's definition of cultural safety is:

The effective nursing practice of a person or family from another culture, is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

The outcomes of research studies (Iganski et al., 1998; Beavan, 2006) and initiatives from health and social care services focusing on meeting the needs of diverse communities in the United Kingdom and other countries is essential to supporting the implementation of professional recommendations, but first there is a need for a common understanding and appreciation of the issues to be addressed.

One of the important factors influencing decisions about the needs of multicultural groups is that there is a shared understanding of different cultural backgrounds. This involves understanding the use of language and terminology related to care. In the literature, three terms are frequently used in discussion about cultural care practices, namely culture, race and ethnicity. An understanding of the meaning of these terms in relation to health care is the focus of this chapter.

However, Baxter (1997) cautions us about using the terms 'culture' and 'multicultural', in that such usage ignores issues of race and 'does not provide an adequate explanation of how racial discrimination arises or how it can be addressed'. While this is acknowledged, we have

observed when teaching that if the broad cultural issues are explored first and students are clear about the background of different cultural groups (e.g. in terms of lifestyle and beliefs), then the subsequent teaching and discussion of issues related to race and racism become easier and less confrontational because the student has a clear and safe framework within which to explore his or her own views and experiences. This view is unchanged since the first edition of this book. Giving students and practitioners a good foundation of understanding the needs and practices of different cultural groups can enable situations which could be considered discriminatory to be managed differently. One of the most important aspects of ensuring the needs of all patients is effective communication underpinned by an understanding of potential differences which could impact the nurse–patient relationship (Jirwe et al., 2010; Durey et al., 2011; Taylor et al., 2013; NMC, 2015).

Each chapter in this book will give both student and teacher the opportunity to begin a reflective learning process in order to bring about change in their own beliefs and practice, and in addition to begin to influence that change in others. To enable them to begin this reflection and learning, it is essential to understand the meaning of the major terms and concepts we shall be exploring and using throughout this book.

THE MEANING OF CULTURE

The terms culture, race and ethnicity are often confused in their interpretation by healthcare professionals and the public in general. In order to determine what is meant by culture, let us examine the following definitions:

> **Culture is … a complex whole, which includes knowledge, beliefs, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.**
>
> *(Tylor, 1871, cited in Leininger, 1978b, p. 491)*

> **Culture is the learned and transmitted knowledge about a particular culture with its values, beliefs, rules of behaviour and lifestyle practices that guides a designated group in their thinking and actions in patterned ways.**
>
> *(Leininger, 1978b, p. 491)*

> **Culture is … a set of guidelines (both explicit and implicit) … that an individual inherits as a member of a particular society and that tell them how to view the world and learn how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces and gods and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual. To some extent, culture can be seen as an inherited 'lens' through which the individual perceives and understands the world that he inhabits and learns how to live within it.**
>
> *(Helman, 2007, p. 2)*

There appears to be agreement in these definitions that culture is an inherited or learned set of guidelines through which we come to know how to live in our own social group or within society.

Henley and Schott (1999, p. 3) point out that culture is 'not genetically inherited', nor is it 'fixed or static', but in fact 'changes in response to new situations and pressures' (Jirwe et al., 2010).

Andrews and Boyle (2012) viewed culture as having the following four main characteristics:

1. **It is learned from birth through the process of language acquisition and socialization. From society's viewpoint, socialization is the way culture is transmitted and the individual is fitted into the group's organized way of life.**
2. **It is shared by all members of the same cultural group: in fact, it is the sharing of cultural beliefs and patterns that binds people together under one identity as a group (even though this is not always a conscious process).**
3. **It is an adaptation to specific activities related to environmental and technical factors and to the availability of natural resources.**
4. **It is a dynamic, ever-changing process.**

(Andrews and Boyle, 2012, p. 10)

Different cultures have established values and norms that govern how individuals communicate with one another and how they behave towards each other. All societies have 'norms' that guide the ways in which individuals do this, and they can be either rewarded or punished as they conform to, or deviate from, the established norm. Our culture therefore determines the pattern in which we undertake both roles and responsibilities related to family, friends and the workplace.

For example, nurses have their own professional and social culture and student nurses learn through gaining experience in different types of practice placements and establishing what knowledge and skills are essential in order to 'survive' in that culture. So, student nurses have to know how to behave when in uniform and what is expected of them when they are working on a ward. Holland (1993) found that there were aspects of nurses' culture, such as the order in which they carried out their work, which had remained unchanged since Florence Nightingale's day. She also found that there were many rituals that were important in ensuring that everyone, including the patients, knew what to do in hospitals. One of the most important rituals was that of the handover report, when information was communicated by nurses about the patients and their care. Other researchers have also found rituals associated with nursing culture (Wolf, 1988; Street, 1992; Kaminski, 2006), including the handover (Strange, 1996; Philpin, 2006).

De Santis (1994) stated that when patients and nurses meet one another, there is in fact a meeting of three cultures:

1. The *nurse's own professional culture*, with its beliefs, values and practices;
2. The *patient's culture*, based on the patient's life experiences of health and illness and their personal values, beliefs and practices;
3. The *culture of the setting* in which they meet (e.g. hospital, community or family setting).

If we can understand that these cultures exist when we are communicating with patients, this will enable us to begin to understand some of the actual and potential problems that may arise when assessing, planning and implementing care.

One other culture that De Santis (1994) did not account for, and which can have a substantial effect on the nurse–patient relationship, is that of the nurse's. For example, if the nurse is a Muslim and is caring for a Muslim patient (male or female) there may well be an occasion for conflict where body care or personal preference is concerned. In some situations, the student nurse may be asked to interpret for the patient as he or she speaks that particular language. However, this is not always viewed positively by students, especially if they are asked frequently to undertake this role:

> **I didn't mind doing this [interpreting] for patients, as it saved time and helped them straight away – and I can speak four different languages, which, of course, was even more useful. But I found I was being asked to do it on other wards as well and it was not helping me to make sure I met my learning objectives on my ward.**
>
> *(Adult nurse student, Year 1)*

Consider the following Case Study, which explains this meeting of cultures as explained by De Santis (1994) (Box 1.3).

Box 1.3 Patient case study

Mr Mohamed Kalhid Quereshi, a 68-year-old Muslim man, is admitted to a large district general hospital after having been seen by the consultant in the diabetic clinic of the outpatients department. He has been admitted with glycosuria (sugar in the urine).

The first 'culture' he meets is that of the *hospital (organizational culture).* His previous experience of hospitals will determine his behaviour and his understanding of all that is taking place. If it is his first visit, he is immediately faced (like anyone coming into hospital) with the dilemma of where he has to go. The signs on the doors and walls will not necessarily be familiar. If it is a hospital that acknowledges the needs of a multicultural society, the signs will at least be in different languages, but it would be incorrect to assume that he can actually read these.

Walking through the hospital, this patient will encounter many different individuals in different uniforms of different colours. On reaching the outpatients department, again there will be an array of signs for different departments (e.g. Orthopaedic, ENT, CT Scan, Diabetic Clinic). To those who work in the hospital, these signs will be familiar as they have been learned and they are part of the hospital culture. However, to Mr Quereshi, even in his own language their meaning may not be readily understood unless he is familiar with the cultural language of the hospital. At this stage he may begin to experience what Herberg (1995) has termed 'culture shock'. This is similar to what happens when one travels to a different country and for the first few days everything is very strange or alien. People are also uncertain how to behave in such new environments (Burnard and Gill, 2008).

The second culture Mr Quereshi may encounter is that of the *nurse (nursing culture)*, who may ask him for 'his sample' and who may, if she does not receive a response, hand

continued

Box 1.3 Patient case study (continued)

him a container and ask him to go to the toilet and 'bring the sample back'. Here the nurse is assuming that the patient understands the terminology and the language used by healthcare professionals and which is specific to them. New student nurses may experience a similar situation to Mr Quereshi when, for example, listening to a handover report for the first time, with phrases such as 'nil by mouth', 'in situ', 'doing the obs', 'he's crashed' and 'she's not p.u.'d yet' being commonplace.

The patient's own cultural and individual beliefs (*patient culture*) about their body and how it works may also be completely different from those of the healthcare professionals. Mr Quereshi may believe that his diabetes has nothing to do with passing urine, and he may therefore wonder why he has to give this sample to the nurse. He may find that the toilet does not have adequate washing facilities for his personal needs, further increasing his anxiety and concern.

To be able to understand and manage these cultural encounters effectively, the nurse and other healthcare professionals must have the appropriate knowledge and skills. In order to determine your own needs in relation to ensuring culturally appropriate care, consider the issues with regard to Mr Quereshi's encounters with health care.

Reflective exercise

Imagine that Mr Quereshi is a patient on your ward. You are to be his named nurse and have to undertake an assessment of his needs on admission to the hospital.

1. What will you need to know about his admission to the hospital from the outpatients department?
2. How will you ensure that he understands the role of the nurse and other healthcare workers who will be caring for him?
3. What knowledge of his culture will you need in order to ensure that the assessment of his needs is culturally appropriate?

Your responses may have considered the following issues with regard to the three cultures identified by De Santis (1994).

Organizational culture

Organizations such as NHS Trusts have equality and diversity policies which ensure that all patients, regardless of culture, are afforded equal care. (See Chapter 13.)

(Check the NHS England website for further information and access to the Equality Act 2010: http://www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-the-NHS.aspx.)

For example, any information that is given to Mr Quereshi about his admission to hospital should be provided in his own language as well as in English. We do not know if he speaks English as well as another language or if he speaks English minimally. However, whatever language he speaks mainly, we cannot assume that he is able to read. This is important to recognize for any patient regardless of their main spoken language. This could be a language such as Bengali. (An example of a site for diabetic patients to access in many different languages about their condition is that of the Diabetic Association: http://www.diabetes.org.uk/Other_languages/Bengali/.)

In addition to written information, many hospitals employ the services of trained interpreters or link workers who offer a very valuable service to both health service staff and non–English-speaking clients. A study by Alexander et al. (2004) found that 'the role and practice of interpreters has become professionalized' (p. 60). They made the following observations:

> **As a crucial part of this professionalisation. There is increasing stress on codes or guidelines for standards of behavior and practice. These guidelines differ according to the various types of interpreters: linguistic interpreters, community/cultural interpreters, interpreter-advocates and so on. The linguistic model for example, is simply interpreting what is said, neither adding nor taking away, and is the primary model for work in the legal field. …In contrast the community and advocacy models are more likely to be found in the health and social care fields, for example informing a health visitor about the cultural issues involved in a client's situation. (p. 60)**

They also found that, regardless of which model was used, there 'are standards and ethics of good practice in which the interpreter needs to be trained and accredited and which need to be followed in order to provide a professional service' (p. 60). There still remained the untrained interpreters, mainly those from families and friends. These cause a number of problems, because of such practice as 'bias and distortion because of lack of language competence, especially knowledge of specialist terminology, inaccurate translation and mistranslation because of poor skills and also personal unsuitability and lack of confidentiality' (p. 61).

A study by Hadziabdic et al. (2014) exploring 'Arabic-speaking migrants' experiences of the use of interpreters in healthcare' identified the following issues which relate to those above and can also be seen as applying to many other different populations and cultural groups where inter-cultural communication in important situations becomes problematic:

> **The main findings were that the use of interpreters was experienced as both a possibility and as a problem. The preferred type of interpreters depended on the interpreters' dialect and ability to interpret correctly. Besides the professional interpreters' qualities of good skill in language and medical terminology, translation ability, and neutrality and objectivity, Arabic speaking participants stated that professional interpreters need to share the origin, religion, dialect, gender and political views as the patient in order to facilitate the interpreter issue and avoid inappropriate treatment. (p. 49)**

Mr Quereshi of course may or may not require the services of an interpreter to ensure that his admission to the hospital takes into account his cultural needs as well as his health needs. Recognizing some of the issues that could arise as stated in the above research will enable you to consider various options regarding the type of interpreter needed.

Reflective exercise

As a student nurse, have you ever been asked to interpret for a patient while in clinical practice?

1. If yes, reflect on the experience and consider how it affected your learning experience and the person you were interpreting for.
2. If no, consider how effective communication would be achieved without an interpreter being available for a patient unable to speak English.

Access the research studies mentioned in the previous Organisational Culture section to support your answer.

Nursing culture

As Mr Quereshi will usually be cared for by female nurses, he may find receiving care an embarrassing and uncomfortable experience. Being aware of his specific beliefs and needs as they relate to his Muslim culture will help nurses to interact with him in a sensitive manner. The way in which he relates to the nurses may also be influenced by his views about women and nursing. The role and status of nurses in some societies may be lower than those in the United Kingdom because of the links to beliefs about 'dirt and pollution' (Jervis, 2001). Lawler (1991) and Somjee (1991) cited the example of Indian nurses, where the touching of excreta is linked to low status and low caste in Indian society. Johnson (2011), in her study on professional identity, and nursing in India, also raises similar issues and again links nursing with evidence of a low status.

Nurses need to ensure that patients of all cultures understand their role in order to avoid misunderstanding.

Being cared for by nurses from his own culture would not necessarily help Mr Quereshi, even though communication on cultural needs would be an asset.

This is because the relationship between men and women in Muslim culture is very restrictive and to be cared for intimately by a Muslim female nurse might be more embarrassing than being cared for by a non-Muslim nurse.

Patient culture

Mr Quereshi is a Muslim man and, in order to ensure that his care is appropriate, the nurse must have an awareness of his specific cultural needs. For example, diet will be an important aspect of care, given that he has glycosuria (sugar in the urine) and may be diabetic. Any medicine he may be prescribed should be alcohol-free, and 'capsules should not contain gelatine' (Community Practice, 1993, p. 333). If he requires insulin, the human form would be prescribed, because pork is a prohibited food (Pennachio, 2005). A devout Muslim would need to be able to pray five times a day while in the hospital. This is essential to well-being, although illness does allow exemptions. If it were the time of Ramadhan, he would be required to fast in the hours between dawn and sunset. This may cause personal conflict because of the treatment for his diabetes. If he is a very devout Muslim, he may refuse to take anything at all into his body – 'through the mouth, the nose,

by injection or suppository between dawn and sunset' (Henley, 1982). The Holy Qur'an (Holy Koran) allows for flexibility, and if Muslims cannot fast at all 'they are permitted in the Qur'an to perform another virtuous act such as providing food for the poor' (Henley, 1982).

Wehebe-Alamah (2008) believes that it is important for nurses to understand the 'level of adherence to religious and cultural practices' that a patient undertakes, and that beliefs range from 'the very liberal to the extremely fundamentalist' and in particular that:

> **Knowledge of generic (folk) care practices that are common among Muslims is critical to providing culturally congruent care. (p. 85)**

Reflective exercise

Obtain a copy of the following articles and:

1. Consider their content in relation to understanding the cultural and religious beliefs of patients in your care.
2. How they can enable you to change your practice in relation to ensuring effective communication between you the nurse and the patient?
3. Discuss the articles with your colleagues and students in practice.
   - **a.** Wehebe-Alamah, H. 2008. Bridging generic and professional care practices for Muslim patients through use of Leininger's culture care modes. *Contemporary Nurse*, 28, 83–97.
   - **b.** Taylor, S. P., Niole, C. and Maguire, M. 2013. Cross-cultural communication barriers in healthcare. *Art & Science*, *Nursing Standard*, 27(31), 35–43.
   - **c.** Jirwe, M., Gerrish, K. and Emami, A. 2010. Student nurses' experiences of communication in cross-cultural care encounters. *Scandinavian Journal of Caring Studies*, 24, 436–444.

Key points

1. Culture is an inherited or learned set of guidelines which social groups use to live in wider society.
2. Different cultures have their own values and beliefs about health and health care.
3. Nurses have a different role and status according to how individual societies view their work and their gender.

THE MEANING OF RACE

There appears from the literature to be general agreement with regard to the definition of race. For example, Fernando (1991) defines race as 'a classification of people on the basis of physical appearance … with skin colour the most popular physical characteristic'.

Country of origin is also frequently used with this concept of race (e.g. African–Caribbean). However, race has not just been expressed in this way. Jones (1994) reminds us that in the past it was 'a way of dividing humankind which also denoted inferiority and superiority, which was linked to patterns of subordination and domination'. She cites colour as being a very important determinant in this classification, with 'black' people being defined as inferior and more primitive whereas 'white' people were viewed as superior. However, Cashmore (1988) pointed out that the main issue is not what 'race' is, but how the term is used. He states that nearly all social scientists, for example, use the term to define social groups according to their physical or bodily attributes, which are then linked to their social behaviour.

Because race has become such a crucial concept in health care generally, it is important to examine how theorists view it. This will also help us to understand why and how people adopt such different views about living in a multicultural society both generally and locally. Jones (1994) believed that there are two distinct theories of race, namely consensus (functionalist) theories and conflict theories. Consensus theories suggest that following an initial disruption of society by large numbers of immigrants, 'social consensus will be restored through resocialisation and integration' (Jones, 1994, p. 298). It is believed that any new social group, with its individual customs, will become no different from the rest of society, and that it is they who have the 'problem' not the majority culture. They become 'indistinguishable from the majority and integrate through mixing with the host society' (Jones, 1994), while not losing their cultural norms and values altogether. Another theory is one in which there is a more liberal view and acceptance of 'subcultures, norms and values, which are different but equal' (Jones, 1994). In communities that adopt this view, there may be a more open acceptance of other cultures (e.g. in regular multicultural religious services).

In contrast, conflict theories view race relationships as part of an ongoing struggle between the dominant and subordinate groups in society. This creates racial conflict where they experience racism, which, according to Dobson (1991), is 'a mixed form of prejudice (attitude) and discrimination (behaviour) directed at ethnic groups other than one's own'. This occurs at two different levels: 'individual and institutional' (Dobson, 1991).

An example of institutional racism can be seen in the recruitment of African–Caribbean women to enrolled nurse and pupil nurse training because the entry qualifications for SRN training were geared to UK education criteria and values (Jones, 1994; Culley and Mayor, 2001).

Fernando (1991) stresses that in any 'racist' society, the identification of individuals according to their race and ethnicity is not to be undertaken lightly, and he points out that they both carry 'racial' connotations. He stresses that simply renaming a racial group as 'ethnic' does not get rid of the racial persecution of that particular group.

Laird (2008, p. 5) discusses the difference between *street racism* and *institutional racism*, whereby 'the first consists of overt racism such as abusive language, criminal damage and physical assault – acts usually perpetuated in public spaces'.

Institutional racism she explains 'includes negative stereotyping of people from ethnic minorities, patronizing language or actions due to ignorance of a person's culture, the inequitable treatment of people from ethnic minorities and the failure to take into consideration an individual's cultural background' (p. 6).

Reflective exercise

1. Examine your own views with regard to how different cultural groups should live alongside one another.
2. How could these views affect your caring for people in both community and hospital settings?

To help you to explore your own views on this issue, consider the following scenario:

> **During attendance at a Summer School, a student is asked to share a room with a colleague who is Asian. Her reply is: 'I'm not racist but … I don't think that's a good idea. I'd rather share with an English colleague just in case there are any problems with food or something, like she may want to pray on her own'.**

The statement 'I'm not racist but' indicates that the student cannot be considered non-racist. The additional comment that she would prefer to share with an English colleague also indicates a view of culture and race that excludes members of minority ethnic communities as not being English – yet they may have been born in England.

These types of comments could be viewed as harmful if they intrude into the nurse–patient relationship. Nurses who hold such views could let them influence the way in which they deliver care. For example, if Mr Quereshi rang the nurse call bell, the response could be: 'I'm not racist but … you go and answer that; he doesn't make any effort to understand me so why should I go? You're better with him than I am'.

These are examples to help you to explore your views, and they are adapted from real situations. There are examples discussing some of these issues throughout the book.

Reflective exercise

1. Consider other situations where you have heard the phrase 'I'm not racist but …' and reflect on how you felt when you heard this.
2. What, given your reading of this chapter, do you believe was the cause of the speaker's statement?
3. What was the outcome?

Key points

1. The nurse has a responsibility to ensure that patients 'come to no harm' while in his or her care. This includes protecting them from racist behaviour by other patients and healthcare colleagues.
2. Racism can occur at both individual and organizational levels.
3. Racial discrimination and prejudice can prevent the implementation of equal opportunity policies.

THE MEANING OF ETHNICITY

Jones (1994) states that the term ethnicity:

> **…refers to cultural practices and attitudes that characterise a given group of people and distinguish it from other groups. The population group feels itself and is seen to be different by virtue of language, ancestry, religion, common interests and other shared cultural practices such as dietary habits or style of dress. Ethnic differences, in other words, are wholly learned – they are the result of socialisation and acculturation – not genetic inheritance.**
>
> *(Jones, 1994, p. 292)*

However, it is important to remember that in belonging to an ethnic group, each individual within that group must still be acknowledged. In addition, using the term 'ethnic' to describe differences between cultures has often led to discrimination and prejudice owing to differences in customs, dress and language. Baxter (1997) defines an ethnic group as:

> **a group of people who have certain background characteristics such as language, culture and religion in common; these provide the group with a distinct identity, as seen by themselves and others. Although the term also covers white people (ethnic majorities) and includes such groups as Greeks, Poles, Italians, Welsh and Irish, it is often used inaccurately to describe black or ethnic minority groups in Britain.**
>
> *(Baxter, 1997, p. xvii)*

From these two definitions we can see that belonging to an ethnic group will affect the way in which we communicate both verbally and visually with others. They also show that we all belong to an ethnic group.

POST – Parliamentary Office of Science and Technology (2007) noted that:

> **Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person's identity and how they seem to others. People identify with ethnic groups at many different levels. They may see themselves as British Asian, Indian, Punjabi and Glaswegian at different times and in different circumstances.**

However, the problem with using the terms 'race' and 'ethnicity' to differentiate between social groups is highlighted in a report published by the British Medical Association (BMA) in 1995 on the need for multicultural education for doctors and other healthcare professionals. The report considered that ethnicity has replaced 'race' as a health research definition but that it is 'a fluid variable; its meaning can change over time and the borderlines between groups are not clearly demarcated' (British Medical Association, 1995).

This is unlike race, which is related to physical attributes (Cashmore, 1988). The report concludes that this makes it very difficult to create an effective system for differentiating between groups in order to determine specific health needs. There are problems with any such classification system. A system that is based on racial categories fails to take into account the many individual and cultural differences between groups, and one that is based on ethnicity may not address specific issues about 'discrimination and equal opportunities' (British Medical

Association, 1995). From April 1995 it has been a mandatory requirement by the Department of Health that ethnic monitoring of inpatients takes place (Karmi, 1996). Previously this was undertaken mainly for 'employment practices' but it has now become increasingly important for monitoring health services (Department of Health, 2007). Karmi (1996) believed that:

> **…if properly implemented, ethnic monitoring can provide valuable information on the epidemiology of disease in ethnic groups. It can also reveal inequalities of access. The information can be used to make changes, which should go towards improving the service and ensuring that it is sensitive, equitable and appropriate.**
>
> *(Karmi, 1996, p. 10)*

However, as noted previously, there are limitations to any classification system, and if it is not used properly (i.e. collecting the data without any consequent change), then it could be viewed suspiciously as collecting 'race data for clandestine use' (Karmi, 1996). The Department of Health in the United Kingdom published a practical guide to ethnic monitoring in the NHS and Social Care, which includes an outline of why ethnic monitoring is important in ensuring equality of health and social care provision to all cultural groups (Department of Health, 2007). The data enables health inequalities to be identified, in particular ethnic health inequalities (POST, 2007). They offer examples of this in Box 1.4.

Box 1.4 Examples of ethnic health inequalities (From Parliamentary Office of Science and Technology: Postnote, 2007)

Cardiovascular disease (CVD)

Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population.

Bangladeshis have the highest rates, followed by Pakistanis, then Indians and other South Asians. By contrast, men born in the Caribbean are 50% more likely to die of stroke than the general population, but they have much lower mortality to coronary heart disease. Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations, and there is debate about how much they can be explained by socioeconomic factors. Many researchers think that there are biological differences between ethnic groups, and a lot of research has been carried out on the potential mechanisms.

Cancer

Overall, cancer rates tend to be lower in BME groups. For lung cancer, mortality rates are lower in people from South Asia, the Caribbean and Africa, which relates to lower levels of smoking. The highest mortality is found in people from Ireland and Scotland. Mortality from breast cancer is lower for migrant women than for women born in England and Wales. Researchers think this reflects the fact that it takes time to acquire the detrimental lifestyle and other risk factors associated with living in this country.

continued

Box 1.4 Examples of ethnic health inequalities (From Parliamentary Office of Science and Technology: Postnote, 2007) (continued)

Mental health

Ethnic differences in mental health are controversial. Most of the data are based on treatment rates, which show that BME people are much more likely to receive a diagnosis of mental illness than the White British. Studies show up to 7 times higher rates of new diagnosis of psychosis among Black Caribbean people than among the White British. However, surveys on the prevalence of mental illness in the community show smaller ethnic differences. There is evidence of ethnic differences in risk factors that operate before a patient comes into contact with the health services, such as discrimination, social exclusion and urban living.

There is also evidence of differences in treatment. For example, Black Caribbean and African people are more likely to enter psychiatric care through the criminal justice system than through contact with the health services. Some researchers suggest that psychiatrists diagnose potential symptoms of mental illness differently depending on the ethnicity of the patient.

During the assessment process on admission to the hospital, nurses may be required to collect data on ethnic origin, and it is important that they explain to patients the rationale for this in terms of healthcare planning.

CULTURE, RACE AND ETHNICITY IN NURSING AND HEALTH CARE

In order to establish an understanding of these concepts as they apply to healthcare practice, consider the following case study:

Patient case study

Mrs Dorothy Jones is a 60-year-old woman from Jamaica who moved to the United Kingdom in 1952 with her parents. She has worked as a nursing auxiliary for the past 30 years in a large teaching hospital and has been married to Ernest for 40 years. They have 4 children and 10 grandchildren who, apart from one daughter who is a ward sister at the hospital, have all made their home in Jamaica. For the past four years, Dorothy's diabetes has been gradually getting worse, and she has now developed two large ulcerated areas on both legs. This has necessitated long periods off work, and she is becoming increasingly house-bound. The district nurse, Sister Jan Rowan, visits Dorothy daily and has experienced some difficulty in trying to encourage her to lose weight. Dorothy is reluctant to do so, as she says she is happy with her body and her shape. Jan has recently completed a short course on cultural awareness and is trying to understand Dorothy's health and illness beliefs in order to

continued

Patient case study

help her. Unfortunately, Dorothy does not have a good relationship with her general practitioner (GP), Dr Vijaykumar Patel, a Hindu man. She feels that he has not been very helpful with pain relief, and she has no faith in the medication he does prescribe. Dorothy and her husband would like to retire to Jamaica, as she feels that this is where she 'belongs', but her health problems are making it less likely to happen. She feels that her only link to her home is the Pentecostal church, which she is now also finding increasingly difficult to attend.

1. How are culture, race and ethnicity reflected in this Case Study?
2. Has Mrs Jones become integrated into UK society?
3. What are the specific ethnic differences between Mrs Jones, Sister Rowan and Dr Patel?
4. What needs to happen in this healthcare scenario to enable Mrs Jones to improve her health?
5. Reflect on your personal experiences of caring for patients in similar situations and identify personal objectives for future learning needs.

Some key points that you could explore in your reflections could include:

- Mrs Jones' 'cultural' roots in Jamaica and her need to return there to live with her family;
- The use of the term African–Caribbean (or Afro-Caribbean) which Karmi (1996, p. 44) defines as being a term used to 'describe people of African origin, who came to Britain from the Caribbean Islands, notably Jamaica, Trinidad, Tobago, Grenada, Dominca, Barbados, St Lucia and the British Virgin Islands'.
- Her health and illness beliefs with regard to her body and body image (see Chapter 3);
- The three different cultures of Mrs Jones (patient), Sister Rowan (healthcare profession – nursing) and Dr Patel (healthcare profession – medicine);
- Dr Patel and Sister Rowan's own cultural and religious beliefs as well as their professional ones;
- The need for Mrs Jones to improve her health by losing weight;
- An altered diet would also improve the diabetes and healing of the leg ulcers;
- Mrs Jones' personal beliefs may not help the district nurse to implement a mutually agreed plan;
- Mrs Jones' poor relationship with her GP – a man from another culture and healthcare profession – is also contributing to her non-compliance with care/treatment which would help her to realize her long-term goal of 'going home' to Jamaica.

Pierce and Armstrong (1996) believe that:

> **… diabetes is a particular problem for African–Caribbean people living in the UK, for two reasons. The first is that rates of diabetes are very high in this population … reflecting the high prevalence of the disease in the Caribbean … and is according to Alleyne et al. (1989) a leading cause of death in Jamaica … The second reason why diabetes is a particular problem is the importance of patients' beliefs about diabetes and their effect on health-related behaviours.**
>
> *(Pierce and Armstrong, 1996, p. 91)*

In the Case Study above, Mrs Jones would have to make radical changes to her lifestyle in order to manage her diabetes with any degree of success (Brown et al., 2007). However, as Pierce and Armstrong (1996) have highlighted, the cultural beliefs of African–Caribbean people about their diet and body shape (e.g. the relative merits of African–Caribbean food versus English food and the concept of 'ideal' body size) can make it very difficult for health professionals to recommend changes with which Mrs Jones would agree (see Chapter 3 for further information on food and diabetes in African–Caribbean culture).

CONCLUSION

As the above Case Study illustrates, it is essential to understand all three cultures in a nurse–patient encounter in order to ensure culturally safe and appropriate care. It is important to recognize that the nurse's own culture can influence the nurse–patient relationship. The responsibility for ensuring that nurses have the knowledge and skills to do this should lie with both them and their employers.

CHAPTER SUMMARY

1. Any understanding of the terms culture, race and ethnicity is essential if culturally safe and appropriate care is to be ensured.
2. In every nurse–patient relationship there is a meeting of three cultures, namely those of the organization, the patient and the nurse.
3. Racism, discrimination and prejudice continue to prevent the implementation of care that is culturally safe and appropriate.

FURTHER READING

Bhopal, R. S. 2007. *Ethnicity, Race and Health in Multicultural Societies: Foundations for Better Epidemiology, Public Health, and Healthcare.* Oxford: Oxford University Press.
This book discusses race and ethnicity as seen internationally as well as practical examples of the key concepts in a health context.

Culley, L. and Dawson, S. 2001. *Ethnicity and Nursing Practice*. Basingstoke: Palgrave.
This book introduces theories of race, ethnicity and racism and explores how an understanding of these can help nurses and other healthcare professionals meet the needs of minority ethnic communities.

Reddy, S. 2015. *Nursing & Empire: Gendered Labour and Migration from India to the United States*. Chapel Hill: University of North Carolina Press.
This book written by Sujani Reddy 'examines the consequential lives of Indian Nurses whose careers have unfolded in the contexts of empire, migration, familial relations, race and gender'. It is a new find for me and having begun reading the book I can see it is full of wonderful stories that intersect with each other in terms of topics to be discussed. Issues such as the Indian caste system are discussed in different ways.

Sewell, H. 2009. *Working with Ethnicity, Race and Culture in Mental Health*. London: Jessica Kingsley Publishers.
This book is called a Handbook for Practitioners and it certainly offers a broad spectrum of content related to these issues of ethnicity, race and culture in relation to mental health in the context of mental health services. Not only does it look at such various illness models to help practitioners understand patient illness, but it also considers the education and training required for developing competence from within the organization's own needs and interpretation of its meaning. It also offers excellent case studies throughout.

WEBSITES

http://anthro.palomar.edu/culture/culture_2.htm
A website which discusses through exercises and examples the nature of human culture and its characteristics and the methods used by anthropologists to study it.

http://visiblenurse.com/nurseculture6.html
This website focuses on aspects of Kaminski's study of nursing culture and gives access to her whole study to download as a Pdf document. The study is called: Nursing through the lens of culture: A multiple gaze.

http://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/RaceEqualityinhealthsocialcareGoodpracticeguide2002.pdf
This site links to a Guide for Racial Equality in Health and Social Care: Good practice guide for the Department of Health, Social Services and Public Safety. The 'At a Glance Summary' of this guide offers translation in Chinese, Urdu, Portuguese and English, on key issues for racial equality in health, such as communication, diet, religion and patient choice (accessed via Google on 16 March 2016).

http://www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-the-NHS.aspx
This site offers a wide range of resources with regard to equality and diversity. Here, for example, is a link from this page to many issues related to Black health:

http://www.nhs.uk/Livewell/Blackhealth/Pages/Blackhealthhub.aspx

This site offers guidance on a number of health issues such as diabetes and sickle cell anaemia.

http://www.raceequalityfoundation.org.uk/dh-strategic-partners/ITS/resources

This link offers resources regarding interpreters and translation for different cultural groups and health services. It also offers many more resources on aspects of racial equality such as access to the NHS Report called Beyond the Snowy White peaks of the NHS examining the lack of equality of black and minority ethnic staff in the NHS, http://www.raceequalityfoundation.org.uk/resources/downloads/beyond-snowy-white-peaks-nhs.

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CHAPTER 2

Cultural care: Knowledge and skills for implementation in practice

Karen Holland

INTRODUCTION

The importance of approaching care of individuals from different cultures and with different belief systems in a holistic way is central to the way in which the chapters in this book have developed. The importance of cultural awareness is threaded through the whole book but in this chapter it will be explored both as a topic in its own right and also as part of implementation of cultural care in practice.

This chapter examines the nature of the knowledge and skills required by nurses for implementing cultural care in their everyday nursing practice. It will also explore the need for nurses to have an overall awareness of cultures, their health and illness beliefs and daily living practices, in particular those that they may come across less frequently.

To help us consider both of these needs, that is, cultural awareness and implementing cultural care, we will discuss some of the common frameworks that have been developed to help nurses consider these needs when caring for patients in different care environments.

A case study approach will enable nurses to test out the model frameworks that they may wish to use for the assessment of individual cultural needs and the implementation of culturally appropriate care.

This chapter will focus on the following issues:

- The importance of cultural care
- Developments that promote culturally sensitive nursing practice
- Cultural awareness
- Cultural knowledge
- Cultural care and interventions
- Models and frameworks for care assessment and delivery:
  - Leininger's model of transcultural care diversity and universality
  - Giger and Davidhizar's model of transcultural nursing assessment and intervention
  - Purnell's model of cultural competence

- Josepha Campinha-Bacote model of cultural competence in healthcare delivery
- Littlewood's Anthropological Nursing Framework
- Papadopoulos, Tilki and Taylor's model of transcultural skills development
- Roper, Logan and Tierney's model of nursing

THE IMPORTANCE OF CULTURAL CARE

Before examining the nature of knowledge and skills required for cultural care, two questions need to be considered. First, why is cultural care an important issue for healthcare professionals? Second, what are the rights of patients and their families with regard to receiving care that is culturally appropriate? (It is recommended that Chapter 1 be read first as this introduces the reader to many of the issues that will be explored in this chapter.)

For nurses in the United Kingdom, the importance was highlighted in the UKCC code of professional practice (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1992), which stated that they should 'recognise and respect the uniqueness and dignity of each patient and client and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor'.

The UK Nursing and Midwifery Council (NMC) Code, *The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives* (Nursing and Midwifery Council, 2008), however, appeared to assume that ethnicity and cultural awareness had been internalized by nurses and midwives, for example:

> **Make the care of people your first concern, treating them as individuals and respecting their dignity.**
>
> - **You must treat people as individuals and respect their dignity.**
> - **You must not discriminate in any way against those in your care.**
> - **You must treat people kindly and considerately.**
> - **You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.**

The current NMC standards for preregistration nursing education (Nursing and Midwifery Council, 2010) focuses more on achieving competence in understanding how culture, amongst other factors such as environmental and socioeconomic issues, can impact on health and illness and therefore their practice in caring for patients and their families. (See Chapter 1 for additional information and an exercise exploring how you could achieve such a competency in your practice.)

Those for preregistration midwifery education (Nursing and Midwifery Council, 2009) are more explicit and reference to cultural beliefs can be found throughout many of the standards. For example:

> **Practise in a way which respects, promotes and supports individuals' rights, interests, preferences, beliefs and cultures. This includes:**
>
> - **Offering culturally sensitive family planning advice**

- **Ensuring that women's labour is consistent with their religious and cultural beliefs and preferences**
- **The different roles and relationships in families, and reflecting different religious and cultural beliefs, preferences and experiences**

(NMC Standard – Domain: Professional and Ethical Practice, 2009)

This makes it clear that student midwives will need to be given every opportunity to gain an understanding of the way culture and religion affects any care delivered in partnership with women. (See Chapter 6 for cultural and religious beliefs and practices impacting on women's health care.)

In New Zealand, the Nursing Council has developed specific guidelines, for both nursing education and practice, in relation to cultural issues; this is directly linked to the wider societal changes in New Zealand with regard to the Maori people (Nursing Council of New Zealand, 2011). This is the adoption of a cultural safety model into all curricula; the revised model for teaching this in nursing programmes includes teaching about the Treaty of Waitangi and Maori health as separate but inter-linked issues.

Their definition of cultural safety (in Maori language: kawa whakaruruhau) is

> **The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.**
>
> **The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of the individual.**
>
> *(Nursing Council of New Zealand, 2011, p. 7)*

The concept of cultural safety is also implicit in midwifery curricula and competencies (Midwifery Council of New Zealand, 2007). Farry and Crowther (Part 1: 2014a and Part 2: 2014b) offer an insight into both the development of midwifery practice in a bicultural context in New Zealand and the way in which this is then evidenced in the partnerships between midwives and Maori women and their families. The development in 2006 of *Turanga Kaupapa*, a set of health principles and values that appear alongside the standards for practice in the Midwives Handbook for practice issues by the NZCOM (2008) can be accessed from the Farry and Crowther article (Part 2: 2014b).

Care that acknowledges the culture and ethnic background of the individual takes into account the beliefs and way of life that are shared by members of the same cultural groups (see also Chapter 1). These beliefs extend to all areas of daily living, including those related to health and illness. Although many of these will be common to all members of a cultural group, it is important to remember that even within cultures each person is an individual.

The Patient's Charter Standard in the United Kingdom in 1996 in relation to religious and cultural beliefs (Department of Health, 1996) stated that 'all health services should make provision so that proper consideration is shown to you, for example, by ensuring that your privacy, dignity and religious and cultural beliefs are respected', and the publication of a guide on religion and belief

by the Department of Health (2009) much later appeared to extend beyond that of the cultural needs of patients to also take account of the religious and cultural needs of its staff. It recognized the need for religious observance of holy days by staff and how this could be accommodated through the use of the multifaith event calendar and year planner to provide advanced warning for those completing duty rotas. This kind of development clearly acknowledged the need for all staff working in the UK NHS to know what such events may mean to individuals and to the patients in their care, who will also require consideration of such holy days whether as a hospital inpatient or in their own homes.

How, then, have nurses contributed to ensuring care that takes into account the cultural and ethnic background of their patients and clients? Is this the same in your country?

Reflective exercise

1. Consider your own beliefs about religious and cultural needs and how this has had an impact on how you have experienced being a student or working as a qualified member of staff in a healthcare context.
2. What knowledge and skills would you consider essential to being able to work in a culturally competent or culturally aware way?

The following sections should help you with these two questions and will consider past and present developments and evidence available in relation to nursing practice.

DEVELOPMENTS THAT PROMOTE CULTURALLY SENSITIVE NURSING PRACTICE

Within nursing and other healthcare professions there have been attempts worldwide to address issues related to cultural health care. This has been mainly in response to the needs of those societies across the world that are becoming increasingly multicultural in their constitution. The effect of this change has been to create a different set of healthcare needs, which then require healthcare delivery systems that will ensure culturally appropriate and relevant care.

Within the nursing profession, one such attempt has been the development of transcultural nursing care (TCN) – a concept that was relatively new to nursing in the United Kingdom (Weller, 1991) when we wrote the first edition of this book. This has now changed in terms of availability of information about cultural care in the NHS and to some extent in the United Kingdom and international nursing literature (Darvill, 2003; Nairn et al., 2004; Jirwe et al., 2010; Gebru and Willman, 2010; Williamson and Harrison, 2010). Despite this, making sure that curricula include cultural competency statements is not always visible in the evidence-base for nurse education. Lauder et al. (2008) in an evaluation study of preregistration nursing and midwifery education programmes in Scotland found, for example, that 'students (nursing and midwifery) were given exposure to the issues rather than any competency development' and commented that 'work needs to be undertaken to ensure that the provision of education in responding to the needs of the increasingly ethnically diverse community, develops consistently to meet local needs' (Lauder et al., 2008, p. 196).

In relation to transcultural nursing as a way forward for nursing practice and education, the main advocate and developer of the transcultural nursing model has been Madeleine Leininger, an American nurse anthropologist, who has undertaken extensive cultural and ethnographic studies in an attempt to determine the nature of 'culture-specific and cultural universal nursing care practices' (Leininger, 1978b). She believed that 'today's world situation and concern for the welfare of mankind is challenging us to understand the culture concept' (Leininger, 1978b), and that nurses and other healthcare professionals in their role as carers have an obligation to try to understand the meaning of being a 'cultural individual'. Leininger (1978b) claimed to be the originator of what she calls 'the sub-field of transcultural nursing', and she believed this to be an essential prerequisite for effective nursing practice, and that nurses learn about those cultures for which they care. She has written extensively about transcultural nursing (Leininger, 1978a, 1984, 1985, 1989a,b, 1990, 1994, 1998, 2002) and in the United States she was the founder and first editor of the *Journal of Transcultural Nursing,* which is now a leading journal for this field of nursing (http://tcn.sagepub.com/). Madeline Leininger died in April 2012 at age 87. She is considered a pioneer for developing a framework for helping nurses care for people of all cultures and societies but also for her early work as a nurse anthropologist. This work, which she published in 1970 as a book– *Nursing and Anthropology: Two Worlds to Blend*, was a major influence in the development of her model of transcultural nursing.

Leininger's definition of this 'transcultural' subfield of nursing is

> **the comparative study and analysis of different cultures and subcultures in the world with respect to their caring behaviour, nursing care, and health-illness values, beliefs and patterns of behaviour with the goal of generating scientific and humanistic knowledge in order to provide culture-specific and culture universal nursing care practices.**
>
> *(Leininger, 1978b, p. 8)*

Herberg has a similar view that transcultural nursing is

> **concerned with the provision of nursing to the needs of individuals, families and groups. Such individuals, families or groups often represent diverse cultural populations within society, as well as between societies.**
>
> *(Herberg, 1995, p. 3) 61*

However, transcultural nursing care has had both advocates and critics within the nursing profession. James believed that Leininger's 'establishing transcultural nursing as a speciality has made it an elitist area' of practice (James, 1995). Bruni (1988) believed that as a result of focusing on culture as the means of 'determining patterns of behaviour', other important variables such as class and gender are left out of important healthcare-related discussions and decisions. Bruni cited the healthcare problems and situation of the Australian Aborigines as an illustration, whereby:

> **the culturalist explanation focuses on the inability of the people to relinquish their traditional ways. The force of strength of traditional beliefs and practices is seen to prevent their successful adoption of Western practices.**
>
> *(Bruni, 1988, p. 29)*

The subsequent lack of success in implementing healthcare programmes is then blamed on the fact that the Australian Aborigines want to adhere to their traditional explanations of ill health. However, when the Aboriginal people took charge of their own healthcare services, which recognized both gender and class inequalities, a much more successful outcome was achieved with regard to health education and health care (Bennett, 1988).

The health of Australian Aborigines nevertheless remains of concern and the rates of illness amongst them are higher than any other group of people in Australia (see the list of websites at end of this chapter).

Best and Fredericks (2014) have edited a book specifically for the nursing and midwifery care of Aboriginal and Torres Strait Islanders and it is called Yatdjuiligin (Yatdjuligin means: 'Talking in a good way'). I found this wonderful book during my searches for new international material that readers of this book would find helpful in their care of people from any culture, but especially for non-indigenous nurses and midwives who may choose to work in Australia from other countries. Odette Best was awarded her PhD in 2011 for her incredible research by the University of Southern Queensland entitled: *Yatdjuligin: The Stories of Queensland Aboriginal Registered Nurses 1950–2005*, which can be sourced at: http://eprints.usq.edu.au/21525/2/Best_2011_whole.pdf.

I have started to read this incredible story of Odette's and realised that there is not one very special cultural story being told but many others all 'criss-crossing' each other. I would like to thank the authors for sharing their history and nursing experience with qualified nurses and midwives and students in these professions internationally.

On a more general level, a study by Pinikahana et al. (2003) found that, regardless of what was advocated in practice, in nursing education in Australia the inclusion of transcultural issues in the curriculum, focusing on how different cultures may respond to different situations, often did not prepare students enough for meeting the complexity of health needs of a multicultural society. This seems to reflect the findings of a study by Lauder et al. (2008) in the United Kingdom.

Cortis (1993), an advocate of the implementation of TCN in the United Kingdom at that time, discussed some of the issues that are problematic with regard to the concept of culture within health care. He cited Bottomley's (1981) view that 'the study of culture can be interpreted as a mechanism for avoiding the real issue which is racism', and that there is an additional problem of stereotyping culture through focusing on its own potentially static and universal nature (e.g. African culture). However, Stokes believed:

> **whilst the intentions of the transcultural nursing movement may be honourable, the reality is that a new group of so-called 'experts' will not replace the need for well-prepared and informed nurses who are able to plan care from basic principles.**
>
> *(Stokes, 1991, p. 42)*

Wilkins (1993), in an extensive literature review of transcultural nursing, took a similar view and concludes that there 'could well be a danger in discussing culture-specific nursing care', and that nurses should be taught cultural awareness and sensitivity that acknowledges the uniqueness of the individual regardless of their cultural origins. This view appears to be a strong recommendation in both UK and US literature on what nurses need to be encouraged to learn in order to care for a multicultural community.

It is one we have adopted in this book, but again how nurses and midwives and other healthcare colleagues learn to care for and support patients from very diverse communities must be viewed in the social and political context of each country. So many people are now displaced from their own country (see Chapter 11) and 'transplanted' in a country they have no affiliation with, yet they are faced with accessing a healthcare system which is totally unprepared in many cases for practicing culturally appropriate care.

A small study by Megson (2007) reported on how students, on a combined learning disability/social work undergraduate programme, gained more awareness of ethnicity and culture through examining aspects of their own ethnic identity, but that issues regarding multicultural learning remained unresolved. In particular, there was a message for educators 'against choosing learning environments that feel right and comfortable for them as they may be creating learning environments based on their own cultural norms and not one that is multicultural' (Megson, 2007, p. 115).

A research study by Soomal (2012) to enhance the experience of volunteer nurse educators from Canada, focused on using the Leininger Model of TCN as a 'lens into Bangladeshi people's worldviews, social structures, environment, cultural values, language, religion and history and its influence on nursing education so that the visiting faculty can be better prepared to teach culturally contextual nursing education'.

There were many issues arising from this study but an important one was that the educators should teach what is relevant to the Bangladeshi nursing student, meaning that it was essential that what was taught should be culturally congruent and context specific. Learning therefore about the country and its people was therefore essential to the successful experience of the volunteer educators. The model, used here as a research tool, offered many questions as well as answers but Soomal believed that the model could also be used as a curriculum model for nursing education in Bangladesh.

Serrant-Green's (2001) view is that 'transcultural nursing needs to be embedded in the clinical education of nurses so that they are able to detect signs, symptoms and presentations of disease in all patients, irrespective of ethnic group or skin colour' and that 'if nurse educators continue to isolate transcultural issues to concerns about communication and adhere to the "menus" approach to teaching, there will continue to be negative consequences for the provision of clinical care for minority ethnic patients and a failure to "value diversity" in the education of the profession'.

These issues were also highlighted in a study by Tuohy et al. (2008) who explored the 'educational needs of nurses when nursing people of a different culture in Ireland'. One of their recommendations was 'to review nursing curricula and increase transcultural nursing education at both pre- and post-registration level'.

The general theme that nursing education is not preparing students for working in a multicultural society is not unique to the United Kingdom (Gebru and Willman, 2003), and a study in Sweden (Gebru and Willman, 2010) highlighted that 'there was still a need to develop curricula in Swedish nursing programmes that enable nursing students to become culturally competent'. Ensuring that educators, both in the university and practice contexts, have the requisite knowledge and skills themselves to deliver learning experiences which integrate the wider cultural and ethnic perspective is an issue that is not widely explored but one that is vital

if students are to engage with multicultural communities. In addition there is a need to increase the evaluation and research of how nurses and other healthcare professionals utilize cultural competency in their work, both in their care of patients and their families and also with each other.

One such study was undertaken by Fleming et al. (2008) in examining 'the influence of culture on diabetes self-management in Gujarati Muslim men in the northwest of England'. As well as the main findings, Fleming et al. (2008) also offered some very insightful narratives from the men who participated in the study which were linked to their health beliefs about food and alternative healing and complimentary therapies. (See Chapter 7 for a further discussion of men's health.)

Their overall findings led them to many conclusions including this one:

> **Current policy suggests that specialised programmes of education and care, which are tailored to meet the cultural needs of diverse groups of people (such as "South Asians" and "African–Caribbeans"), are an appropriate means to develop and deliver culturally competent diabetes nursing care. On a pragmatic level, such an approach is appealing; however, we are concerned that this uniform perspective fails to acknowledge that culture is subjective, and therefore, important in terms of everyone's (including people who are part of the majority ethnic group) health beliefs and behaviours.**
>
> *(Fleming et al., 2008, 57)*

CULTURAL AWARENESS

In order to provide culturally appropriate and sensitive care, we take a similar broad view but suggest that there is a need for two levels of knowledge, namely specialist expertise in one or more cultures and a general awareness of many cultures. For example, in certain parts of the United Kingdom (e.g. rural Wales), caring for a patient from Japan is a rare occurrence. However, caring for Gypsy Travellers may be a regular event and demonstrates the fact that the nurse will require a more in-depth knowledge of this cultural group and their way of life over time, in order to care for them. For example, a study by Parry et al. (2004) highlighted many issues of relevance to nurses and healthcare workers, in particular those working in a community setting. They found that: Gypsy Travellers have significantly poorer health status and significantly more self-reported symptoms of ill-health than other UK-resident, English speaking ethnic minorities and economically disadvantaged white UK residents (Parry et al. 2004).

In 2007, Van Cleemput, Parry, Thomas et al. undertook a study to determine health-related beliefs and experiences of Gypsy Travellers as part of understanding how to improve services to this community. This was a qualitative study and the paper offers us some excellent narratives from the participants about their beliefs. Here is one example from one of the Themes:

> **Low expectations of health:**
>
> **I suffers from asthma and I had, must be getting on two years ago, I had about like, four or five mini strokes. Well I just took me tablets now for it (frozen shoulder) and that so I got**

> **tablets really to control that – arthritis –, I got that and …like I can't um –like… I can bounce back about the place and just dust and do what I can reach and that, but there's like, clean windows, can't do anything like that – so I still got this stuff…. When I starts walking and I finds I'm getting a little pain or a bit breathless, I just takes that.**
>
> *(Van Cleemput et al., 2007, p. 209)*

More on health beliefs can be found in Chapters 4 and 5.

This awareness of the need for cultural sensitivity is of course applicable to all cultures that you meet, and an example here could be when caring for a Japanese patient, where because of global travel and work you may be caring for someone from that culture and also mentioned here because both Japanese and Gypsy Traveller cultures have similar belief systems with complex pollution taboos in relation to the bodies.

For the Gypsy Travellers:

> **the primary distinction is between washing objects for the inner body and the washing of the outer body. Food, eating utensils and tea towels for drying them must never be washed in a bowl used for washing the hands, the rest of the body or clothing.**
>
> *(Okley, 1983, p. 81)*

An example of the conflict caused by lack of understanding on the part of a Gorgio (Gypsy name for a non-Gypsy or a Gadje as noted by Vivian and Dundes, 2004) health visitor, is cited by Okley:

> **A Gorgio health visitor discovered that a traveller had a deep cut in his foot. Well versed in Gorgio germ theory, she grabbed the first bowl she saw inside the trailer - the washing-up bowl - poured in disinfectant and water and bathed the man's foot in it. Afterwards the travellers threw away the bowl and recounted the incident with disgust. The bowl was permanently mochadi (ritually polluted).**
>
> *(Okley, 1983, p. 81)*

Vivian and Dundes (2004) also point out, however, that 'the proper term to use to refer to the Gypsies is "Roma"' and that 'to the Roma, the term Gypsy is offensive and derogatory because it misrepresents the Romani heritage'.

In Japanese culture, 'outside' is associated with dirt and impurity and 'inside' with cleanliness and purity. For the Japanese, 'hospital, where the dirt of others is concentrated, is one of the dirtiest places' (Ohnuki-Tierney, 1984). It is important to understand this belief should you be required to care for a Japanese person who has been taken ill on holiday in the United Kingdom. For the same reason if a nurse were to visit a Japanese patient in their own home it would be appropriate to ask whether they should remove their shoes prior to entering. Ohnuki-Tierney (1984) in her book on *Illness and Culture in Contemporary Japan* explains why this practice is so important to any Japanese person. Firstly is the fact that 'outside', that is outside of where anyone lives, 'is equated with dirt and germs because that is where the dirt of others is seen to be most concentrated' (p. 22). She notes that many Japanese homes have what is known as '*genkan*, a square or rectangular space at the entrance where people take their shoes off'.

Today, there are many websites where you can read about customs and practices of Japanese people, for travellers who visit their country. (See the websites list at the end of this chapter.)

Brink (1984) has stated that there is a need for nurses to be able to access easily transferable information about cultures, such as the above examples, from an anthropological standpoint. She believed that 'nurses are inherently pragmatic' and 'will want to read what they can use' (Brink, 1984). In other words, they may find a great deal of literature about different cultures very interesting, but unless they can use it at the point of contact with the patients it will be of little value to them. An ethnographic study of Punjabi families by Dobson (1986) provides an example of how an understanding of culture and family systems could help health visitors in their postnatal visits to Punjabi mothers. Some of the families followed the Sikh religion and others followed Islam, but 'a Punjabi culture pervaded and unified both groups' (Dobson, 1991).

It is important therefore that we do not stereotype individuals according to their culture. Individuals can belong to one culture (e.g. Punjabi) yet may have different religious beliefs from one another (e.g. Sikhism and Islam).

These examples demonstrate the complexity of knowledge that is required to ensure culturally appropriate care that also meets individual needs.

Key points

1. The NMC Code (2015) and the Department of Health (2008) in their *Confidence in Caring* report recognize the importance of care that is culturally appropriate.
2. An increasing number of nurses and other healthcare professionals are becoming proactive in promoting cultural and racial awareness.
3. Transcultural nursing as a specialist field of nursing practice is not widely promoted in the United Kingdom but in other countries like the United States it is promoted through such organisations as the Transcultural Nursing Society: http://www.tcns.org/ and internationally through the *Journal of Transcultural Nursing*: http://tcn.sagepub.com/.

CULTURAL KNOWLEDGE

Watkins (1997) reminds us that Kuhn (1970) and Polanyi (1958) identified two types of knowledge, namely 'knowing how' and 'knowing that'. According to Manley (1997), this 'know how' knowledge is usually acquired through practice and experience and often cannot be theoretically accounted for by 'know that' knowledge, which is synonymous with practical knowledge. However, 'know that' knowledge encompasses theoretical knowledge such as that found in textbooks (Manley, 1997). However, it is important to remember that in nursing practice these two types of knowledge are not regarded as separate but rather as interlinked, with one informing the other. Weller provided a case study to demonstrate this.

Case study

Mr C is in a surgical ward recovering from a prostatectomy. His primary nurse is trying to arrange a good oral fluid intake and takes care to explain why this is necessary. However, Mr C, who is of Chinese origin, consistently refuses to take the cold drinks he is offered.

Explanation

The drinking of 'cold fluid' does not fit in with Mr C's ideas of a humoral system of beliefs about health and healing. Surgery is considered a 'hot' condition and the drinking of cold water unhealthy and to be avoided at this time. In this situation, a flask of warm tea at the bedside would be acceptable.

(Weller, 1991, p. 31)

We can use these types of knowledge to determine what cultural knowledge may be required by community nurses to care for the patient in the following case study.

Case study

Cheung-Ng Wai-Yung, an elderly Chinese woman, has moved to Manchester to live with her unmarried daughter, Chung Mee-Ling. She has registered with a new GP and it has been discovered that she requires an initial visit for continuing care for a chronic leg ulcer. The district nurse will need to undertake an assessment of Mrs Cheung's needs.

Examples of 'know that' knowledge required to carry out this process would include the following:

1. Understanding the naming systems of Chinese culture in order to ensure respect for the individual and accurate recording of the patient's name. According to Schott and Henley (1996):

   In traditional Chinese naming systems the family name comes first, followed by a two-part personal name always used together (or occasionally a single personal). In many families the first part of the personal name is shared by all the sons, and another by all the daughters. A woman does not change her name on marriage. She usually adds her husband's family name before her own, for example, Cheung is the husband's family name. Chinese Christians may have a Christian personal name as well.

   (Schott and Henley, 1996, p. 110)

2. A knowledge of Mrs Cheung's religious beliefs: she does not have a Christian name, therefore she followed the traditional Chinese society beliefs based on the philosophy of Confucianism, Taoism or Buddhism.
   a. Confucianism: This philosophy emphasizes 'social harmony, through a code of personal and social conduct' (Schott and Henley, 1996), stressing many virtues such as honesty, respect for older people and traditions.

   b. Taoism: This philosophy 'stresses the perfection and beauty of nature and the importance of achieving purity and union with the natural world through meditation' (Schott and Henley, 1996). Harmony may be achieved by avoiding conflict and confrontation.

   c. Buddhism: This philosophy is 'concerned with achieving an understanding of the human situation and the means whereby suffering and death can be transcended so that a new state of being is achieved' (Schott and Henley, 1996). This philosophy is characterized by a belief in reincarnation.

3. 'Know how' knowledge, such as communication (Burnard and Gill, 2008), may be used by nurses alongside the 'know that' knowledge related to Chinese culture to plan care that is essential both for Mrs Cheung's physical health problem and for her personal well-being. McGee (1992) recorded a nurse-patient interaction that illustrates this. The scenario described was that of a Chinese woman admitted to the hospital after a car accident. The patient refuses pain relief, 'yet she is clearly in pain. What the nurse has not taken into account is her personal philosophy. The patient knows that physical pain is a sign that something is wrong with her body – its natural balance and harmony have been disturbed and must be restored' (McGee, 1992, p. 2). However, the nurse's explanation of the effect of the medication has made the patient believe that it will make her drowsy, causing further disharmony in her body. Thus, communication between the nurse and patient has not been effective.

Mrs Cheung may also practice Chinese traditional medicine, which is based on achieving a state of physical and mental balance (yin and yang) within the body. This may be important in the nursing care plan related to the chronic leg ulcer which will require treatment from the district nurse. Finn and Lee (1996) report that in China both healthcare systems coexist (see also Chapters 4 and 5 for additional discussions of this topic).

Reflective exercise

1. Reflect on the care that you have given to patients from different cultures.
2. How would knowledge of their cultural background and religious beliefs help you to assess their individual needs?
3. Consider one situation where you have had to care for a patient from a different culture and find out information about their belief system and culturally specific practices. Make notes and key points which will be valuable to you in a future encounter with someone from that culture or with those same beliefs. If you're a student, you could undertake this as part of a learning outcome for a clinical placement.

CULTURAL ASSESSMENT AND CARE INTERVENTIONS

In order to provide care, the nurse requires not only knowledge related to the culture of the patient but also knowledge that enables the nurse to provide the care. The nursing process offers a

problem-solving framework for care planning and delivery. This involves four main responsibilities for the nurse, namely assessment of patient needs and subsequent planning, implementation and evaluation of the care (Holland et al., 2008).

In order to ensure that the nurse assesses the needs of the individual patient in a systematic way, there are numerous nursing models (frameworks) which organizations have utilized in their nursing care documentation (patient-record systems). Some of these are now being incorporated into the development of Integrated Care Pathways documentation, which uses the multidisciplinary contribution to patient care (Stead and Huckle, 1997; Atwal and Caldwell, 2002). There are a few theoretical frameworks that have been developed specifically for cultural care, the most well known being Madeleine Leininger's 'Sunrise' model of transcultural care diversity and universality. However, a range of nursing theorists advocate that nurses should ensure their understanding of cultural needs (Roper et al., 1996).

Higginbottom et al. (2011) undertook an extensive review of the literature to identify 'nursing assessment models/tools validated in clinical practice for use with diverse ethno-cultural groups'

Eight main ones fulfilled the criteria set by the review (and the review can be accessed directly at http://www.biomedcentral.com/1472-6955/10/16 given that it is an Open Access paper). Their work did not at the time include Australia and New Zealand but they recognized the importance of work being undertaken there, especially the Cultural Safety Model in New Zealand. They also concluded that the main research and use of these tools had been evaluated in relation 'to education and training of nurses and health professionals' rather than 'specifically investigate the use of a model or tool in improving nursing care delivery and patient satisfaction outcomes'.

This section will examine seven of those nursing models or frameworks that identify the need for cultural awareness and cultural knowledge, to care for patients and their families. However, it must be noted that nurses in practice require a tool that is easy to use and can readily identify the healthcare needs of patients. It could be argued that some of those presented here do not offer that. However, for the purpose of learning about the possible approaches, we present them for discussion and assessment of their value for helping students learn that it is important to ask the right questions to ensure relevant care is given to patient, that is, a learning tool or for practitioners to build in to their daily care plans elements of these models to support culturally aware and appropriate care. All of them can be seen to be underpinned by the same principles, such as cultural knowledge and cultural awareness.

Reflective exercise

1. Before reading about these nursing models, consider how you identify the cultural, spiritual and religious needs of your patients.
2. Obtain a copy of the tool used to identify these needs and consider the knowledge you require to ensure that their specific needs are met.
3. After reading this chapter (plus accessed resources) and some of the other others, write down what you now know about those cultures and religions.

Leininger's model of transcultural care diversity and universality

This model was developed in 1955 (Higginbottom et al., 2011) and Leininger (1985) stated:

> **The theory of transcultural care diversity and universality explains and predicts human care patterns of cultures and nursing care practices. It can explain and predict factors that influence care, health and nursing care. Folk, professional and nursing care values, beliefs and practices, as well as multicultural norms, can be identified and explained by the theory. From these knowledge sources three kinds of culturally based nursing care actions are predicted to be congruent with and beneficial to clients. They are**
>
> **a. Cultural care preservation (maintenance);**
> **b. Cultural care accommodation (negotiation);**
> **c. Cultural care repatterning (restructuring).**
>
> *(Leininger, 1985, p. 210)*

Leininger's model of care attempts to establish a theory of care as it is perceived by individuals, cultures and nurses in order to be able to use these constructs to care for people from different cultural groups. Her model has four levels of analysis (of needs) which should be taken into account when planning patient care, and is similar to other models in this respect. For example, Roper et al. (1996) identified five factors that influence activities of living that need to be accounted for during the individual care assessment, planning, implementation and evaluation process (i.e. biological, psychological, sociocultural, environmental and politico-economic factors):

Leininger's four levels of needs analysis are interpreted as follows:

- Level 1: Social systems and social structures which include technological factors, religious and philosophical factors, kinship and social factors, cultural values and beliefs, politico-legal factors, economic factors and educational factors. It takes into account both language and environment contexts.
- Level 2: The nature of care and health in different healthcare systems.
- Level 3: The folk, professional and nursing subsystems.
- Level 4: The development and application of all the data collected in terms of delivering nursing care (Leininger, 1985).

These four levels of assessment are then linked to three main aspects of nursing care:

- Maintenance – Those cultural behaviours that help individuals to preserve and maintain positive health and caring lifestyles.
- Accommodation – Those helping behaviours that reflect ways of adapting or adjusting to individual health and caring lifestyles.
- Restructuring – New ways of helping clients to change health or lifestyles that are meaningful to them (Leininger, 1985).

This approach was viewed by Leininger (1985) as offering culturally competent (nursing) care. It is not apparent from searching the literature whether there are examples of this model in its being used in UK nursing practice.

However, there was evidence of how it had been used as part of a wider analysis of transcultural models, in order to identify a new model for cultural competence for primary care nurses in their management of asylum applicants in Scotland (Quickfall, 2004).

There is evidence of using this approach with other cultures. For example, Finn and Lee (1996) used the model to help them to gain an understanding of the Chinese 'world view, cultural values and healthcare systems', which they would need to provide culturally appropriate care for individuals from a Chinese culture. Rather than use it to plan care, Gebru et al. (2007) used the model to evaluate whether nursing and medical documentation actually reflected the cultural background of their patients. They found that although the care was not 'culturally congruent', 'the nursing care was based on cultural assessment, as the documentation related to kinship and social factors, ethnohistory, language and educational factors' (Gebru et al., 2007, p. 2064). However, it appears that despite its use in the United States as a framework for nursing care, its use appears limited in the United Kingdom. It must be remembered however that the United States and United Kingdom are what Seaton (2010) calls different 'geo-cultural contexts', being not only on different continents but also with very different political and social contexts, in particular those affecting health and social care organisations.

An example from the United States which illustrated the commitment to enhancing cultural competencies (American Association of Colleges of Nursing, 2008) was a toolkit that included a description of some of the nursing models which promoted 'culturally competent care' (p. 5), and in particular 'Leininger's Cultural Care diversity and Universality Theory/Model' (p. 6). (See end of chapter for website details.)

Wehebe-Alamah (2008) used Leininger's cultural care concepts to provide us with a guide to Traditional Muslim Generic (Folk) Care Beliefs on a number of key areas in the lives of Muslims worldwide, such as health and illness, dietary needs and death and bereavement. This paper offers a valuable insight into Muslim beliefs and practices around health, from an 'emic' (insider) generic folk beliefs view and the incorporation in a 'professional "etic" (outsider) plan of care' (p. 94).

Giger and Davidhizar's model of transcultural nursing assessment and intervention

Giger and Davidhizar (2008) offer a completely different approach in focusing on a framework for 'cultural assessment and intervention techniques'. This is based on the use of six 'cultural phenomena' that they believe are in evidence in all cultural groups (see Box 2.1).

Box 2.1 Giger and Davidhizar's six cultural phenomena (2008)

- Communication
- Space
- Social organization
- Time
- Environmental control
- Biological variation

Each of these phenomena will be defined in terms of its significance both within and across cultures.

Communication

The importance of communication in a nurse–patient relationship is viewed in relation to both verbal and non-verbal forms, especially during the assessment process. In particular, they state that 'nurses must have an awareness of how an individual, although speaking the same language, may differ in communication patterns and understandings as a result of cultural orientation' (Giger and Davidhizar, 2008, p. 21).

Space

This is defined in terms of personal, tactile and visual space, which is an area within the nurse–patient relationship that is not always given credence in terms of cultural care practices.

Giger and Davidhizar (2008, p. 55) cite Hall's (1966b) view of personal space in a Western culture as having three dimensions, namely 'the intimate zone (0–18 inches), the personal zone (18 inches to 3 feet) and the social or public zone (3–6 feet)'. These zones are linked to different types of activities in different cultures. For example, touching (intimate zone) between individuals of the same sex in Arab cultures could be misinterpreted if it was attempted in a more reserved culture such as that of North America.

Social organization

This phenomenon is explained in terms of the role of the family in society and social structures. Giger and Davidhizar (2008, p. 68) believe that 'patterns of cultural behaviour are learned through a process called enculturation which involves acquiring knowledge and internalising values'. They state that it is important for nurses to be aware of individual and cultural beliefs and values when caring for people at various life events such as 'birth, death, puberty, childbearing, childrearing, illness and disease' (p. 68).

Time

This phenomenon is a relatively unexplored area within the assessment process. However, in many cultures the concept of time is managed differently. Social time reflects the 'patterns and orientations that relate to social processes and to the conceptualisation and ordering of social life' (Giger and Davidhizar, 2008, p. 111). Cultural perceptions of time determine how people live and conduct their daily activities.

Environmental control

This cultural phenomenon is viewed as 'the ability of an individual or persons from a particular cultural group to plan activities that control nature … [it] also refers to the individual's perception of ability to direct factors in the environment' (Giger and Davidhizar, 2008, p. 129). Giger and Davidhizar state, 'In the broadest sense, health may be viewed as a balance between the individual and the environment' (p. 129). This issue of how people view the link between health and the environment is illustrated by how individuals determine whether to use Western medical healthcare practices or folk medicine.

Biological variation

This phenomenon is linked to epidemiological differences between cultures and the ways in which their biological structure and systems influence their response to health and illness. An example is the need for nurses to make an accurate observational assessment of skin colour changes

(e.g. cyanosis or jaundice) (Giger and Davidhizar, 2008). Giger and Davidhizar (2008, p. 151) state that 'skin colour is probably the most significant biological variation in terms of nursing care. Nursing care delivery is based on accurate client assessment, and the darker the clients skin the more difficult it is to assess changes in skin colour'.

These six phenomena are then used to offer culturally appropriate care to individuals from different cultures. Examples of individual cultures that are examined in this way include American Eskimos (Yipik and Inupiat), Navajo Indians and Vietnamese Americans. Each has different concepts of illness which can influence the way in which they manage healthcare situations. There may be misunderstandings about treatments, as in the following Vietnamese examples:

> **Drawing blood for diagnostic purposes may cause a crisis for a Vietnamese American patient. The patient may complain, although often not to the healthcare workers, of feeling weak and tired for varying periods following the procedure. Such symptoms may last for months. A Vietnamese American patient may feel that any body tissue or fluid removed cannot be replaced and that once it is removed, the body will continue to suffer the loss, not only in this life but in the next life as well.**
>
> **Giving flowers to the sick is a practice that may surprise and upset a Vietnamese American patient who has not been given an explanation of this practice. In Vietnam, flowers are usually reserved for the rites of the dead.**
>
> *(Giger and Davidhizer, 2008, p. 512)*

Giger (2013) continues to work with this model of Transcultural Nursing, her colleague Ruth Davidhizer having died in 2008. This model has much to offer nursing practice and assessment of patient needs in other countries.

Karabudak et al. (2013) used this model in practice and offer a case study of the model in action. The case discussed is that of a young boy aged 9 years old who has chronic kidney failure and is having haemodialysis treatment. One of the most interesting aspects of this case was the belief of the mother that the reason for his illness and recovery was God's will, until the Imam discussed with the family that organ transplantation was not a sin (p. 344).

The new book continues to offer a range of case studies with care plans, which although mainly focused on US multicultural communities, does offer an insight into how this framework could be used alongside a nursing model such as Roper Logan and Tierney Model of Nursing (1996) which has five factors that influence the activities of living (Holland et al., 2008). The five factors are biological, psychological, sociocultural, environmental and politico-economic.

Purnell's model of cultural competence

Purnell and Paulanka (2008) offer a similar model for cultural competence, which is based on 12 domains (of culture) that are essential for assessing the ethno-cultural attributes of an individual, family or group, namely:

1. Overview, inhabited localities and topography;
2. Communication;
3. Family roles and organization;

4. Workforce issues;
5. Biocultural ecology;
6. High-risk behaviours;
7. Nutrition;
8. Pregnancy and childbearing practices;
9. Death rituals;
10. Spirituality;
11. Healthcare practices;
12. Healthcare practitioners.

These 12 domains are then used as a framework for identifying specific cultural issues in relation to different cultures within the United States (e.g. Amish, Irish Americans, Chinese Americans). In his *Guide to Culturally Competent Health Care*, Purnell (2009) has specific chapters that outline key aspects of the cultural heritage of different people and groups to be found living in the United States. Many of these cultures, however, can now also be found in many different parts of the world, due to different global changes in their communities. These changes can be due to such events as the outcome and impact of war, changes in climate conditions such as the results of earthquakes or simply due to normal migration. However the majority of the chapters relate to well-established groups of people living in the United States who have retained many of their cultural heritage customs and practices.

Reflective exercise

1. Consider how many different cultures can be found in your local community that may not have been living in that area 20 years previously.
2. When you have done this use some of the 12 Domains of Culture you think are relevant to understand the cultural heritage of these groups of people who are now integrated into the communities in which they live, yet retain their important cultural practices such as religious beliefs and celebrations.
3. Consider also in a general sense those groups of people who may have found it very difficult to establish their heritage in a different country and imagine how health and social care services can support them (see Chapter 11 for additional discussion on asylum seekers and refugees).

Littlewood's anthropological nursing model within the nursing process framework

Although this is not a nursing model in the traditional sense, it does raise issues of the importance of another discipline which could influence the nursing care of a patient. I have decided to retain it

here for that reason, and because nurses need to learn to use the knowledge from social sciences as well as biological sciences to care for patients.

Littlewood (1989) proposed a model for nursing which utilized knowledge from anthropology – a discipline that, like nursing, views the individual as a 'holistic being'. Her main premise was that when using the nursing process, nurses need to pay more attention to 'lay concepts of health and causation of illness' in order to ensure that they and the patients are working together towards the same goal. The role of the nurse as someone who can mediate between the patient and the doctor to ensure culturally appropriate care is also considered to be important. Littlewood used the model to show how medical anthropology could be used as part of the nursing process. The focus is very much on the importance of taking account of 'lay concepts of health and causation of illness' (Littlewood, 1989). In particular, she stresses its importance at the assessment stage of the nursing process. She identified her framework as a 'generalised nursing model within the nursing process framework'.

The case example she used to illustrate the model was that of a woman with high blood pressure during pregnancy. Examples of questions/care patterns using the nursing process framework include the following:

- *Assessment*: What does the patient regard as the cause of her presenting problems and debility? What does she feel are the disturbances in terms of basic physiological needs?
- *Planning*: Care is then planned which takes into account other help (e.g. alternative or complementary therapy).
- *Interventions*: Nursing care/treatment is carried out as negotiated with the patient, including other 'healers'.
- *Evaluation*: Does the person feel healed? The main point is that the care is patient-centered rather than professional.

The premise made by Littlewood (1989) that anthropology has much to offer nurses in their care of patients is one that I entirely support. However, there is insufficient detail within Littlewood's paper describing the proposed framework to support its application in practice by nurses. For the nurse to have some knowledge of the nature of anthropology as it relates to health and illness and healthcare practices in different cultures is a potential challenge (see Chapters 4 and 5 for information relating to health and illness beliefs).

However, the introduction of anthropology to the nursing curriculum in the United Kingdom has not been as focused as in the United States, where nurses are encouraged to undertake postgraduate and doctoral studies in anthropology as part of the transcultural nursing movement led by Madeleine Leininger, who is herself an anthropologist (see above). In considering her model for nursing, it is clear that it is very much influenced by the discipline of anthropology. The inclusion of anthropology, as well as other social sciences such as sociology as a discrete subject, remains a choice in the development of the overall education curriculum of student nurses in the United Kingdom. However, there are some organisations such as my own where students can choose modules such as a Cultural Awareness, Health Care and Globalisation where anthropological concepts such as culture and health beliefs are discussed and shared by a multicultural group of students.

Josepha Campinha-Bacote model of cultural competence in the delivery of healthcare services (Campinha-Bacote, 1998a)

This model is like others named after the person who developed it and is according to the author:

> **a model that views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)**
>
> *(Campinha-Bacote, 2002, p. 181)*

This model is very much focused on the actual context of care and the healthcare provider's responsibility in providing appropriate care that is culturally appropriate for its service users. Again, it has been developed for the healthcare context found in the United States and was very much influenced by Madeline Leininger's work.

The model itself is composed of five main areas for developing cultural competence, that is: 'the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire' (p. 181).

The American Association of Colleges of Nursing (2008) developed a toolkit of resources to support the development of cultural competency in student nurses and offers a good explanation into the meaning of each of these five areas. They are

- **Cultural Awareness. The nurse becomes sensitive to the values, beliefs, lifestyle and practices of the patient/client, and explores his or her own values, biases and prejudices. Unless the nurse goes through this process in a conscious, deliberate, and reflective manner, there is always the risk of the nurse imposing his or her own cultural values during the encounter.**
- **Cultural knowledge is the process in which the nurse finds out more about other cultures and the different worldviews held by people from other cultures. Understanding of the values, beliefs, practices and problem-solving strategies of culturally/ethnically diverse groups enables the nurse to gain confidence in his or her encounters with them.**
- **Cultural skill as a process is concerned with carrying out a cultural assessment. Based on the cultural knowledge gained, the nurse is able to conduct a cultural assessment in partnership with the client/patient.**
- **Cultural encounter is the process that provides the primary and experiential exposure to cross-cultural interactions with people who are culturally/ethnically diverse from oneself.**
- **Cultural desire is an additional element to the model of cultural competence. It is seen as a self-motivational aspect of individuals and organizations to want to engage in the process of cultural competence.**

(Campinha-Bacote, 2002 cited in American Association of Colleges of Nursing, 2008, p. 5)

Ingram (2011) used this model 'to examine the relationship between health literacy and cultural competence' in the literature and came to the conclusion that 'nurses can care for ethnic minorities by using resources that target health literacy deficits and by increasing their own cultural competence'.

We can see that commonalities between the models discussed in this chapter are appearing in these mainly US context developed models and we can also see the influence in the next one which has been developed by a small group of colleagues in the United Kingdom.

Papadopoulos, Tilki and Taylor's model of developing cultural competence

Papadopoulos, Tilki and Taylor recommended using a

> **model for transcultural care that is underpinned by the principles of anti-oppressive practice; the successful application of this model depends on the commitment by the whole organisation not just by those who deliver hands-on care.**
>
> *(Papadopoulos et al., 1998, p. 175).*

Their model was called the transcultural skills development model, and it was built around four stages:

- Cultural awareness;
- Cultural knowledge;
- Cultural sensitivity;
- Cultural competence.

For each stage they built in a set of exercises that the reader could pursue in order to obtain a more detailed knowledge of different cultures. One exercise used 'ethno-history', and cited as an example the former Yugoslavia as an area from which refugees have arrived in the United Kingdom. The importance of understanding the culture of the refugees is relevant from both physical and mental health perspectives. Culture shock and the effects of being displaced from their own country may be mixed with the aftereffects of mental and physical trauma. This could result in severe stress and communication problems. An understanding of how these people came to be refugees is therefore crucial to helping them. This example illustrates the need for an awareness of cultures other than those that are established in the United Kingdom.

The achievement of cultural competence is dependent on the healthcare practitioners addressing 'prejudice, discrimination and inequalities': that is, practice which is 'anti-discrimination and anti-oppressive' (Papadopoulos et al., 1998). Since 1998 the model has been developed further (Papadopoulos, 2006), but has retained the four essential elements of cultural awareness, competence, knowledge and sensitivity (Papadopoulos, 2006), and is named as a model for developing cultural competence. Papadopoulos (2006) also recommends the model for assessing the cultural competence of researchers, by utilizing the four elements to assess whether studies actually take account of cultural issues such as 'cultural self-awareness' in interviewing others of a different culture.

Since developing this early nursing model, Papadopoulus and colleagues have been developing new areas related to cultural awareness, namely culturally compassionate care (Papadopoulos and Ali, 2015) and how that links with their original model as discussed. This is also linked to the publication of 'Compassion in Practice' (Department of Health, 2012) which has established the '6 Cs' of care, compassion, competence, communication, courage and commitment,' as the key values to aspire to for all those nurses, midwives and other care staff in the NHS. An outline of their project into this area can be seen at this link:

http://www.mdx.ac.uk/__data/assets/pdf_file/0005/59774/Teaching-and-Learning-Compassion.pdf (accessed 14 March 2016)

Roper, Logan and Tierney's model of nursing

A nursing model that is familiar to most nurses in the United Kingdom is Roper, Logan and Tierney's model based on the activities of living (Roper et al., 1996; Holland et al., 2008). This model identifies factors that affect 12 activities that they consider to be a part of every individual's daily living. These are

- Maintaining a safe environment;
- Communicating;
- Breathing;
- Eating and drinking;
- Elimination;
- Personal cleansing and dressing;
- Controlling body temperature;
- Mobilizing;
- Working and playing;
- Expressing sexuality;
- Sleep;
- Dying.

In addition to these activities of living are key factors that can influence them and are essential in the assessment of a patient's needs. These are biological, psychological, sociocultural, environmental and politico-economic.

Although cultural perspectives are promoted in relation to each activity of living, the model does not offer specific examples to illustrate its application to different cultural groups. However, the model framework could be used in much the same way as Purnell's model of competence, using the 12 activities of living to analyse individual cultures. It is important, however, that this does not become a 'recipe' approach to individualized care, but could offer guidance to practitioners to consider key issues when assessing someone's needs and planning and carrying out care.

An example of its use 'transculturally' can be seen in the experience of Heslop (1991) working in a Tibetan refugee settlement in Northern India. She undertook an assessment of the activities of daily living of a young Tibetan child called Tensin using Roper et al.'s model of nursing. The boy's father, Sonan, by using these activities as a guide, was able to identify the child's problems in relation to the poliomyelitis from which he was suffering. A plan of care was then implemented and evaluated. An understanding and awareness of the family's beliefs in Tibetan medicine and Buddhism had been an essential prerequisite to the provision of holistic care.

However, there is a danger of using cultural assessment guides as checklists (Fleming et al., 2008), and Mulhall (1994) believes that it is important to ensure that nurses take into account how patients 'perceive and interpret sickness in terms of their own symbolic systems'. One way of doing this could be through undertaking research that takes into account the 'insider's' experience of their

culture and illness. For example, a study by Payne-Jackson (1999) of adult-onset diabetes in Jamaica shows how a community training programme is being established to ensure that conflict between the biomedical and folk models of illness would be reduced. The researcher gained an 'insider' cultural perspective on how adult Jamaicans perceived diabetes and how they managed their own treatment.

Reflective exercise

1. Identify the knowledge and skills that you will need to undertake an assessment that is culturally appropriate for all patients.
2. Discuss with your colleagues how you can help one another to understand more about different cultures, their health and illness beliefs and how their religion can influence the care they require (see the Appendices for further information about the influence of religion on healthcare practices).

The following case study may be of value in helping you to identify some of these issues.

Case study

Mrs Amina Begum, a 45-year-old woman, is admitted to Ward 5 in a large district general hospital for investigations related to a persistent cough, increased sputum and loss of weight. She has also become very tired and unable to undertake her normal household activities. She has recently returned from a visit to her relatives in Pakistan and was persuaded to consult her GP by her sister, who had noticed her increasing health problems. The GP sent her to a consultant physician who, following preliminary tests, felt that it was necessary to admit her to the hospital.

On arrival at the ward, Mrs Begum is accompanied by her daughter, who explains that this is her mother's first visit to a hospital and although she is able to converse in English, she does not always hear properly and therefore may not understand the questions asked or information given to her. Her daughter informs the staff nurse that her mother is waiting for a new hearing aid but is unable to use sign language. The staff nurse, after introducing himself, asks how Mrs Begum wishes to be addressed, and is told that Amina would be acceptable during her stay in the hospital. The nurse then undertakes a full assessment of her needs and enquires whether Amina has any food preferences and any personal cleansing and dressing requirements. The nurse informs Amina and her daughter that shower and bidet facilities are available on the ward and that her cultural dietary needs would be met. As weight loss is a problem, Amina will need to have additional supplements to ensure adequate nutrition. After this initial assessment, both women are taken round the ward and shown the day-room and dining room, but this tires Amina, who begins to cough, and the nurse notices blood on the tissue she used.

Exercise

Using a model of nursing of your choice, assess Amina Begum's specific cultural needs during her first week in the hospital.

Listed below are some of the specific cultural needs that you may have considered if you used a nursing model such as that of Roper et al. (1996). A similar example using the Roper et al. model of nursing, of a Muslim lady named Razia Bibi, can be seen in Holland et al. (2008).

1. *Communication*: This patient has no difficulty in either speaking or understanding English. However, she has a hearing problem which could affect the nurse's perceptions of her ability to communicate effectively.
2. *Eating and drinking*: She will need an appropriate diet (e.g. Muslim diet). She may eat halal meat or be a vegetarian.
3. *Elimination*: She will require facilities for washing after elimination (e.g. bidet or shower facilities).
4. *Personal cleansing and dressing*: She may wish to wear her own clothes (e.g. shalwar kameez). These are worn day and night. She may also wear a long scarf, chuni or dupatta, particularly when being visited by strangers, older people or men (Henley, 1982).
5. *Expressing sexuality*: This includes aspects such as body image, weight loss and religious preferences. She might not be happy about a male nurse caring for her, especially if she needs to discuss matters of a personal or intimate nature.

If nurses are to be sensitive to the needs of patients from different cultures, they need to be able to:

- Assess and identify the specific cultural needs of their patients and how these would affect their other needs;
- Understand the cultural background of their patients;
- Plan interventions with the patient (as necessary) which take into account their cultural care needs;
- Have skills and knowledge to enable them to intervene on their behalf or access others in the wider community who can do so;
- Manage care for a number of different cultural groups.

Higginbottom et al. (2011) undertook an extensive review of the literature with regard to nursing assessment models/tools (including five of the above) which were 'validated in clinical practice for use with diverse ethno-cultural groups' but in conclusion agreed that 'a paucity of research exists that specifically investigates and evaluates the use of a model or tool in improving nursing care delivery and patient satisfaction outcomes'. They did find that some looking at the delivery of culturally competent care had been used in research studies 'involving the education and training of nurses and health professionals'.

CONCLUSION

We can see that the implementation of cultural care is dependent on many factors, including the nurse's own personal beliefs and practices. Prejudice and racial discrimination have no place in the delivery of culturally sensitive and appropriate care. When using frameworks for care assessment

as identified in this chapter, it is also essential to ensure the individuality of the patient and not be influenced by cultural and religious stereotypes.

Nurses cannot be 'experts' in the cultural knowledge and competencies required to care for patients from the many different cultures that make up societies worldwide. Being culturally aware, however, of the various possible needs of someone from a culture that is different to their own can make a significant difference to the care that they deliver to patients in the variety of healthcare settings.

CHAPTER SUMMARY

1. Patient care needs both to be appropriate to the individual and to take into account their cultural and religious beliefs.
2. When using nursing model frameworks for care, nurses need to ensure that they undertake an assessment that takes into account the cultural and religious background of the patient as it affects all aspects of their daily living.
3. Although nurses do not need to be cultural experts, it is essential that they have an awareness of the possible effects that cultural differences can have on all aspects of care delivery.

FURTHER READING

Burnard, P. and Gill, P. 2008. *Culture, Communication and Nursing*. Harlow: Pearson Education.

This book offers valuable insight and guidance on many issues related to culture and communication and how these can be integrated into nursing.

Jirwe, M. 2008. *Cultural Competence in Nursing*. Unpublished PhD study, Karolinska Institute, Sweden (accessed online 11 August 2009).

A thesis that explored the meaning of cultural competence and how it was understood by nurses, student nurses, nurse teachers and researchers.

Tortumluoglu, G. et al. 2006. The implications of transcultural nursing models in the provision of culturally competence care. *ICUS NURS WEB Journal*, January–April 25, 1–11.

This article offers an evaluation of three main cultural models discussed in this chapter and an evaluation of their value in application in practice. There is an extensive reference list to support the evidence-based evaluation.

WEBSITES

http://www.gypsy-traveller.org/health/health-status

This website offers an insight into a range of issues, including health and education related to Gypsy Travellers in the United Kingdom.

http://www.nurseinfo.com.au/becoming/aboriginalhealth

This website offers an insight into a range of topics and resources for those considering becoming a nurse in Australia and has links to other major developments in relation to health of Aboriginal communities, for example, http://ww2.health.wa.gov.au/Improving-WA-Health/About-Aboriginal-Health.

http://www.health.nsw.gov.au/nursing/aboriginal-strategy/Pages/default.aspx

This site focuses on the New South Wales Australia Aboriginal Nursing and Midwifery Strategy but also includes a link to the NSW Aboriginal Health Strategy http://www.health.nsw.gov.au/aboriginal/Pages/aboriginal-health-plan-2013-2023.aspx.

http://www.aacn.nche.edu/education-resources/toolkit.pdf

This site focuses on the American Association of Colleges of Nursing:
Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses
Their overview of this toolkit states: 'The purpose of the Cultural Competency Tool Kit is to provide resources and exemplars and to facilitate implementation of cultural competencies in baccalaureate nursing education. The toolkit identifies significant content, teaching-learning activities and resources that will help faculty integrate cultural competency in nursing curriculum. The contents in this toolkit are not necessarily the only information to consider as there are many references, organizations and links related to cultural competency' (AACoN, 2008).

https://www.youtube.com/watch?v=-pgCPJSiKoo

This site is a very different site and as long as you discount the initial opening it is very informative and has been accessed many times. It is called Japan; Tradition and Culture. It looks at Shinto beliefs and meditation; traditional cuisine and eating and communication with Japanese people explained through the eyes of different Japanese people, including the Japanese Tourist Board which actually shows the general issues impacting the country and therefore the people who live there.

https://www.lonelyplanet.com/japan/travel-tips-and-articles/77764

This site is related to a book company and must not be treated as an explicit evidence-based site. However, the content is very informative for the reader about visiting Japan and ensuring respect for their culture and beliefs.

https://www.youtube.com/watch?v=V8tOasE3hEU

This site is called: Cultural Awareness in Healthcare: Understanding the Need.
It involves the late professional Madeline Leininger and many other examples of communication between nurses and patients. She also talks about her model.

CHAPTER 3

Religious beliefs and cultural care

Karen Holland

INTRODUCTION

Nurses care for individuals who have different religious beliefs and backgrounds, and Neuberger (1994) believes: 'The first requirement for anyone caring for a patient and wishing to recognise his spiritual and cultural needs is to know something of the basic beliefs of the religion concerned' (Neuberger, 1994, p. 8).

This chapter provides an introduction to some of the main religions practised in the United Kingdom and the ways in which these influence healthcare practice. These religions are also found internationally, and as such must always be viewed against the broader cultural, political and social context in which they exist. This context in turn will have a major impact on health care in various countries worldwide, and beyond the scope of this chapter and book to explore them all.

Four religions form the focus of this chapter, namely *Jehovah's Witnesses*, *Christian faiths* (see also Appendix 1), *Islam* (see also Appendix 4) and *Hinduism* (see also Appendix 3). These were chosen to reflect the impact of major belief systems on aspects of daily living and health care. Other religions and associated practices are introduced throughout the book, and a brief summary of Buddhism, Judaism and Sikhism can also be found in the Appendices.

This chapter will focus on the following issues:

- Religion and spirituality
- Religions and healthcare practice
- Jehovah's Witnesses
- Christian faiths
- Islam
- Hinduism

RELIGION AND SPIRITUALITY

The Department of Health in the United Kingdom had long recognized the need to ensure that religious and cultural beliefs of patients and their families were met by both staff and the wider organization (Department of Health, 1996). This was also important for their carers and members of community and hospital healthcare teams. The Department of Health (1996) stated, 'You can

expect the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places' and a National Association of Health Authorities and Trusts (NAHAT) report (1996) offered the following guidance to NHS Trusts in their responsibilities to meet this standard:

- **Adopt a holistic approach to the delivery of health care.**
- **Recognize that 'spiritual' does not necessarily mean 'religious'.**
- **Treat people as individuals and do not make assumptions about their spiritual needs because they come from a particular social or ethnic group.**
- **Accept that not all religions are based on the same criteria.**
- **Enable people in hospital to have access to those who are most likely to be able to help them to meet their spiritual needs.**
- **Provide a platform for all sections of the community to meet their spiritual needs in the hospital.**

(National Association of Health Authorities and Trusts, 1996, p. 5)

As a result of this commitment, NHS Trusts ensured that they had guidance in place to assist staff in meeting patients' needs through providing guidance on various religions and cultures and how this affected their care needs (see the websites list at the end of this chapter for examples). The Department of Health in the United Kingdom then published a new guide for the NHS entitled *Religion or Belief* (Department of Health, 2009), which offered not only guidance on how religion and belief should be considered in care but also offered some examples from practice and links to other resources. An example of this is information on how religious beliefs influence end-of-life care (see Chapter 12).

Since 2009, however, the focus has been more on the actual culture of care in organisations (National Audit Office, 2014-Care Quality Commission Report) in the aftermath of the investigation and subsequent published report (Francis, 2011) and religion, spirituality and health beliefs of people have become an integral part of the outcomes across all of health care in England. An example of this can be seen in the Religion & Belief Code of Practice: Guidance document (St George's Hospital, 2014) which 'outlines what reasonable accommodation the institution may offer for reasons of religious observance' which 'may be requested by students undertaking healthcare work/study both within the university and while on placement' (Introduction page).

It is, however, essential in any difficult situation involving change in organisations which impact on people's lives and well-being not to forget the spiritual and religious beliefs involved in caring for patients.

When people are ill we know, for example, that the way they feel about themselves or their attitude to life can affect their progress. This can be either positive or negative. Consider the following statement made by a woman with breast cancer:

> **I relied on God mentally a lot. I was afraid and scared so I wanted someone to rely on. I begged him that I was repentant about the bad things that I had done, so wouldn't he please let me live. I believe that God is eternal and omnipotent, so he has enough power to take care of me. I sometimes get tired of him and sometimes not. But now he is a big help to me.**
>
> *(Kyung-Rim, 1999, p. 91)*

Reflective exercise

Consider how you would have reacted if a patient had said this to you, and then asked 'What do you think?'

There is no right or wrong answer to this question. As nurses, we are expected to be able to communicate and reassure our patients, but sometimes this is difficult, especially if we have not come to understand our own beliefs about such life-threatening situations. However, not all religions are based on such beliefs in God, and it is important for nurses to have some understanding of the basic principles that underpin other religious and spiritual beliefs.

RELIGIONS AND HEALTHCARE PRACTICE

Jehovah's Witnesses

According to the BBC website (2009; see the websites list at the end of the chapter) there are reportedly 'about 6.9 million active Witnesses in 235 countries in the world (2007), including 1 million in the United States and 130,000 in the United Kingdom'.

Jehovah's Witnesses believe in both the Old and New Testaments of the Bible, and they regard Jesus Christ as the Son of God (Jehovah). However, they believe that the cross is a 'pagan symbol and shun its use' (Schott and Henley, 1996), they do not regard Sunday as a holy day, and they do not celebrate Christmas or Easter. Jehovah's Witnesses refer to each other as 'brothers' and 'sisters', and each congregation is led by a group of men known as Elders. They also believe in trying to reach the community with their religious messages, in much the same way that Jesus did. They have their own publication, called *The Watch Tower*, which they give to people during their household visits. Their religious beliefs about blood and blood products are of major significance in terms of health care. They are not allowed to eat blood or blood products, neither are they able to receive blood transfusions, as they believe that a human being must not have his or her life prolonged with another creature's blood (Schott and Henley, 1996).

The influence of Jehovah's Witnesses' beliefs on healthcare practice

Jehovah's Witnesses will normally accept all forms of medical treatment with the exception of infusion with blood and blood products. Most Witnesses carry cards which state this clearly and hospitals also have forms that Witnesses are required to sign refusing blood and blood products. This includes:

> **Whole blood, red cells, white cells, platelets and plasma. Blood fractions such as Factor 8, anti-D and globulins are considered to be substantially different from whole blood and from the constituents that nourish and sustain the body. These are therefore not strictly prohibited and it is up to individual Witnesses to decide whether to accept these products.**
>
> *(Schott and Henley, 1996, p. 326)*

Auto transfusion (transfusion of one's own blood) can be used, but only if the blood has not been stored and it is used immediately. It is acceptable for a patient to have a blood test provided that no blood is retained. A major ethical dilemma for many nurses and healthcare practitioners occurs

when a parent refuses a blood transfusion for their child, and in some extreme cases the decision has been overruled by a court order. The Jehovah Witness Hospital Liaison Committee will offer help and advice on all matters related to the health of Witnesses (Henley and Schott, 1999).

Consider the following case study of Mr Alias.

Case study

Mr Alias, a 40-year-old man, is admitted to the intensive-care unit following a road traffic incident. He is diagnosed as having lacerations to his liver and abdominal injuries. The doctor orders that he is to go to the operating-theatre for surgery. The patient informs the nurses that he is a Jehovah's Witness and agrees to the surgery, but will not allow them to give him any blood transfusions.

(Adapted from Carson, 1989)

1. What are the implications for nurses of a patient refusing a blood transfusion?
2. How would the nurse ensure that the Nursing and Midwifery Council (NMC) Code of standards of conduct, performance and ethics for nurses and midwives (2015) was adhered to, and ensure that the patient's own spiritual and religious needs were met?

Points to consider

1. All events involving the nurse and the patient need to be documented as fully as possible in the patient's nursing notes.
2. Information that is given to the patient about alternatives to blood products must be recorded.
3. The patient's family may require additional support; they may or may not be Jehovah's Witnesses themselves.
4. If Mr Alias dies during surgery, the nurses and doctors may wish to discuss their own feelings and beliefs with someone, especially with regard to the religious beliefs of the patient. Such an incident can cause much stress among staff.

Jehovah's Witnesses are also not allowed to undergo termination of pregnancy or sterilization, as these interventions are interpreted as taking life and interfering with nature; euthanasia is, therefore, also not supported. There are no special practices related to death other than prayer and Jehovah's Witnesses can be either cremated or buried after death. There are many special cases reported in the papers in different countries about the courts in those countries having to intervene in the health care of some Jehovah's Witnesses, especially children (Woolley, 2005).

Christian faiths

Most people in the United Kingdom who are practising Christians belong to the Church of England (the Anglican Church), the Roman Catholic Church or the Free Churches (e.g. Methodist, Baptist or Pentecostal churches). The holy book of Christians is the Bible, and the Christian holy day is Sunday. Other important times of the year are listed in Box 3.1.

Box 3.1 Important days in the Christian calendar

- Christmas Day (celebrates the birth of Jesus Christ)
- Ash Wednesday (first day of Lent)
- Lent (a 6-week period during which some people fast or abstain from certain foods as penance)
- Good Friday (in remembrance of the torture and death of Jesus Christ on the cross)
- Easter Sunday (celebrates Jesus rising from the dead)
- Ascension (celebrates Jesus rising physically into heaven)
- Pentecost (celebrating the descent of the Holy Spirit on the disciples)

In conjunction with these holy days there are special religious 'rites' which involve either the individual or the whole community. Some of these are particularly important for patients who are ill either at home or in the hospital. In normal circumstances only an authorized person may carry out the associated rites, which are also known as sacraments. Christian rites are listed in Box 3.2.

Box 3.2 Christian rites

Individual rites – Baptism, confirmation and marriage
Community rites – Communion and mass; penance and confession; anointing Baptism – when a person is admitted to the Christian community
Confirmation – A personal commitment and acceptance by the individual (of the Christian community)
Marriage – The personal commitment of two individuals to family life
Communion/mass – 'Feeding' of the community and spiritual communion with God (usually in a church or other consecrated area)
Penance – A formal acceptance of blame for some past wrongdoing, which requires the individual to strive for a better way of life
Confession – Acknowledgement to a priest of some past wrongdoing and a request for forgiveness to enable the individual to begin to live in a better way
Anointing – A spiritual strengthening by a nominated chaplain or priest at times of stress, sickness or death

Prayer is very important to most practising Christians, especially during periods of stress and crisis (e.g. dying). They may wish to be provided with a Bible if they are admitted to the hospital without their own copy. Roman Catholic patients may have rosary beads with them, or may wish to have religious pictures pinned to their bedclothes. Some Christians may also wear religious jewellery, such as a cross or medallions of saints (e.g. St Christopher). These must not be removed unless it is absolutely essential, and even then only with the patient's permission (as is the case for all cultures who wear jewellery of religious significance).

Reflective exercise

Find out what services and facilities are available for Christians in:

1. Your local hospital.
2. The community around your local health centre.

You will probably find that services and facilities vary according to the social and cultural groups to be found in the local population. Most hospitals have an area identified for multidenominational worship, and many have a Christian chapel. In large district general and teaching hospitals, there are hospital chaplaincies that employ either part-time or full-time chaplains. A local priest may also have special responsibility for the religious and spiritual care of Roman Catholics in the hospital. In the community there will be church and chapel buildings, but as the population has changed with regard to its beliefs and culture, these may no longer be used for Christian worship. This has resulted in many of these buildings being converted for other uses (e.g. restaurants, private housing).

Effects of Christian beliefs on healthcare practice

Blanche and Parkes (1997) provide an insight into how Christian beliefs become evident during periods of crisis, and readers of this book may recall similar stories. Consider the following example of George Jones, aged 73 years, who was having a heart attack and, with his wife Phyllis and his neighbour, was waiting for the ambulance to take him to the hospital.

Case study

Phyllis was an Anglican; she believed in God and went to the local Church of England regularly. She had learned her religion from her parents and saw the Godhead very much as a Holy Family. She loved Jesus, whom she knew to be the Son of God and regarded him as a personal friend. She particularly enjoyed the pictures of Mary and the baby Jesus which reminded her of her relationship with her own children. She had confidence that when her turn came, Jesus would find a place for George and her in heaven. She sometimes worried about his refusal to go to Church. George thought religion was nonsense but he explained to his friends that this did not mean that he was an atheist. He went to weddings and funerals, and he reprimanded his grandchildren when they swore. George survived in hospital for less than a day.

(From Blanche and Parkes, 1997, p. 131)

How do you think Phyllis (with her Christian beliefs) would cope with George's death?

Points to consider

1. Phyllis could gain great comfort from her beliefs and her church, but she might also feel that her God had let her down. This is particularly often the case in situations that involve a sudden bereavement or watching someone in severe pain.

continued

Case study

2. After her husband's sudden death Phyllis might wish to spend some time on her own or in the hospital chapel. The hospital chaplain may already have been to see her husband in order to offer to pray with them both.

All practicing Christians in hospital should be offered the support of the hospital chaplains, and many will want to continue with their normal Christian rites at this time. For example, on Good Friday or Ash Wednesday, Catholics do not eat meat or drink alcohol. This is regarded as a symbolic sacrifice in memory of Christ's death, and some Christians continue to follow this practice every Friday. Fish may be eaten instead. However, as in many other religions, the requirement for fasting is lifted during hospitalization (Carson, 1989). An example where this is essential is in relation to the potential effects of fasting on Type 1 diabetes, where there is a risk of a hypoglycaemic (low blood sugar) coma (Morris and Worth, 2006).

Different groups of Christians 'behave differently at the time of death' (Neuberger, 1994). For example, patients from an Orthodox Church may wish to keep a family icon with them at all times. However, Neuberger (1994) points out that these icons are often of monetary as well as personal value, which could make it difficult to keep them safe in a hospital environment. She suggests that sensitivity to the patient's needs in such cases is important.

For nurses involved in family planning services or working in gynaecology wards, the rules with regard to contraception and termination of pregnancy are of particular significance. Schott and Henley (1996) state, 'The Roman Catholic Church forbids all artificial contraception, including sterilisation, on the grounds that it interferes with God's natural law. Contraception using the safe period (rhythm method) is permitted' (p. 297).

Termination of pregnancy is viewed by practising Catholics as murder and a mortal sin. Practising Anglicans also believe strongly that abortion is wrong, but like many Catholic women today some will agree to a termination if the baby has a serious congenital abnormality, or if they have been subjected to rape.

Reflective exercise

1. Find out the current position of the Nursing and Midwifery Council in the United Kingdom or the professional body in your own country, with regard to nurses and their personal religious objections to taking part in the termination of pregnancy and the care of women in the preoperative and postoperative period.
2. Discuss your findings with colleagues from different cultures and religious backgrounds.

Your discussion will probably have revealed significant individual and cultural differences. However, it is important to remember that, as a nurse or healthcare practitioner, you are bound by a professional code of conduct that gives guidance on how you should act in your role. Your personal beliefs may conflict with professional expectations in situations such as participating in the termination of pregnancy. This leads some nurses, once qualified, to deliberately choose not to work in clinical areas where they would experience such conflict.

Key points

1. Christians belong to many different churches (e.g. Roman Catholic, Baptist, Church of England).
2. Prayer is important to practising Christians during periods of crisis and illness.
3. Many Christians carry or wear jewellery which has religious significance (e.g. St Christopher medallion).

Islam

Islam is one the world's major religions; it is the religion of Muslims. There are many different Muslim sects, and it is important to be aware of this, especially as some are stricter in their practices than others. The two main branches are Sunni Muslims and Shia Muslims. According to Henley (1982), Sunni Muslims believe that 'every Muslim has an equal status before God', whereas the Sihia Muslims believe that there is 'a continuous line of divinely designated charismatic leaders'. Being a Muslim involves obeying the rules which practising Muslims have to follow in all aspects of their life (Henley, 1982); it is therefore not just a religion but a way of life. Muslims believe that the Prophet Mohammed is the messenger of the one and only God, and that they must observe the five main duties or pillars of Islam: 'faith, prayer at five set times every day, giving alms, fasting during the month of Ramadan and making a pilgrimage to the sacred city of Makka [Mecca] in Saudi Arabia' (Schott and Henley, 1996, p. 313).

The Muslim Holy Book is the Qur'an (Koran), which according to McDermott and Ahsan (1993) is

> **the foundation and the mainstay of Muslim life; it binds Muslims together, gives them a distinct identity and fashions their history and culture. It deals with all the important aspects of human life, the relationships between God and man, between man and man, and between man and society, including ethics, jurisprudence, social justice, political principles, law, morality, trade and commerce.**
>
> *(McDermott and Ahsan, 1993, p. 20)*

The Muslim community in the United Kingdom is largely Asian, originating mainly from Pakistan, Bangladesh and India, although some also originate from East Africa. The main Muslim groups, together with their first language (Henley, 1982), are listed in Box 3.3.

Box 3.3 Muslim groups and their first language (Adapted from Henley, 1982, p. 9)

- Pakistan Muslims come from Mirpur District (first language, Punjabi–Mirpur dialect), Punjab province (Punjabi)
- Bangladesh Muslims come from Syhet District (first language, Bengali–Syheti dialect)
- Indian Muslims come from Gujarat State, especially the Kutch region (first language, Gujarati or Kutch dialect)
- Muslims from other areas of India often speak Urdu as their first language

The main place of worship is the mosque, and some NHS Trusts provide a small mosque or prayer room within their hospital. In some hospitals, the Muslim prayer room has become larger than the Christian chapel area because of increased use by the local Muslim communities which need their religious beliefs supported whilst either a patient or relative in hospital. In one mental health institution, it was shown by Saleem et al. (2012) that 'There was a significantly higher uptake of pastoral care services amongst those of Muslim faith compared to Church of England and Roman Catholic Christians'. Possible reasons for this are discussed within the article itself, an example being the presence of a Muslim faith chaplain.

The mosque is mainly a place of worship for men; it is also used for teaching children. In the United Kingdom, the Imam is in charge of each mosque. He also teaches the children as well as oversees all religious functions and offers pastoral support to those who may be ill and have no family. This segregation of men and women for worship, however, is being challenged in the United Kingdom by the Muslim Women's Council (see http://www.muslimwomenscouncil.org.uk/) and they have plans for a first women's only managed Mosque in Bradford (see http://www.muslimwomenscouncil.org.uk/news/). However, plans for this mosque are generating much debate.

EXERCISE

1. Read the information about the Muslim Women's Council and consider how religion impacts the lives of all members of the family. (See Chapter 6 for more about women and culture and Chapter 9 about children and young people.)

Muslims have to adhere to certain food restrictions as laid down in the Holy Qur'an. They do not eat pork or anything made from it or its products. Other meat is acceptable provided that it is 'halal' (i.e. killed according to Islamic law). This involves cutting an animal's throat and consecrating it in the name of Allah. If halal meat cannot be provided in the hospital, Muslims will eat a vegetarian diet. Jewish kosher food is an acceptable alternative, as this is killed in the same way. Alcohol in any form is forbidden. Every adult Muslim is expected to pray at five set times each day: 'after dawn, around noon, in the mid-afternoon, early evening (after sunset) and at night' (Henley, 1982).

Muslims are required to wash before praying and they must face Mecca during prayers. Washing is of special significance to Muslim patients, and in particular it should be noted that they are unable to pray if they have not washed themselves after urination or defecation. This is especially important for those patients who are unable to get out of bed. However, there are exemptions from the five daily prayers, including all patients who are seriously ill and women up to 40 days after childbirth and during menstruation, as they are considered unclean at these times.

The Muslim holy day is Friday (Raza or Siyan). There are certain times of the year when fasting is also compulsory and considered to be a form of worship. This means abstaining from taking food between dawn and dusk. This main compulsory fasting time is at Ramadan, the dates of which may vary from year to year in accordance with the time of the new moon. This makes it difficult to predict in advance when Muslim healthcare workers may require special

leave arrangements. This is more important if it occurs during the summer months, when the period of fasting is longer than in the winter months. Towns and cities where there are significant Muslim communities very often publish the dates of Ramadan in their local newspapers. The end of Ramadan is marked by the festival of Eid-ul-Fitr (often shortened to Eid). The word Eid means 'anniversary' and, after the first prayers, the day is spent visiting relatives and friends and exchanging gifts. Muslims also pay the Sadaqah al-Fitr (welfare due) for the poor (McDermott and Ahsan, 1993). In addition, those who can afford to are encouraged to make a pilgrimage to Mecca (Haj) at least once during their lifetime.

Reflective exercise

1. Discuss with a Muslim colleague or student:
   a. How they manage to work and cope with the fasting period at Ramadan;
   b. How they celebrate the festival of Eid-ul-Fitr.
   (See this site at University of Calgary Student Information for Muslim students and others to help with this exercise: http://www.ucalgary.ca/fsc/resources/general-resources/muslim-students.)
2. Find out about other Muslim festivals and their meanings.

Effects of Islamic beliefs on healthcare practice

As modesty is an obligation of Islam, nakedness and exposure of the body can be very distressing to both men and women. If at all possible, Muslim patients should be examined by a doctor or nurse of the same sex as themselves (e.g. during childbirth or gynaecological examination), and similarly 'diseases which require examination of the male genitalia and anus are likely to cause acute embarrassment when performed by a female doctor' (McDermott and Ahsan, 1993, p. 60). It is important to be aware of and responsive to the need for prayers, and the fact that associated bathing or washing will be important (for a discussion of death rituals, see Chapter 10). A study by Zeilani and Seymour (2011) looked at how Muslim women felt about 'bodily change and care during critical illness' (p. 99) and concluded that there is a 'complex interrelationship between religious beliefs, cultural norms and the experiences and meanings of bodily changes during critical illness' (p. 99).

There are certain issues that should be considered during pregnancy and childbirth which have a religious significance. Schott and Henley (1996) highlight the following:

- **Labour: A few Muslim women may be reluctant to use narcotic methods of pain relief on religious grounds as narcotics are forbidden in the Qur'an except in cases of overriding medical need.**
- **Immediately after the birth: Many Muslim parents consider it very important that a baby should be washed immediately after the birth to get rid of any impurity … Some may be distressed if the baby is given to them unwashed and may not want to hold or feed the baby until he or she has been cleaned properly.**

(Schott and Henley, 1996, p. 320)

McDermott and Ahsan (1993) also explain in the Islam Foundation Muslim Guide another Islamic practice which is of major importance to Muslims, namely that of saying the adhan (call to prayer) into the ears of the baby immediately after childbirth:

> **The whole 'ceremony' does not take more than 3–4 minutes; either the father or any member of the family stands in front of the baby and calls out the adhan in the ear of the baby as a mark of blessing. Sometimes members of the family prefer to bring along a learned member from the Muslim community to give the adhan for the child. The hospital authorities are not always aware of this Islamic religious custom, and often appear reluctant to allow a person other than the husband to visit the baby outside the visiting hours of the hospital. Muslims will be grateful if the parents are allowed to invite one other person to perform this brief ceremony – simple and short yet very essential for Muslims.**
>
> *(McDermott and Ahsan, 1993, p. 62)*

Reflective exercise

1. Consider how a midwife can demonstrate cultural awareness and respect for the Muslim faith at the time of labour.
2. Find out your local maternity department policy with regard to the Islamic practice of saying the 'adhan'.

Key points

1. Muslims believe that the Prophet Mohammed is the messenger of Allah, the one and only God.
2. The Qur'an (Muslim holy book) is the guide to Muslim life.
3. Washing and modesty have religious as well as practical significance.

Hinduism

Hinduism is not only a religion but also a whole way of life for a large number of people from India. Unlike other religions and belief systems, it has 'no single founder or major prophet from whom all events are dated' (Henley, 1983) and no single holy book to which Hindus can refer. However, the most popular book is the Bhagavad Gita. There is a fundamental belief in the Hindu Dharma (ways of conduct or laws of nature) and a belief that God is One and is called by different names. They also believe that this God can take many forms – male, female or animal.

The three main Hindu gods are 'Brahma, the Creator, symbolizing creative power, Vishnu, the Preserver, who preserves and maintains what has been created, and Shiva, the Destroyer, who brings all things to an end' (Henley, 1983, p. 3).

These three gods represent the Hindu belief that everything in the universe is in a constant eternal cycle. Because of this, Hindus believe in reincarnation and that their eternal soul (atman) does not die but is reborn again in another body.

Most Hindus are from India, and the main groups in the United Kingdom are listed in Box 3.4.

Box 3.4 The main Hindu groups in the United Kingdom and their first language

- Gujarat (first language, Gujarati)
- Punjab (first language, Punjabi or Hindi)
- Small groups from Delhi (first language, Hindi or Punjabi)
- West Bengal (first language, Bengali)
- Kerala (first language, Malayali)
- Tamil Nadu (first language, Tamil)

Karmi also informs us:

> **every Hindu is born into a caste which is determined by individual karma in a previous life. This reflects the central Hindu tenet of reward for good deeds and punishment for wickedness. Orthodox Hindus believe that a person's karma is permanent and cannot be altered, and disapprove of the mixing of castes through contact in any form. The caste system continues to exert a strong influence in Indian society as well as among Indians in Britain, particularly when marriage partners are chosen.**
>
> *(Karmi, 1996, p. 20)*

The four castes are

- Brahmins (highest caste)
- Kshatriyas
- Vaishyas
- Shudras (the lowest caste)

There are also individuals with no caste who are known as the Outcastes or Untouchables. These people undertake work that is considered to be 'spiritually polluting, such as cleaning streets and lavatories and dealing with dead animals' (Schott and Henley, 1996).

Effects of Hindu beliefs on healthcare practices

In order to understand how the Hindu religion and way of life influence the care that is given to patients in the hospital, consider the following case study.

Case study

Shri Rajkumar Sharma, a 55-year-old man, is to be admitted to the hospital for removal of the prostate gland. He is accompanied by his wife and son, who inform the Ward Sister that it is Diwali, the Hindu Festival of Lights, in 2 days time.

continued

Case study

As the nurse who will be caring for him, you will need to undertake an assessment of his needs in order to plan culturally appropriate care. The following factors will require specific consideration on his admission to the hospital:

1. The Hindu naming system;
2. Specific dietary needs;
3. Specific personal cleansing and dressing needs;
4. Religious practices whilst in the hospital.

The following information will help you to make an informed decision.

Hindu naming system

The first point to note is the man's name. 'Shri' is the equivalent of Mr (if the person was a woman it would be Shrimati – Mrs). Rajkumar – Raj is the man's personal name and Kumar is his middle name (only used with his first name and not normally used on its own).

Sharma is the surname or family name. This is often a caste name. Many Hindu families in the United Kingdom share the same caste or family name (Henley, 1983) because most of them originate from the same geographical areas in India (i.e. Gujarat and Punjab). The family name of Patel is therefore very common.

However, it is very important to remember that according to Hindu custom only the first and middle name will be given (e.g. Rajkumar). This could be wrongly recorded (e.g. Kumar being identified as the surname). It is therefore important to ask for the first name, middle name and surname for recording purposes. When asked for her name as 'next of kin', his wife will include her husband's name after her own first and middle name (e.g. Lakshmidevi Rajkumar Sharma).

This naming system is most important when patients on a ward have the same family name (e.g. Sharma or Patel) (see Chapter 8 for a discussion on children's names).

Dietary needs

Hindus believe that all living things are sacred, and most will not eat meat or meat products. In addition, many Hindus will not eat fish or eggs. The cow is considered to be sacred, and dairy produce is only acceptable if it contains no animal fat. Some Hindus will eat meat but not beef or pork. The pig is considered to be an unclean animal.

It will be important to check whether Mr Sharma is able to read English in order to understand the menu sheets, and that any questions he may have about the content of the hospital food or how it is prepared are answered truthfully. Many older people refuse to eat any hospital food, preferring their meals to be brought into hospital by relatives. If this is the case, it is important that nurses or the dietician ensure that foods prohibited on medical grounds are made known to them (see Chapter 10 for a further discussion of food preferences).

Personal cleansing and dressing needs

Mr Sharma may wear a kameez (a loose shirt with or without a collar) and trousers with a drawstring (pyjama). If he is a high caste (Brahmin) he may also wear a sacred thread (janeu) which consists of white cotton thread with three strands and is worn over the right shoulder and round the body. This must not be removed unless it is absolutely necessary. The head is

considered to be the most sacred part of the body and the feet the dirtiest. Therefore, when putting his clothes in his bedside locker, it is important not to store his shoes in the same place.

Washing in running water is very important to Hindus. Mr Sharma will be unable to do this for himself in the immediate postoperative period, and he will need help with it, as until he has washed in this way he will be unable to eat or drink.

Having a catheter will be a potential source of embarrassment to him: urine is considered to be polluting and he may be upset by having to look at the catheter bag. During visiting hours he could sit in a chair and the catheter bag could be covered up by a blanket. All body products and fluids that leave the body are considered polluting (i.e. urine, faeces, saliva, menstrual blood, mucus, sweat and semen). It will be important to Mr Sharma if all matters related to his surgery and its aftereffects can be discussed with either a male doctor or a male nurse (see Chapter 8 for men's healthcare issues).

Hindu religious practices

Hindus have a chosen god whom they worship, and every home has a prayer room (puja). The Bhagavad Gita (holy book) must be kept clean and safe if it is brought into the hospital. It is usually wrapped in a cotton or silk cloth for protection (Henley, 1983).

Mr Sharma will be able to attend the hospital temple (if one is available) before going to theatre if he wishes, and could be taken there when he is well enough postoperatively. If unable to attend a temple, privacy could be ensured for prayer by pulling the bed curtains around him.

There are no set times for prayer, although many Hindus pray first thing in the morning, around midday and in the evening. Holy days and festivals will be celebrated according to the main god that Hindus worship. The two main festivals are Holi and Diwali:

- Holi – Hindu spring festival (February/March);
- Diwali – Five-day festival of light and the goddess Lakshmi, the goddess of good fortune and prosperity (October/November).

It would be good practice, whenever possible, to take these important festivals into consideration when planning patient hospital admissions.

Key points

1. **Hindus belong to one of four main castes or one outcaste.**
2. **Hindu religion does not allow the eating of pork or beef, as the pig is considered to be an unclean animal and the cow is regarded as a sacred one.**
3. **The Hindu religion has no single founder or major prophet.**

CONCLUSION

As can be seen from this brief introduction to some of the world's major religions, their impact on health care is significant. An awareness of their meaning and importance for patients and clients and their families should therefore be an essential part of the induction of staff within healthcare environments. Healthcare organisations have a duty of care to both their staff and

the patients for whom they care, to ensure that there is information available for them to both understand each other's religious beliefs, and also how to engage with each other during a clinical or administrative situation.

Reflective exercise

1. Obtain and read a copy of your NHS Trust/Health Board guidelines for good practice with regard to the religious, cultural and spiritual needs of patients.
2. Discuss with your colleagues how these are being implemented in your workplace.
3. If a student, consider how your university supports the religious and cultural needs of its students and staff. An excellent example for you to consider as a baseline for your searching is that by St George's Hospital London which has developed a Code of Practice for healthcare students to help them understand differences in religion and belief (http://www.sgul.ac.uk/images/about/Policies/religion-belief-code-of-practice.pdf).

CHAPTER SUMMARY

1. Religion plays a significant role in the health and well-being of patients.
2. Nurses need to be sensitive to the religious practices of patients when they are ill.
3. Healthcare trusts are responsible for implementing patient charter standards that take into consideration the privacy, dignity and religious and cultural beliefs of patients.
4. *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (Nursing and Midwifery Council, 2008) acknowledges the importance of the spiritual and religious beliefs of patients and their carers.

FURTHER READING

Andrews, M. M. and Boyle, J. S. (2012) *Transcultural Concepts in Nursing Care*, 6th edition. Philadelphia: Wolters Kluwer Health/J B Lippincott.
This book offers a broad introduction to transcultural care and includes an excellent chapter on religion, culture and nursing.

Burnard, P. and Gill, P. (2008) *Culture, Communication and Nursing*. Harlow: Pearson Education.
This book includes a short chapter on beliefs and religion.

Kirkwood, N. A. (2005) *A Hospital Handbook on Multiculturalism and Religion*, 2nd edition. London: Morehouse.
This book offers practical guidance on a wide range of religions and related practices.

McSherry, W. (2007) *The Meaning of Spirituality and Spiritual Care within Nursing and Health Care Practice*. London: Quay Books.

Mootoo, J. S. (2005) *A Guide to Cultural and Spiritual Awareness*. London: RCN Publishing Company.
This book offers guidance for nurses on spiritual and cultural beliefs of a wide selection of different religions and cultures.

Sampson, C. (1982) *The Neglected Ethic*. Maidenhead: McGraw-Hill.
Although not a current text, this book still offers valuable insight into the spiritual and cultural beliefs of patients and the associated decisions required by healthcare practitioners. (It therefore remains on our list for this edition.)

WEBSITES

http://www.bbc.co.uk/religion/religions
This is a BBC website devoted to all aspects of religious beliefs. It has a large number of resources, including pictures of different religious practices at weddings, pilgrimage to Haj and Muslim prayer movements. There are also some quizzes that test your knowledge of various different religions and practices. (This is now an archived site on the BBC website: information available but no longer updated.)

http://www.rcseng.ac.uk/publications/docs/jehovahs_witness.html
This is a useful website for the code of practice for the surgical management of Jehovah's Witnesses (The Royal College of Surgeons of England).

http://www.scottishinterfaithcouncil.org/resources/Religion+and+Belief.pdf
This website links to a report on religious beliefs on health care in Scotland by the Scottish Inter-faith Council.

http://www.nes.scot.nhs.uk/education-and-training/by-discipline/spiritual-care/about-spiritual-care/publications.aspx
This is the NHS Education for Scotland site for spiritual care issues and has a large number of resources available including this document on Multi-Faith Resource Guide for Healthcare Staff, http://www.nes.scot.nhs.uk/media/3720/march07finalversions.pdf.pdf (accessed on 14 March 2016).

http://www.culturaldiversity.com.au/resources/practice-guides/spiritual-support
This site offers a range of resources from the Centre of Cultural Diversity in Aging from Australia. On this site there are many resources such as Guide to Care for Muslim Patients and An Outline of Different Cultural Beliefs at the Time of Death.
There are resources there that would also be of value in our other chapters.
Children of Jehovah's Witnesses and Adolescent Jehovah's Witnesses: What Are Their Rights? At website: **http://adc.bmj.com/content/90/7/715.full**
A site with additional up-to-date articles and resources regarding Jehovah's Witnesses.

https://www2.rcn.org.uk/development/practice/spirituality/about_spirituality_in_nursing_care
United Kingdom Royal College of Nursing website (2010) Spirituality in nursing care: online resource introduction.

CHAPTER 4

Understanding the theory of health and illness beliefs

Debbie Fallon

INTRODUCTION

An individual's views and beliefs about health and ill health are known as 'health beliefs'. We do not enter the world with an innate set of health beliefs; rather, from the moment we are born our lives are shaped by the health beliefs of those closest to us – which have often been passed down through generations. Through the processes of primary and secondary socialization we begin to embrace these ideas and come to view them as the norm, living by these unwritten health rules and perpetuating them until the moment of our own death. Many of these ideas are cultural in origin, where culture refers to the *way of life* of its members, the ideas and habits that they are taught and then pass on to the next generation. This means that daily decisions about what to eat, what to drink, or even how to engage with others will be influenced by an individual's cultural background (Bourdieu, 1984; Helman, 2007).

Culturally based beliefs have great influence during key life events such as confinement practices following childbirth, transition to adolescence, during motherhood, in terms of parenting, and in the rituals associated with death and dying and many of these life events have health-related dimensions. Healthcare professionals, whether working in institutions or in a community environment, will be tasked with accommodating the many and varied health beliefs of those they are caring for whilst simultaneously trying to help them maintain optimum health over the whole life course. They therefore need to understand the potential impact of culture on health behaviour, and to understand the relationship between culture, health and health inequality. It is important to acknowledge that whilst some cultural practices may enhance an individual's life experience, some will inevitably constrain – in terms of freedoms (e.g. child marriage) or bodily integrity (e.g. female genital mutilation) and it is crucial to understand the role of the healthcare worker in these circumstances.

This chapter will focus on the following issues:

- Health beliefs
- The three systems of health beliefs (or healing systems), namely biomedicine, personalistic and naturalistic systems
- The sectors of health care, namely the popular sector, the folk sector and professional medicine
- Pluralism in health care

HEALTH BELIEFS

What is a health belief?

Put simply, a health belief is a belief about health, what it means to 'be healthy' and ideas about the best way to behave in order to maintain the state of good health. It encompasses an individual's understanding about how illness and disease is caused, how it should be treated, and how and whether it can be controlled or cured. But this is a very individual enterprise, and as such can be complex, particularly since the definition of health is itself being debated (see Huber et al., 2011).

The concept of health is broad and complex and has a wide range of meanings. People's perceptions of health may change over their lifespan.

Perceptions of 'health' can change as a person gets older since the ageing process may result in loss of energy, function or ability to cope, whereas young people may view health in terms of their level of fitness and energy. Thus, health is not simply a well-functioning physical state, but rather it is a complex dynamic interplay of forces that is dependent on many variables, not least social, psychological, spiritual and emotional factors. Health beliefs are also ideas and conceptualizations about health and illness that are derived from the prevailing worldview. Often they relate closely to the world in which we live, where we live and the dominant social and economic environment. They are extremely complex and, like the notion of 'culture', they may change and evolve over time.

Health beliefs are activities undertaken by people in order to protect, maintain or promote health. Health maintenance practices are those guidelines and actions that are specific to each cultural group. These actions help people to stay well. Spector (2009) notes that in the United States black populations stress the need for diets that include three meals a day and in particular a 'hot breakfast'. Laxatives are also considered to keep the system 'running' or 'open'. Kaunonen and Koivula (2007) note that Finnish people place great value in the role of the sauna in maintaining health. Saunas are said to alleviate physical and mental stress, pain and tension, and promote good sleep. Parry et al. (2004) noted in interviews with Gypsy Traveller women that they placed great importance in keeping a clean home as a matter of pride and because cleanliness and hygiene were considered very important for health as a precaution against infection. Another woman noted that 'if this place wasn't clean I'd be depressed'. Indeed, in some Traveller sites bathrooms, toilets and laundry facilities may be kept separate from the main living areas as people may fear contamination.

A study by Prior et al. (2000) investigated the health beliefs of Cantonese-speaking communities in England and found that happiness was thought to be a central part of leading a healthy life: one respondent noted 'If you are happy (kuaile), have a happy family, have no heavy pressure, then you will be in good health'. Happiness was important to the extent that unhealthy behaviours were seen to be acceptable if they led to inner contentment. For example, if smoking made you happy then it was acceptable to smoke.

However, beliefs may also cause people to neglect or jeopardize their health status. An example of how health beliefs can change over time is the practice of sunbathing. In Victorian Britain, tanned or bronzed skin was considered unfashionable and a sign of working outdoors

and therefore belonging to the agricultural or lower classes. Women especially would shield their faces with a parasol, as fair skin was fashionable – a porcelain skin was much sought after. However, in the United Kingdom today, a suntan is generally associated with health ('looking good' and 'feeling healthy'). Suntans are a status symbol that signals affluence (i.e. the freedom to holiday abroad). Individuals may spend the whole of their annual holiday cultivating a suntan and, on returning home, are eager to show off their brown skin to their friends and relatives. They are often met with cries of 'Don't you look well!' Although medical advice warns against suntans, as they are associated with a high incidence of skin cancer, they continue to be associated with health and well-being. This example demonstrates that attitudes and beliefs are often socially constructed and change over time.

Why are we interested in health beliefs?

A working knowledge of the impact of culture on health beliefs and in turn on health behaviours helps us to understand why people might take up or avoid health services, health promotion advice or prescribed treatments. It also potentially enhances our understanding of an individual's attitudes to risk taking and as such may help us to understand or change harmful health behaviours.

Another important reason is to enhance our understanding of how an individual's transition to another culture, through immigration, or as a refugee or asylum seeker, can have a negative impact on their health and well-being, and what we can do as health professionals to help ameliorate this.

How do we form health beliefs?

There are a variety of factors that influence an individual's own perceptions of health – for example, their age, culture, ethnicity, religion, and the social context in which they experience this. However, Quah (2010) maintains that culture is not simply one of several factors that influences health 'but rather it is the *context* within which health related behaviour unfolds' (p. 27).

It is clear that culture plays a fundamental role in the formation of health beliefs. 'Socialization' is a key concept in sociology that refers to the process by which individuals *learn the culture* of their society – including ideas about health and illness. Primary socialization takes place in our early childhood years, usually within the confines of the family group. When a child begins to expand his or her social circle, moving out of the family surrounds into schools, peer groups or occupational groups, he or she is then exposed to the process of secondary socialization.

So, how do we learn to 'do' health? What health-related behaviour have we absorbed through primary and secondary socialization?

Examples of health beliefs include individual perceptions of

- What counts as illness?
- What are the causes of illness?
- Where do we go when we are ill?
- What do we do?
- What sort of behaviour do we undertake in order to maintain a state of optimum health?

EXERCISE

1. Consider these examples and make notes as to how you see them at the beginning of reading this chapter and Chapter 5.
2. Reconsider them when you have read these and see where you have developed new knowledge that will help you to care for patients in the future.

In the next sections we will look at some of these issues and also ask you to consider your own beliefs about health and illness.

HEALTH BELIEFS WITHIN A VARIETY OF SYSTEMS

Every society has its own way of dealing with sickness and healing, or its own 'ethnomedicine' (Helman, 2007) and unsurprisingly these systems often reflect the basic cultural principles of that society. This might include attitudes to illness, beliefs about the causes of illness or potential cures, or beliefs about the place of the 'healer' and the 'patient' in society – reflecting social hierarchies or gender roles.

It is important to acknowledge that these 'systems' have been discussed in different ways by different commentators. So, for example, whilst Quah (2010) suggests that these systems fall into three general categories which she terms 'healing systems' and which are

- Modern or Western biomedicine
- Traditional systems (Arabic, Hindu, Chinese traditions)
- Popular systems (complimentary or alternative)

Helman (2007) refers to healthcare 'sectors' using these categories:

- Professional – biomedicine
- Popular – lay, non-professional
- Folk – sacred or secular (Shamen) but suggests Indian and Chinese traditional medicine (TCM) have become 'professionalized'

Beliefs about causes of illness or illness aetiologies

The discussion of these systems tends to focus on how illness is treated in different ways, but underlying these systems is the very important notion of what individuals believe is the *cause* of illness – which necessarily impacts how illness is treated, or who an individual will seek treatment from since what may seem illogical in one system seems perfectly logical in another.

Helman (2007) calls these lay theories of illness causation and suggests that they are

1. Within the individual – Dealing with malfunctions in the body, common belief in the West where the emphasis is on lifestyle to alleviate (biomedicine).
2. In the natural world – Aspects of the natural environment that are thought to cause ill health.
3. In the social world – Blaming each other, common in smaller scale societies, witchcraft, sorcery and the evil eye – ascribed to interpersonal malevolence. Power to hurt others is thought to be passed on.

4. In the supernatural world – Illness is ascribed to gods, spirits or ancestral shades, spirit possession.

Foster and Anderson (1978) classify lay illness aetiologies in a different way – differentiating between personalistic (caused by a supernatural being such as a god or a human being such as a witch or sorcerer) and naturalistic (holistic) systems – caused by natural forces such as cold or damp or by disharmony within the individual or social environment such as the hot-cold system of Ayurvedic medicine in India and the Yin-Yang system of TCM.

THE BIOMEDICAL MODEL

In Western society, our understanding of health and illness has been dominated by the biomedical model of disease (or biomedicine) for approximately 200 years (Giddens, 2009). Biomedicine is sometimes referred to as allopathic, modern or Western medicine or simply the medical model and involves the explanation and treatment of disease based on biological factors. This model is significantly influenced by the natural sciences of biology, chemistry and physics. When explaining the origins of biomedicine, sociologists acknowledge the legacy of the Enlightenment, where rationality and reason triumphed over previous explanations of the world which were based on superstition or religion (Barry and Yuill, 2008; Giddens, 2009).

These 'scientific' ideas advanced alongside the growth of industrialized society, evolving and adapting with the development of new technologies such as radiography and surgical dissection techniques that increased the ability to look inside the body and which in turn advanced the understanding and classification of disease (Helman, 2007).

There is some debate about the number of defining characteristics of the biomedical model. Giddens (2009), for example, suggests that there are three main assumptions where Nettleton (2006) suggests there are five.

There is agreement though, that in the biomedical model, the patient represents the sick body (Giddens, 2009) rather than a whole individual, reflecting the notion that the mind and body are separate entities. This 'mind–body dualism' is considered to be one of the defining characteristics of the biomedical model (Nettleton, 2006; Giddens, 2009).

A further defining feature is that illness and disease or the 'breakdown' of the normal bodily state is due to 'faulty' or worn organs or systems, or changes that occur as the result of biological threats such as invading pathogens (bacteria or viruses), nutritional or chemical imbalance, injury, or simply through the ageing process.

In this way, the body has come to be viewed as a complex *mechanism* in which all of the parts must function together to ensure health. Helman (2007) suggests that health professionals both encounter and reinforce this 'machine' metaphor, for example, in the simple reference to food as 'fuel' for this body machine, to rest as a 'recharging of batteries' or through discussion of how parts of the body like parts of a machine may 'go wrong' – requiring repair or replacement in surgical procedures. Nettleton (2006) maintains that this mechanical metaphor is a defining characteristic of biomedicine.

The job of medicine, therefore, is to fix the body when it breaks down (Bowler, 2008) through the study, diagnosis and manipulation of physical and biochemical processes. The diagnostic

process usually involves physically examining the patient, and then treating him or her, which may involve repairing or controlling the affected body systems. An important feature in this system, therefore, is the role of the clinician (medical), who intervenes to limit damage and to help to resume normal functioning in the event of a bodily malfunction. Indeed for Giddens (2009) that trained medical experts are considered the only expert in the treatment of disease is the third defining characteristic, as he suggests 'there is no room for self-taught healers' (p. 392).

Practitioners of biomedicine are expected to remain objective and analytical, drawing on their specialist knowledge to treat the disease or injured part of the body. They hold a privileged position within society, and are generally well-educated and respected specialists who practice in settings that resemble laboratories and other scientific institutions. As one of the learned professions established in medieval times (along with law and divinity) their position is upheld in law, giving physicians the authority to treat patients, to prescribe powerful medicines and to withhold treatment if they believe this is necessary. They also have the right to detain patients in hospital if, for example, it is believed that they are suffering from a mental illness or are a danger to other people (Hogg, 2010).

Health beliefs in naturalistic (holistic) systems

Vaughn et al. (2009) suggests that there are three commonly held paradigms of disease across cultures: naturalistic, personalistic and emotionalistic.

Interestingly, Vaughn et al. (2009) suggest that the biomedical model is a naturalistic disease theory because it explains disease in scientific terms, identifying 'medical' causes such as pathogens.

However, compared to biomedicine, which is a relative newcomer, naturalism (also known as holism) has a long tradition. It originated in the ancient civilizations of Greece, India and China and continues to form the basis of traditional health practices in many Asian countries, including China, Japan, Singapore, Taiwan and Korea, South America, the Philippines, Iran and Pakistan.

In naturalistic systems, human life is seen as part of the wider natural cosmos. According to naturalistic systems, health is seen as the balance of elements (e.g. heat and cold) in the body and imbalance causes illness, disease or misfortune.

Perhaps the two most well known of the naturalistic systems are TCM and Ayurvedic medicine.

Traditional Chinese medicine (TCM)

According to Quah (2003), TCM is 'the practice and substance of the Chinese healing system throughout the entire history of China from the classical healers and texts of antiquity to the present Chinese system of healing as practiced today in China and by the Chinese diaspora around the world' (p. 1998).

Quah's (2003) definition highlights how TCM is recognized as a well-organized and highly respected system of medical knowledge that is rooted in Chinese philosophy. There are three basic interrelated principles that form the 'cosmology' of TCM, and Quah (2003) suggests that this trilogy is not only fundamental to physical health, but through 'reaching forth across the centuries this trilogy of beliefs lends moral and cultural identity to traditional Chinese medicine' (p. 2003). In this way, these beliefs transcend the realm of healing and have become an 'ethics blueprint' for the Chinese.

The first of these principles is that of Ying-Yang. This principle teaches that all things and events are the products of two elements or forces which are Yin (which is passive, weak and destructive) and Yang (which is positive, active, strong and constructive) (Quah, 2003). Yin is regarded as a cold, dark, watery (female) force, while Yang is a hot, fiery (male) energy. In TCM, the normal functioning of the body depends upon maintaining a balance between these two opposite energies since a deficiency of energy, or disequilibrium is thought to produce changes in the body, causing illness and disease to occur.

The second principle relates to the five agents or elements (wu xing) which are metal, wood, water, fire and earth and which are an elaboration of the Ying-Yang idea, adding the concepts of rotation, regeneration or succession (Quah, 2003). It is significant that both of these principles reflect an understanding of the close connection between humans and the natural world and how the natural surroundings, social relationships and the supernatural world are linked and regulated by the adequate management of opposites and similarities.

The third principle in this trilogy is Qi (or Chi), which has its origins with Taoist philosophy (Quah, 2003). Qi represents the link between the body and the universe. It is a force or energy that irrigates the human system, presupposing 'the presence of vessels through which the Qi circulates within the body either parallel to or mixed in with the circulation of the blood' (p. 2002). Indeed Qi provides the theoretical foundation for acupuncture. The strength and flow of Qi depends on the correct balance of Yin and Yang and with health resulting from sufficient and adequately distributed energy.

Practitioners of TCM are highly respected in Chinese cultures. The role of the practitioner in TCM is to restore the balance of these vital forces so that the patient is able to overcome his or her illness. Illness is diagnosed by questioning the patient about the complaint, observing his or her general appearance and taking the pulse. The practitioner may then prescribe a variety of cures to restore the balance. Various practices may be used, such as acupuncture, foods, herbs, exercise, dietary restrictions and enema poultices, all of which are aimed at restoring the balance between hot and cold. In contrast to Western medicine, there are few invasive procedures. Sometimes coins may be used on the skin to treat headaches and other minor ailments (Jones, 1994; Schott and Henley, 1996; Gervais and Jovchelovitch, 1998).

Ayurvedic medicine

Ayurvedic medicine is a traditional Hindu system of medicine which is over 2000 years old and is practiced mainly on the Indian subcontinent. There are 500,000 registered Ayurvedic healers in India alone (Bagla, 2011). The term 'Ayurvedic' is derived from 'Ayur', meaning life and longevity, and 'veda', meaning science. The aim of Ayurvedic medicine is to 'integrate and balance the body, mind, and spirit to help prevent disease and promote well-being' (Gawde et al., 2013).

A dominant theme in Ayurveda is the notion of the universe as macrocosm and the human body as microcosm and in this way the individual is seen as part of all that exists in the universe (Valiathan, 2009, p. 1187). In this system, all things in nature are believed to be composed of a combination of five elements or Bhutas, which are earth, water, fire, air and space/ether. For example, the bhutas are thought to make up the seven tissues (the dhatus) of the body (e.g. muscle, blood, bone, fat) and the three primary life forces or dosas (doshas or humours) in the body. These life forces are called Vata, Pitta and Kapha and are thought to govern all bodily functions and

maintain a dynamic balance within the body. Each individual has a unique combination of the dosas, and this combination is called the 'tridosha'. According to ancient Ayurvedic texts, ailments arise when the doshas are in a state of disharmony highlighting equilibrium as the *essential* condition for good health and well-being. It naturally follows that treatment is concerned with finding internal remedies to restore harmony.

Since dosas involve the whole body, every disease is treated as systemic in Ayuveda. That said, every disease is thought to have distinct clinical features that require a different treatment depending on whether it was caused by a disturbance of Vita, Pitta or Kapha, or their combination (Valiathan, 2009).

Ayurvedic healers aim to restore balance to the three doshas, diagnosing the problem based on 'interrogation, inspection, palpation, and listening to bowel sounds' (Valiathan, p. 1190). Therapeutic measure might include fasting or rest, dietary regimens, evacuative measures, or the administration of various drugs of plant, animal or mineral origin (Valiathan, p. 1190). However, treatment is considered to be more than the 'sum of dietary regimen, procedures and medications' (Valiathan, 2009) and may include recommendations for virtuous conduct (Bagla, 2011) illustrating that this system offers something of a model for living.

In India, Ayurvedic medicine is funded by the Indian government and Hakims (the practitioners of Ayurvedic medicine) are trained in Ayurvedic universities. According to Bagla (2011), the Institute of Ayurveda and Integrative medicine in India is the active hub for researchers to 'scour ancient manuscripts for therapeutic recipes, cultivate rare medicinal plants, and attempt to isolate active compounds' (p. 1491).

Health beliefs based on personalistic and emotionalistic systems

Some belief systems attribute illness to intervention by an agent such as another human, witch, sorcerer, non-human, or supernatural force – these are personalistic systems and include magico-religious beliefs.

In contrast to biomedicine, the personalistic system does not have a scientific basis. It is characterized by a strong sense of connection to the spiritual world, and by beliefs based on traditions and values that are passed on from one generation to the next. Personalistic belief systems may also have connections to religion, but they are not necessarily religious in origin. These beliefs are powerful and deeply held, and people might not always be dissuaded from practising their health beliefs by the arguments for biomedicine. Jackson (1993) suggests that personalistic health belief systems are more likely to be found in rural or remote communities that have little contact with the rest of the world, for example, in communities where levels of literacy are low and people have strong ties to their ancestors and their land.

In magico-religious belief systems, illness is thought to be caused by the active intervention of supernatural forces that control the world and those living in it. Such forces include gods or deities, ghosts or evil spirits, or living individuals with assumed supernatural powers such as witches or sorcerers.

For example, in parts of Europe, the Middle East, North Africa and Central and South America the notion of the 'evil eye' as a cause of illness or distress can be found. This relates to the malevolent power of the look or glance of a jealous person (who may be totally unaware of such an accusation) that may cause ill health or damage in the recipient of the look (Helman, 2007). In

addition, the belief and practice of witchcraft, which was common in Europe in the Middle Ages, is still practiced in parts of Africa and the Caribbean. Witchcraft is associated with an individual's malevolent power to harm others, where witches (who are usually perceived as 'different' from others in terms of their behaviour or appearance) are thought to be the sources of misfortune, particularly when an unexplained or untreatable illness occurs.

Their powers are thought to be either inherited or acquired through belonging to a particular group. The practice of sorcery is also common in some non-Western societies where sorcerers are deemed to have the power to alter supernatural events with magical knowledge and ritual. They use 'hexing' or 'fixing' to manipulate social relationships such as dealing with envy or infidelity, or to deal with ill health. In magico-religious health belief systems, supernatural forces may also be considered responsible for non-physical misfortunes such as crop failures, earthquakes and floods, or petty misfortunes such as lost articles or minor injuries.

Clearly then, the cause of illness in magico-religious health belief systems is supernatural aggression or punishment (which may or may not be justified) rather than bodily malfunction (Jackson, 1993) and in this way the sick person is seen as a victim of powers beyond his or her control. In smaller scale societies, where interpersonal conflict is more frequent, and where it is more common to blame other people for one's ill health, the prevention of illness involves avoiding conflict through the maintenance of good social relationships with friends and family, and paying respect to ancestors through prayers and devotions. Individuals may also wear special clothing, talismans or jewellery, or be embraced by spells to protect themselves and their families.

In order to be 'cured' the patient or the victim must identify the agent behind the act and then render it harmless, as well as lift the spell. The 'curers' within this system claim to have supernatural powers and use magical practices (e.g. trances) to detect the cause of the disease or illness and use curing rituals to deal with it. Later, the victim may consult another 'lesser' curer such as an herbalist. For example, the shaman or spiritual curer is found in many cultures, and is usually a member of that community, holding the same beliefs (Lipsedge, 1990). They claim to have special powers, allowing themselves to become possessed by certain spirits until they are able to master or neutralize them. The shaman's powers are healing in that they are able to alleviate guilt, anxieties, fears and conflicts and eradicate them.

Those who subscribe to emotionalistic disease theories believe that illness and disease can be caused by intense emotional states such as sadness, anger, jealousy, shame, grief or fright (Vaughn et al., 2009).

Case study

Mrs Bibi was referred to the community psychiatric nurse by her GP and health visitor, who were very concerned about her low mood, insomnia and complaints of pains in her legs following the birth of her fourth child 6 weeks ago. Her husband said that he had heard Mrs Bibi talking to herself at night. Mrs Bibi moved to England 9 years ago. In England she felt very isolated and found it difficult to learn the language, mainly owing to time limits and the demands of bringing up four children.

continued

Case study

She began to express feelings of unease and anxiety about the house in which they lived. Her husband explained that the previous owners had been Hindus and Mrs Bibi felt that since they had moved in the 'Jinns' had taken possession of the house. They described the Jinns as bad spirits that caused trouble around the house. The couple revealed that they blamed Mrs Bibi's poor health on the Jinns. She felt that the Jinns were making her life miserable and making her feel like a bad mother. The couple decided to contact the Imam at their local Mosque. After visiting the house he decided that they were justified in their interpretation of the situation. The Imam returned to the house and performed a ceremony to drive out the Jinns. Mrs Bibi soon began to feel better. She described feeling more in control and having more patience with the children; her sleep had also improved. She had no further contact with the community psychiatric nurse.

Mrs Bibi, a Muslim, clearly felt that her illness was caused by malevolent spirits or Jinns. In the Islamic world, the Jinns (or ginns) are malevolent spirits that cause ill health. In a biomedical framework, Mrs Bibi might have been diagnosed as suffering from postnatal depression or puerperal psychosis and treated with antidepressant medication. Instead, her beliefs (and those of the people around her) were understood – in the context of her life and her health beliefs – to be the cause of her distress. The appropriate treatment involved removing the cause of her distress by consulting the Imam who performed the relevant ceremony.

Key points

1. There are three broad health belief systems, namely, biomedicine, personalistic (including magico-religious) and naturalistic (or holistic systems).
2. Biomedicine is the most dominant form of health belief system in the developed world.
3. Other forms of health beliefs are powerful and prominent in many cultures.

SECTORS OF HEALTH CARE

Here is an interesting perception from Quah (2003) of how we find people to heal us:

> **Across the ages, a natural response to illness or injury is to seek healing. The search takes the affected person from his immediate circle of relations to more distant potential sources of health until something that works or someone who knows is found**
>
> *(Quah, 2003, p. 2001)*

When people become ill or need medical help they may have several options open to them, depending on where they live, who they are and the prevailing healthcare practices in that culture. Healthcare systems always exist in context – they cannot be isolated from the prevailing

social, religious, political and economic organizations that surround them and indeed shape and influence them.

Kleinman (1986) suggests that in any complex society there are three sectors of health care that often coexist. Each sector has its own way of understanding and treating health problems, deciding who the appropriate person to treat the problem is and how the patient and the healer should behave towards each other. These three sectors of health care are the popular, folk and professional sectors and will be used to explore how patients access health care and healthcare advice.

The popular sector

This sector may also be called the lay sector, and it is usually the first port of call when people are ill. It does not usually involve financial transactions. For example, people may choose to self-medicate or to consult relatives, friends or neighbours. There is often heavy reliance on family members, especially on women.

In a study of Gypsy Travelling communities, Parry et al. (2004) note that many people placed great trust in family carers and the lay referral system. Close family was seen as important in a 'hostile world where sometimes people may be met with hostile reactions from health workers':

> **in a second, you can tell by their attitude, they don't look you in the eye, it's just sort of 'what's the problem'… they do palm you off the minute they find out you are Travellers.**
>
> *(Parry et al., 2004, p. 70)*

Lay referral systems are also important as many people lack confidence in dealing with bureaucracy and in particular with 'form filling' – 'If you don't read and write it's difficult to get information' (Parry et al., 2004).

In this case, the main credentials or qualifications for giving advice are past experiences, which are regarded as effective and worthwhile, and are 'passed on' through families. When people become ill they often treat themselves (e.g. using traditional medicines or foods that have been passed on as cures).

Individuals that may be consulted in the popular sector include women with several children, friends, neighbours, paramedics, nurses, people that have had the same illness, doctors' receptionists, and the spouses or partners of doctors. As nurses, we may often be regarded as a source of knowledge among our family, peers or even the community. Popular help may even extend to anyone who regularly deals or interacts with the public (e.g. the police). Hogg and Warne (2010) discuss the findings of Hogg's PhD study of lay people's beliefs and attitudes about mental health and illness, explored the experiences of a variety of non-mental health professionals who cared for and about people they met in their everyday employment. She highlighted how listening to people in the non-statutory arena, and without judgment can be central to these roles and that individuals often informally consult such popular sectors when they are unsure of the problem they have, or if they are reluctant to refer themselves to the professional sector (Hogg and Warne, 2010). Hogg explained in the 2010 edition of this textbook how a local hairdresser told her the following:

> **I have just started a certificate in counselling. The reason I'm doing it is because it occurred to me some time ago that I spend much of my working life listening to people's problems.**

> **I thought, 'Well, I might as well try to do it properly', so I'm learning how to help people at night school. I just think of it as another skill. To me it's just as important to some people as the perm they have or the right cut.**
>
> *(Hogg, 2010)*

In 2015, the Royal Society for Public Health published a report 'Rethinking the Public Health Workforce' that supported Hogg's PhD findings reporting on the role and public health potential of the 'wider workforce' (Hogg and Warne 2010). This is defined as 'any individual who is not a specialist or practitioner in public health but has the opportunity or ability to positively impact health and well-being through their paid or unpaid work' (CfWI, 2015) and as Hogg identified – includes hairdressers.

See: http://rsph.staging5.pixl8-hosting.co.uk/resourceLibrary/rethinking-the-public-health workforce.html (accessed 4 April 2017).

Another important and popular source of non-professional help is self-help groups, where people may share advice, seek or give support (an acknowledged factor involved in healing) or help novices and newcomers. Self-help groups and voluntary organizations value their members' experience rather than their professional expertise. They value mutual help, and often seek to destigmatize and demystify the health problem.

Key points

1. In the popular sector, help is non-professional.
2. The popular sector values experience and mutuality.
3. In the popular sector, self-help and self-medication are important.

The folk sector (healers)

The folk sector is often a feature of developing countries or non-Western societies. It may take an intermediate position between the popular and professional sectors.

The practitioners or healers in the folk sector are usually based in the community, and are well known and valued by the local people. Consequently, they may share the same values and beliefs as the local community and so are in an ideal position to adopt a holistic approach to the person being treated. For example, they may be able to advise on all aspects of the individual's life or their family position. Although this position is more formalized than in the popular sector, there is little training, and education may be acquired through an apprenticeship.

People may also become healers as a result of special gifts or signs that are bestowed upon them. They may receive the 'gift' of healing from a 'divine' source (e.g. in a vision), or they may gain their skills from their family (usually through the mother). In Ireland, for example, the seventh son of the seventh son is believed to have special powers.

There are many different types of folk healer (e.g. clairvoyants, spiritual healers, shamans). Treatment in the folk sector may include the use of special herbs and medicines.

The folk sector plays an extremely important role in helping people to maintain their psychological health, but unfortunately practitioners are often dismissed as 'quacks' or charlatans

by professional health workers. However, it must be acknowledged that there are unscrupulous operators who masquerade as 'healers', and they need to be distinguished from those who have genuine healing powers.

There are several advantages to healing by traditional practitioners that are often overlooked. Spector (2009) emphasizes that the healer in folk medicine may maintain an informal friendly relationship with the patient and may place great emphasis on building and maintaining a good rapport with the individual and their family. Thus, in folk medicine, people may feel that they have a greater degree of control with regard to the treatment that they are expected to follow. Patients may also find that they are given more time and consideration. Their background and social circumstances are understood, so they are not regarded as impersonal malfunctioning units, but as individuals in their own social context.

Key points

1. **Folk medicine lies in an intermediate position between lay and professional medicine.**
2. **Folk medicine healers may have a central role to play in the spiritual and social welfare of the client.**
3. **Folk medicine healers employ ritualistic and complex methods of treatment.**

Professional medicine

This system of health care is generally regarded as the most highly organized and developed approach. Professions, by definition, have their own collective system of management, education and codes of conduct. They are usually self-regulating and have their own powers and policies. They also have their own knowledge base and highly developed skills. Professional medical practitioners may include not only doctors but also the paramedical professionals (e.g. nurses, physiotherapists).

However, the medical profession has its own group with a powerful hierarchy and a set of prescribed rules and codes of conduct. The medical profession is prestigious and respected in Western society, and members of the profession are financially well rewarded. In the United Kingdom, members of the medical profession are categorized within complex hierarchies of knowledge and power, such as professors, lecturers, consultants, registrars and house officers. They also work in very specialized and highly defined areas of practice related mainly to the nature of patients' problems (e.g. cardiac care, gastroenterology, rheumatology).

When a patient consults a doctor, he or she will use problem-solving skills to determine the cause or individual nature of a specific problem that the patient is experiencing. In the past, patients were often treated away from home in specialist centres, and their problems were considered in isolation, away from their families or communities. However, there has been an increased focus on primary and community care (Department of Health, 2008) whereby patients not only have more say about the nature of professional medicine received but also work together with the medical profession, enabling the patients to take more control over their health.

Doctors are highly trained, with scientific and intellectual skills that are used to diagnose illness (as opposed to spiritual or intuitive processes). They may use technical instruments or make a diagnosis by using quantifiable measurements based on the physiological details of the patient (e.g. blood pressure). In general, the families of patients being treated in the hospital are only allowed to visit at designated times, although this does vary from region to region. Hospitals and health centres have their own rules and codes of behaviour, and these largely reflect cultures and prevailing ideologies in society.

PLURALISM IN HEALTH CARE

In health care, pluralism means the use of two or more different types of health care systems. These may be used concurrently (i.e. in a complementary way) or in place of (as an alternative) leading to the notion of 'complimentary' or 'alterative' medicine (CAM). In the United Kingdom, there is a growing awareness and use of complementary or alternative medicines which may be the result of patient dissatisfaction with allopathic medicine (Gawde et al., 2013) or the belief that the naturalistic practices (e.g. Ayurveda or TCM) are 'natural' and therefore safe to be used either as an alternative or in addition to allopathic approaches.

Gawde et al. (2013) suggest that Ayurvedic medicine is the most commonly practiced form of complementary and alternative medicine (CAM) in India with approximately 80% of Indian patients using Ayurvedic therapy. Whilst Xu and Yang (2009) maintain that in the Chinese health care system, TCM runs parallel with allopathic approaches. Chung et al. (2012) in a systematic review of research related to perceptions of TCM amongst the Chinese population found that Chinese people across the world feel a 'common cultural affinity' for TCM and consider it to be an effective compliment to Western medicine for treating chronic or serious diseases.

Indeed in India, the Ministry of Health and Family Welfare now propose to integrate the study of complementary and alternative medicines such as Ayurveda with the study of allopathic medicine following success in China where medical students take compulsory courses in TCM and apply their knowledge in practice – making the best use of both systems (Gawde et al., 2013). Quah (2010) suggests that some practitioners are already inclined to borrow ideas or procedures from other systems to solve specific problems without necessarily accepting the core values of that system. She termed this 'pragmatic acculturation' using the example of TCM practitioners who measure blood pressure using a sphygmomanometer or an allopathic practitioner who uses acupuncture.

Whilst non-pharmaceutical approaches such as acupuncture or meditative practice may be readily accepted CAM practices, Quah (2003) notes the difficulty of judging the efficacy of TCM against the standards of biomedicine since there is a lack of clinical trials. Similarly, Bagla (2011) notes that Ayurveda has been demonized by modern science in recent times and particularly following a 2008 report (Saper et al., 2008, in Bagla, 2011) which reported that one-fifth of 193 Ayurvedic preparations bought on the Internet contained detectable levels of lead, mercury or arsenic. Such issues highlight the importance of exercising caution if CAM herbal remedies are prescribed since this may give rise to harmful side effects or pharmaceutical toxicity.

A further issue to consider is raised by Couper (2002) who suggests that whilst the use of CAM is perhaps 'here to stay' we need to acknowledge the potential financial burden to some families – since these treatments and therapies can be costly. It is therefore incumbent upon

health professionals to be educated well enough to advise families accessing CAM not only about potential harmful effects, but about potentially costly but ineffective treatments.

CONCLUSION

This chapter outlines three categories of health belief systems, namely, biomedicine, personalistic and holistic systems, and the ways in which healthcare delivery is organized. These distinct classifications are useful, but in practice they are rarely mutually exclusive. They represent different ways of viewing the world and values about health. In the United Kingdom, for example, biomedicine dominates health practice, yet complementary therapies and alternative healers are becoming increasingly popular. There are many nurses and doctors who have skills in therapies such as massage or aromatherapy. The growing popularity of alternative or complementary therapies in the United Kingdom may simply be because of the increased availability of, and publicity about, these practices, as well as some dissatisfaction with biomedicine. This dissatisfaction may have arisen in response to reductionist approaches to health and illness, prompting people to seek more holistic approaches. For example, holism rejects the notion of the mind–body split, and instead recognizes the relationship between individuals and their environment.

Reflective exercise

1. What are your personal views about alternative medicine?
2. Do you think complementary therapies are valuable, or are you cynical about their claims?
3. How would you respond to a patient who wanted to use complementary therapies?

CHAPTER SUMMARY

1. Health beliefs are universal and central to the way in which health care is practised and delivered.
2. The three main health belief systems, namely, biomedicine, personalism and holism, are rarely mutually exclusive.
3. Biomedicine – the dominant health belief system in the developed world – is becoming increasingly influenced by other belief systems, particularly holism.

FURTHER READING

Gabe, J., Bury, M. and Elston, M. A. 2004. *Key Concepts in Medical Sociology*. London: Sage Publications.

This book covers many concepts in relation to the experience of illness, lay and medical knowledge of health as well as range of concepts concerning health work and the division of labour in health care which will be of value in other chapters throughout this book.

Nettleton, S. 2013. *The Sociology of Health and Illness*, 3rd edition. Cambridge: Polity Press.
This is the third edition of this book, which offers a sociological approach to various topics ranging from lay health beliefs to lay and professional interactions.

Ohnuki-Tierney, E. 1993. *Illness and Culture in Contemporary Japan. An Anthropological View*. New York: Cambridge University Press.
This work gives a fascinating insight into a description of Japanese health care.

Winkleman, M. 2009. *Culture and Health – Applying Medical Anthropology*. San Fransisco: Jossey-Bass, Wiley & Sons.
This book has many chapters including concepts of health and various systems, and includes a broad chapter on ethnomedical systems and healthcare sectors, focusing on popular, folk and professional healthcare sectors in particular.

WEBSITES

http://ethnomed.org/
This website is an excellent site for information on many cultures, their beliefs and customs, including patient education information and access to other related websites. There are also video clips in different languages. It has a US focus but is useful knowledge for any reader.

http://www.dimensionsofculture.com/2011/02/culturally-based-beliefs-about-illness-causation/
This site is called Dimensions of Culture and focuses on cross-cultural communications for healthcare professionals. Topics include beliefs about causes of illness, plus a range of additional information on many different cultures and caring for their needs, such as Asian cultures, e.g. Hmong people: http://www.dimensionsofculture.com/category/culture-specific-topics/cross-cultural-communications-for-asian-patientsfamilies-and-their-providers/.

http://www.kidsnewtocanada.ca/culture/influence/
This Canadian site offers a guide and resources for health professionals working with immigrant and refugee children and young people. It focuses on how culture influences health and has a number of case studies for readers to consider. This site would also be a very valuable resource for Chapter 11 of this book.

CHAPTER 5

Working with health and illness beliefs in practice

Debbie Fallon

INTRODUCTION

Chapter 4 focused on health beliefs – reflecting on what they are and the systems in which they work. The chapter also acknowledged that the boundary between each system often can be blurred, meaning that they can, and often do work together in a complementary way. This is known as healthcare pluralism (Helman, 2007, p. 81) and is more likely to occur in modern urbanized societies where there are more therapeutic or treatment options open to individuals.

Indeed Quah (1989) suggests that countries with a single system of health care are now the exception rather than the rule because globalisation and immigration have led to such a wide variety of health choices in many countries. These ethnically plural societies, suggests Quah (1989, 2008) may lead to 'pragmatic acculturation' whereby aspects of non-native cultures are 'borrowed' for the purpose of satisfying specific health needs (1989, p. 6). Here, cultural boundaries become flexible and may be crossed in search of a cure, leading to the adoption of certain aspects of a healing system without necessarily embracing the whole conceptual paradigm or cosmology.

Chapter 4 explained what pluralism in health care is, and this chapter discusses how healthcare pluralism works in practice, acknowledging that whilst different systems can sometimes work in harmony, the blurring of boundaries can also present challenges to health professionals who must then navigate them to achieve the best possible health outcome.

This chapter will focus on the following issues:

- Caring for people with different health beliefs
- How healthcare pluralism works in practice
  - In harmony
  - With challenges
- Magico-religious beliefs in healthcare practices in the United Kingdom
- Strategies
  - Eliciting health beliefs and working with them in practice

CARING FOR PEOPLE WITH DIFFERENT HEALTH BELIEFS

Caring for individuals with different cultural health beliefs to our own can be challenging. As Henley and Schott (1999) pointed out over a decade ago, we tend to trust the system we

have grown up with, assuming that practitioners in this system know what they are doing and mistrusting those who do things differently. An extreme contemporary example of the power of such beliefs is illustrated in the following extract from a letter from a health worker in Sierra Leone at the height of the Ebola crisis in 2015:

> **(this) district … has been put under quarantine after the lock down. In the last five weeks numbers have just been rocketing in the district and in many cases when people realise they are sick, they move to the villages where they're cared for by unknowing families and the spread starts somewhere else. The worst case has been where a leader in one of the villages died and even though the burial team had safely buried him because circumstances surrounding his death were uncertain, the villagers chose to dig him up in the middle of the night and bury him in a befitting manner for a leader. 14 of those that dug up the body and conducted the second funeral caught the virus and soon spread it to all their families and by the time of the lock down the whole village of 700 plus were quarantined and to date 70 people have already died in that village alone. (Permission to use this quote given by the health worker.)**

This letter shows that one of the biggest challenges for all health and social care workers in the context of healthcare pluralism is to navigate the path between safe and unsafe health practices of those we care for whilst simultaneously having an appreciation of and appropriate respect for the origins of these practices.

That is, we need to be on our cultural 'toes', and focused on being culturally aware. However, this involves not only being aware of when cultural context makes a difference, but also when it does not. In a UK context, we need to acknowledge diversity within populations but we should also recognize the similarities between minority and majority groups in society. Fundamentally, it is important to remember that our knowledge of other cultures is not a shortcut for developing effective relationships since there will be immense differences within each of the subcultures – we must continue to treat our patients as individuals, asking for clarifications rather than assuming cultural knowledge.

Waxler-Morrison and Richardson (2005) appear to support this premise about developing effective relationships and believe that we also need to 'know ourselves' and where we as healthcare professionals come from:

> **We have to find a way to connect with each person regardless of how different we might at first perceive that person to be from ourselves. Professional and client may find themselves sharing the discovery that neither fits the other's cultural stereotype. A client sensing such sharing and connections will begin to participate more openly in the meeting. For the professional this implies more than 'knowing the right question to ask'. It means establishing a relationship of mutual respect, opening up a space where differences in perspective can be recognized and managed. (p. 10)**

EXERCISE

1. Consider what you would need to gain such a relationship with patients from different cultural groups, including your own culture.
2. Read the next section on reflecting on your own culture and beliefs and return to consider Question 1.

REFLECTING ON OUR OWN CULTURE AND BELIEFS

In order to do this we need to have some insight into our own culture and beliefs. Sometimes this is influenced by religion and although the United Kingdom is a secular society it is worth noting that nursing and religion have a complex and intertwining history. For example, church attendance was once a requirement in nurse education and ward prayers were once an accepted part of nursing work. This would be seen as inappropriate in a contemporary healthcare setting where our interest in religion is more likely to be focused on providing culturally sensitive care, for example, in terms of food or hygiene needs, or of providing space to worship or contact with appropriate religious support staff.

Spector (2009) argues that, as nurses, we enter the profession with ideas about health and illness that are unique and which have been shaped by our ethnic and cultural background. Spector (2009) encourages nurses to explore their cultural heritage by considering their own beliefs and practices that may have been passed on through female members of the family (e.g. through mothers and grandmothers). Nurses then bring these beliefs to the health arena, wards, community settings and therapeutic encounters in which they are engaged and these can influence nursing practice in the prevention and treatment of illness.

However, these beliefs may change as nurses integrate with their professional groups and absorb the beliefs, values and attitudes of the culture of nursing. An example of this is nursing language. Nursing has its own language – a set of phrases, idioms and terms that may be alien to others (e.g. 'doing the obs', 'off duty', 'doing the cares', 'doing the backs' and 'handovers') (Holland, 1993).

Timmons and Narayanasamy (2011) suggest that some individuals may still decide to become nurses because of their religious beliefs, thinking of it as a 'calling' or perhaps viewing the caring role as an integral part of their faith. However, the nursing students who participated in their study sometimes faced difficulties as religious individuals working in a secular organization such as the NHS in the United Kingdom. They described how they constructed identities for use in the context of clinical practice that were not necessarily congruent with their self-identity as believers. Interestingly, whilst the NHS was described most often as a neutral environment, the participants in the study also described a rise in 'militant atheism'.

They faced particular challenges to their beliefs when confronted by issues such as abortion and emergency contraception. Significantly, in the preamble to their study, Timmons and Narayanasamy (2011) also discuss a number of international studies that indicate that religious students are more likely to oppose the use of complementary and alternative therapies, oppose physician-assisted dying, and the termination of pregnancy, and in some cases their beliefs may correlate with homophobia. This shows how health care itself is not intrinsically culturally 'neutral'.

In addition to personal beliefs, we must acknowledge that medicine and nursing have professional 'cultures' of their own into which individuals are socialized. These professions are recognized by traits (Flexner, 2001) that include specialized knowledge and skills and which have resulted in the development of a medical or nursing 'language'. However, this specialized language can sometimes serve to distance us from those we care for, creating a communication barrier between the nurse and the patient. Unfortunately, it is all too common to hear a patient

say 'I don't understand what the nurses or doctors are saying – they use all sorts of technical language and abbreviations'.

Indeed the interpretation of such medical jargon is often considered to be a key part of the nursing role. This culture of nursing, with its rites of passage, language, codes of behaviour and expectations, may be evident at many levels. (See Chapters 1 and 2.)

However, it is often hidden and, as nurses, we may regard these distinct practices as the norm. Unless we are aware of this, a gap may develop between the provider of health care (e.g. the nurse) and the recipient (e.g. the patient or client).

The health services in the United Kingdom are based on models of health and disease that are part of the UK culture and way of life. In many respects, these customs and practices are taken for granted or we treat them as the norm. They are almost woven into the fabric of our healthcare system. It is only when we distance ourselves or view them through someone else's eyes that these practices may seem strange or illogical. An example in the United Kingdom is the custom of calling a surgical consultant by the title of Mr, Mrs or Miss, whereas a medical consultant will always be referred to as Dr.

THE HEALTH BELIEFS OF THOSE WE CARE FOR

It is clear then, that we fundamentally (however unwittingly) provide health care in the context of our own cultural beliefs and this may originate in religion, class, ethnicity or country of origin, and the culture of health care into which we are socialized. We may think of this context as the norm, but it is important to acknowledge that this might be entirely different from the experiences of those in our care. In our working lives we are likely to be faced with individuals who have very different ideas about the causes of their illness and the best treatment options – which then present us with both treatment and health promotion challenges.

In the United Kingdom, for example, Muslims may consult the Hakim before, after or instead of the GP, and in Hindu communities the Vaid may provide health care. Some people may consult their GP (professional), but ignore the advice given and instead follow the advice of someone else (e.g. a relative or friend).

Li et al. (2014), for example, outline how mental illness in Chinese communities across the globe tends to carry immense stigma and shame which creates a barrier to social acceptance. In their study of older Chinese migrants in Britain, they found that their 'culturally bound' ideas about mental illness were very different from Western diagnostic categories, and that these understandings may have contributed to their failure to seek help.

HOW HEALTHCARE PLURALISM WORKS IN PRACTICE

In harmony

Sometimes two belief systems can guide an individual in terms of their treatment choices and this can work in a complementary way. For example, Gervais and Jovchelovitch (1998) found that the Chinese people they interviewed effectively integrated traditional Chinese and Western medicine, combining these different systems of knowledge and health resources flexibly.

One participant said:

> **I think most of us look at traditional Chinese medicine and Western medicine as coexisting quite nicely. I think that on the whole most of us would try anything as long as it works. You'll find that sometimes [the Chinese] go to both. They see the Western medical doctor and then toddle off to an herbalist to get the herbs, and then they'll use the two together. They wouldn't see the conflict. (Gervais and Jovchelovitch, 1998, p. 51)**

Therefore, the individuals in this study did not rely on one method at the expense of another, believing instead that Western medicine was beneficial because it offered 'quick-fix' solutions, but that Chinese medicine tackles the root of the problem. In this way Chinese medicine, tonics and herbs are used to maintain good health, whereas biomedicine is used to deal with serious diseases.

Such 'healthcare pluralism' is now visible across a variety of medical specialties. For example, in the sphere of oncology across the developed world it is now fairly common for patients undergoing conventional treatments such as chemotherapy or radiotherapy to use complementary and alternative medicine such as yoga (e.g. see Cramer et al., 2012) in addition. Indeed, treatments such as acupuncture and reflexology are sometimes offered as part of the holistic care package in the NHS. The extent of CAM use was highlighted by Horneber et al. (2012), who reviewed evidence from 18 countries and found that the combined prevalence for current use of CAM in cancer patients across all studies was as much as 40%.

Oncology is not the only specialty where CAM is used. Borrelli and Edzard (2010) suggest that the use of complementary and alternative medicine (CAM) among menopausal women has also increased in recent years. In children, too, the use of complementary and alternative therapies including faith healing homeopathy, hypnotherapy and acupuncture have been reportedly used for the treatment of a variety of conditions such as asthma, eczema, cancer, and autism (Curran et al., 2012; Couper, 2002) – often in addition to conventional pharmacological remedies.

The increased use of CAM in health care means that health professionals need to be educated well enough to advise such families effectively, but this is rarely a topic that is included in the UK nursing curricula. Even in Taiwan, Smith and Wu (2012) in their small qualitative study of Taiwanese nurses' attitudes and practices regarding CAM found that whilst their sample had a keen interest in learning more about CAM, their limited knowledge in this area and organisational policies meant that very few nurses integrated CAM into their daily practice.

Key points

1. Pluralism is an important and significant factor in health care that pervades most healthcare systems.
2. People may use alternative or complementary systems concurrently with conventional systems.
3. Individual interpretations of Western or modern medicine sometimes incorporates other facets of health belief systems, such as magico-religious beliefs.

CHALLENGES

There are times, however, when cultural beliefs present healthcare challenges, especially for those carrying out any care.

Beliefs about causes of illness

Some of these challenges begin with beliefs about causes. For example, Hjelm et al. (2005) in a study of men from different cultural backgrounds living in Sweden found that whilst the indigenous Swedes believed that diabetes was caused by factors such as inheritance and lifestyle, foreign-born men attributed their condition to the sadness and emotional stresses related to war and migration which Vaughn et al. (2009) would categorize as an 'emotionalistic' belief system. Those who subscribe to emotionalistic disease theories believe that illness and disease can be caused by intense emotional states such as sadness, anger, jealousy, shame, grief or fright.

Furthermore, the Arabic-speaking participants in this study believed that diabetes was the will of Allah or God. In a similar vein, Barnes et al. (2004) found that the Tongan participants in their study were more likely than the European participants to attribute their diabetes to God's will and Parry et al. (2004) found that similar fatalism was expressed by the Gypsy Travellers in their study where one stated 'if God borned you down to have a short life, you had a short life and if he borned you to have a long life, you'd have a long life – nothing you can do to alter it.' These 'deterministic' beliefs (Singleton and Krause, 2009) reflect a conviction that our health and well-being are predetermined by a higher deity.

Most importantly for the health professional in this belief system is that the patient believes that the will of this deity cannot be changed – which renders them powerless to help themselves. Such fatalistic attitudes to illness may lead to people avoiding screening as medical treatment as it is seen as unlikely to make any difference. (See Chapter 4.)

The notion of God's will or punishment for past wrongdoings can also be found in studies related to other medical conditions; for example, Ismail et al. (2005) found that over half the respondents in their study attributed their epilepsy to the will of God or as punishment for the sins of a past life. However, Ismail et al. (2005) found that this belief did not necessarily lead their respondents to feeling resigned or passive with regard to their illness. Instead, in their study of South Asian communities in Leeds and Bradford, they found that a 'strong network' of traditional healers provided a parallel system of health care which is largely invisible to the mainstream NHS but worked in conjunction with it to provide additional support.

EXERCISE

1. What do you believe about illness? Consider these beliefs in the context of caring for someone who is dying and believes like the notion above – that it is God's will that they are dying.
2. What knowledge and information would help you care for this patient?
3. Discuss with colleagues in your clinical area how to ensure that you have enough knowledge about health beliefs to support your care of patients.

Sometimes beliefs about causes of illness can be based on ideas that we would consider to be neither logical nor rational. For example, Lewis (2007) in a study of British Indian patients in West London found that some individuals believed that diabetes mellitus could be caused by others' jealousy or curses, or as a result of previous transgressions. These magico-religious beliefs occur across a wide range of illnesses; for example, Taïeb et al. (2010) outline the case of a young women whose parents attributed her systemic lupus erythematosus to sorcery related to either the death of her younger sibling or the evil eye being put upon her by the parents of a local bride who perceived her as a threat.

Epilepsy is another condition which perhaps due to its unpredictable nature and difficulty to control has been associated in some cultures with spirit possession or the work of a Jinn (Ismail et al., 2005). Again, in such circumstances, the individual can feel somewhat powerless to help themselves and may look for spiritual guidance rather than medical practitioners for help. For health professionals it is important to acknowledge that these beliefs can impact not only on help seeking behaviour but on any discussion about acceptance of treatment since the individual and the health professional may not agree on the cause of the illness. The following case study explores the complexities and challenges of caring for someone whose health beliefs may be in conflict with one's own.

Case study

Gloria is a 72-year-old woman who immigrated to the United Kingdom from the West Indies in 1952. She lives alone, her husband died 8 years ago, and she has a daughter and two sons living in the neighbourhood. She has been diagnosed with diabetes mellitus and the district nurses are baffled by her reluctance to follow their dietary advice. Gloria says that she gets bored with eating vegetables all day and every day.

Pierce and Armstrong's (1996) research examined the attitudes of African–Caribbean people towards diabetes. Using focus groups, they identified a variety of beliefs about the causes of diabetes and the appropriate care and treatment for the condition. For example, some people clearly associated diabetes with sugar. However, sugar had different properties for different people. One woman believed that her diabetes was 'part of the ovaries breaking down and being unable to handle sugar', and another believed that depression had contributed to her diabetes.

Other individuals in the study blamed their illnesses on English food, and one woman reported that she knew of someone who had returned to the West Indies and found that their diabetes had cleared up. There was also a belief that 'starchy foods were bad'. Foods that grow underground (e.g. yams and potatoes) were believed to be very starchy, whereas those that grow above ground (e.g. bananas and plantain) were not. Pierce and Armstrong (1996) stated:

> **In the West Indies, a lot of starchy foods were eaten, but the hot sun and general heat ensured that these foods were 'burned up'. Perspiration then got rid of the**

continued

Case study

> **food. Thus it was failure to perspire sufficiently in the UK that made starchy foods into a potentially dangerous factor.**
>
> *(Pierce and Armstrong, 1996, p. 96)*

This research may provide some insight into Gloria's reluctance to follow dietary advice. It may be that Gloria is avoiding starchy foods, preferring instead to eat a diet of vegetables in the belief that she should avoid carbohydrates.

What action could the nurse who is caring for Gloria take in this situation?

In this situation, the nurse may find it useful to ask Gloria about her day-to-day life and her understanding of diabetes and the effects that it has on her body. It may also be useful to elicit her attitudes and feelings about the diabetes, and how she perceived the condition prior to diagnosis. For example, the nurse could ask her the following questions:

- What do you know and understand about diabetes?
- Do you know anyone else who is diabetic?
- What do your family think about diabetes?
- What has caused you to have diabetes, and how does it affect you?

Importantly, adult magico-religious beliefs about witchcraft or spirit possession can sometimes have very serious consequences for children or young people. There have been a small number of high profile cases in the United Kingdom where children or young people have been abused or neglected because their parents or guardians have believed them to be either witches or possessed by an evil spirit or demon.

Perhaps the most well-known of these involved Victoria Climbié (November 1991–February 2000) an 8-year-old child born on the Ivory Coast who was sent to live with a great aunt to receive an education firstly in France and then in the United Kingdom. By the time Victoria had died at the hands of her great aunt she had endured months of terrible abuse and neglect, largely because her great aunt believed her to be possessed by an evil spirit. The inquiry that followed (Lord Laming, 2003) highlighted the harrowing details of the abuse, the shortcomings of the health and social care services at this time but also, importantly, brought the notion of child abuse linked to faith or belief into the national consciousness.

Research commissioned by the Department for Education in 2006 found that in the five years between 2000 and 2005, there were 38 cases of child abuse involving 47 children that were linked to accusations of possession or witchcraft. There is now a national working group on child abuse linked to faith or belief, which has developed a national action plan to tackle this issue. The action plan outlines a wide range of potential abusive situations linked to such beliefs (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175437/Action_Plan_-_Abuse_linked_to_Faith_or_Belief.pdf), which includes beliefs that demons or devils are leading a child astray, beliefs about the evil eye or Djinns, and about ritual or multi-murders where the killing of children is believed to bring supernatural benefits or the use of their body parts is believed

to produce potent magical remedies. The action plan also discusses the use of belief in magic to induce fear in children to ensure compliance in exploitative activities.

Following the Laming Inquiry (2003) there are now clear guidelines for health professionals who suspect such cases, all of which must result in the immediate involvement of safeguarding personnel. (See: http://webarchive.nationalarchives.gov.uk/20130401151715/; https:/www.education.gov.uk/publications/standard/publicationdetail/page1/DFES-00465-2007: accessed 20 March 2016.)

Of course, magico-religious beliefs do not always lead to such extreme cases of abuse. Often, the 'actions' taken simply include the use of prayer or the wearing of a talisman or amulets. For example, Ismail et al. (2005) found that the participants with epilepsy in their study continued to use prescribed anti-epileptic drugs but some undertook pilgrimages to seek forgiveness for their sins, or consulted religious healers who recommended reciting certain prayers or the wearing of a Taweez (a prayer amulet or locket that has prayers inside from the Qu'ran). The participants were not always convinced of the healing power of these actions but often felt comforted by the concern of others and considered these additional actions harmless.

Perhaps the challenges for health professionals occur when the actions impact on the uptake of Western medical treatments. Linnard-Palmer and Kools (2005) suggest that there have been 'over thirty churches identified in the literature whose doctrines, religious beliefs or teachings include the limitation, refusal or preference for prayer over traditional Western medical interventions' (p. 49). In their study of paediatric nurses in acute care settings, they found that cultural and religious beliefs can impact on whether parents seek medical attention or indeed accept treatment for their child. Interestingly, the findings of this study acknowledged the impact of this refusal of treatment on the relationships between the parents and the staff. One of their participants described the relationship between hospital staff and the parents of a child who was admitted with an illness related to the parents religious beliefs as 'the greatest of power struggles' and of course some parents risk losing guardianship of their child based on medical neglect if they continue to refuse medical treatment – and this can lead to very damaged relationships between parents and staff. Indeed, the staff participants in this study described their experiences in terms of *moral distress* and three of the participants disclosed long-term consequences of such refusal events on their health and stress levels.

Differences in beliefs can result in both nurses and patients feeling frustrated and failing to understand each other which may cause the patient to abandon or ignore healthcare services – ultimately resulting in health inequalities that are rooted in culture. Conflicting ideas may result in apathy and withdrawal from care that may be manifested, for example, by broken appointments or failure to comply with prescribed medication. The financial cost of this is high because missed appointments mean that valuable spaces on waiting lists are wasted. However, the human costs are perhaps even higher since people who do not seek help or access care may be risking their health and ultimately their lives.

However, if the provider becomes more sensitive to the issues surrounding health care, then more comprehensive and holistic care will be delivered. Of course, as nurses it is impossible for us to become experts on every cultural or ethnic group. Indeed, it is argued that becoming an 'expert' leads to stereotyping and making generalizations about people.

Furthermore, as Henley and Schott (1999) emphasize, not everyone in a particular culture shares the same attitudes and assumptions about illness and health. Indeed, they suggest that

'there may be more similarities between the health beliefs or practices of different ethnic groups at the same socio-economic level than there are within the same ethnic group at different socio-economic levels' (1999, p. 25).

Beliefs about treatments

It is also important to acknowledge that as health professionals we may be working with guidelines that develop and change as new evidence comes to light and that, at times, this can be confusing for patients. A good example of such advice was outlined by Schott and Henley (1996, p. 125) who described one midwife's experience. She explained, 'When I worked in the East End we put a lot of time and energy into trying to persuade Bengali women to put their babies on their tummies to sleep, but to no avail. They persisted in lying them on their backs. The Back to Sleep campaign made nonsense of our advice. I wonder how much else that we think is sacrosanct will also turn out to be wrong.'

There are numerous other guidelines that change between generations and that differ between cultures which may cause confusion or conflict between older and younger family members and the health professionals they come into contact with – for example, about what constitutes a healthy diet or the weaning of children.

EXERCISE

There are still some practices and customs inherent in the UK healthcare system that are based on superstition (or magico-religion). Some examples that are encountered on wards include the sayings and beliefs listed in Box 5.1.

Box 5.1 Superstitious beliefs encountered in nursing practice

'Deaths always come in threes.'
'Bed number 13 is unlucky.'
'Never put red and white flowers together in a vase' (because the colours symbolize death and are therefore unlucky).
'A full moon means there are more people with mental illness around.'
'Whenever there's a death on the ward, open a window so that the soul can fly out.'

Reflective exercise

1. Which of the above beliefs are you familiar with?
2. Do you know of any others?
3. How superstitious are you? List the superstitions you follow (e.g. touching wood, reading your horoscope).

There are strategies we can use to support the patient with various health beliefs. People are unlikely to change their beliefs and practices if they feel under pressure or if they consider that their views are under threat or will be ridiculed. Attempts to try to change people's beliefs are

almost always counter-productive. Instead, where possible, clients should be actively involved in making decisions about their care in a way that does not make them feel threatened or inept – this may result in greater compliance and cooperation.

Jackson (1993) offers a useful set of questions that could be asked in order to elicit information about the client's health beliefs.

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How does it work?
- How severe is your sickness?
- Will it have a short or long course?
- What kind of treatment should you receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused you?
- What do you fear most about your sickness?

It is important to remember to establish rapport with the patient and to ask these questions with sensitivity and care. After eliciting this information, Jackson (1993) advocates taking the following steps in order to negotiate a care plan.

1. *Explain the relevant points of biomedicine in simple and direct terms*. This might involve explaining the cause, signs and symptoms and likely treatment for this particular illness. Although the information may seem alien to the patient, it may in fact be of value to him or her. It may be necessary to use interpreters at this stage.
2. *Openly compare the client's belief system with biomedicine*. Point out the discrepancies, but give the client opportunities to ask questions and clarify terms, and to raise objections.

Jackson comments, 'Familiarity with the client's culture can be helpful to this process because it may give the practitioner clues about possible problems' (Jackson, 1993, p. 41). If the client remains unconvinced about the proposed plan of care, the nurse may find it useful to invite him or her to think of a solution to the problem. Any suggestions may then be discussed together until a plan that meets the needs of both parties can be agreed upon.

Jackson (1993) also emphasizes that, where possible, practitioners should seek to preserve helpful or non-harmful beliefs and practices, given that these often prove to be useful when studied by Western medicine. Some practices may be neutral in their effects but seem irrational to the outsider (e.g. the use of hot or cold foods in postnatal care). However, we need to remind ourselves that our own beliefs and practices are not always logical or scientific, and they may not always 'make sense' to someone from outside our own culture.

However, there may be conflict if health beliefs are considered to be positively harmful or dangerous. It may then seem urgent to change them immediately in order to protect the patient. However, some cultural practices may be ingrained in people's lifestyles, and may

perhaps be part of a strict religious or moral code. They may be difficult to challenge without causing individuals to feel affronted or alienated. People may fear that changing their beliefs or complying with biomedicine may result in punishment (from God or their family, religious groups or peers). These are very difficult ethical dilemmas that are beyond the scope of this chapter. However, the nurse has a duty to allow the patient to express his or her beliefs and ideas about care, and to negotiate and explain his or her perspective in a manner that is non-threatening and respects the other person's belief system as being both valid and meaningful.

Key points

1. People's health beliefs may have a direct impact on their behaviour and the way in which they respond to illness.
2. Nurses need to be aware of these factors and to take particular care when eliciting beliefs about health.
3. The patient needs to be understood in the context of his or her own life and personal circumstances.

CONCLUSION

Kleinman (1986) argues that medical systems do not just deliver health care. They are part of society and, as such, they reflect the wider social and cultural systems. Biomedicine is therefore merely a product of our UK culture – as is the National Health Service (NHS) that is the vehicle for UK health beliefs. This chapter has outlined how health beliefs from different cultures often overlap. In the United Kingdom we live within a plurality of health belief systems. Ostensibly we adhere to, or align ourselves with, the biomedical model, but some clients and indeed nurses may still believe in practices that are neither scientific nor logical in the context of the biomedical paradigm. It is important not to negate or ridicule these practices, but to place them within their social and cultural context. There are a variety of complementary, alternative or even magico-religious health practices available to those in the United Kingdom which, whilst not superior to the biomedical system still need to be acknowledged as belonging within the realm of health options in the United Kingdom. Thorne (1993) makes the following argument:

> **Thus the nature of healing and the social expectations upon healers reflect a range of options which are better understood in the context of the culture than in contrast to one another. In each case there is considerable logic to the system, although the logic reveals considerable variation in the starting point. The prevalence of both the naturalistic and personalistic traditions in most cultures challenges us to examine our own healing practices for their own non-naturalistic elements.**
>
> *(p. 1938)*

CHAPTER SUMMARY

1. Pluralism is the use of concurrent approaches to health care.
2. Health beliefs that differ from one's own require careful and sensitive elicitation.
3. The exploration of health beliefs needs to be undertaken within the person's life and social context.

FURTHER READING

Brown, K., Avis, M. and Hubbard, M. 2007. Health beliefs of African–Caribbean people with type 2 diabetes: A qualitative study. *British Journal of General Practice*, 57, 461–469.
This paper explores the accounts of the way in which African–Caribbean people living in Nottingham experience and manage their diabetes.

Fadiman, A. 1997. *The Spirit Catches You and You Fall Down*. New York: Noonday Press.
This work describes the dilemmas that face a child of a Hmong refugee's family from Laos who suffers from epilepsy in an American hospital. It vividly portrays the culture clash, and provides an interesting account of health beliefs that are at odds with biomedicine.

Fedorowicz, Z. and Walczyk, T. D. 2007. A trisomial concept of sociocultural and religious factors in healthcare decision-making and service provision in the Muslim Arab world. In: Papadopoulos, I. (ed.), *Transcultural Health and Social Care Development of Culturally Competent Practioners*. Edinburgh: Churchill Livingstone, 265–281.
This chapter (Chapter 16) gives an interesting and informative account of Islamic medicine and healthcare issues.

Helman, C. G. 2007. *Culture, Health and Illness*, 5th edition. London: Hodder Arnold.
This book explores all aspects of cultural beliefs and practices and is also an excellent resource for other chapters in this book. Chapter 4, Caring and curing: the sectors of health care (pp. 81–121), is particularly relevant to this chapter.

Loewenthal, K. 2006. *Religion, Culture and Mental Health*. Cambridge: Cambridge University Press.
This book explores a range of issues linking religion and cultural beliefs with mental issues.

Pool, R. and Geissler, W. 2005. *Medical Anthropology*. Maidenhead: Open University Press, McGraw-Hill Education, Understanding Public Health Series.
This book offers an anthropological view of issues that can challenge the healthcare services and professionals. Topics such as patients' experiences of illness and treatment, use of medicines and healing practices and concepts of culture are included as well as case studies and interactive activities.

WEBSITES

http://www.evidence.nhs.uk/Search?q=Health+Beliefs+

This site draws on evidence from across a range of information sources. It is the work of NICE (National Institute for Health and Care Excellence), which offers an opportunity to search for various topics related to health and health care.

http://www.bing.com/videos/search?q=cultural+beliefs+in+nursing&&view=detail&mid=4270ED5082F2398C4C164270ED5082F2398C4C16&FORM=VRDGAR

This is a video explaining Cultural Matters: Indigenous Perspectives on Behavioural Health Care. It is a North American perspective working with indigenous groups of people to understand their health beliefs and how to integrate and work with them to improve health care to these communities. It is a very valuable resource for demonstrating health beliefs and working together across cultures. (Accessed 21 March 2016: 27.20 minutes.)

http://www.qub.ac.uk/elearning/hiv-and-pregnancy/ElearningResource/Module2-LivingwithHIV/Culturallysensitivecare/

This site is a learning resource from Queen's University Belfast. It includes short video clips of women explaining their cultural values and behaviours when living with HIV as a diagnosis.

CHAPTER 6

Women and health care in a multicultural society

Karen Holland

INTRODUCTION

Women have significant roles in most societies as mothers, carers and workers. For example, they represent the majority of the nursing workforce and they also provide the majority of care as mothers and informal carers (Trevelyan, 1994; Buchan et al., 2008). However, in most societies women do not experience equality with men in many areas of their daily lives, and often this will influence how they experience and receive health care.

This chapter focuses on women's health care in a multicultural society. The importance of men's health care is acknowledged as being of equal importance (and will be discussed in Chapter 7) but the potential impact of women's health and health problems significantly influences the lives of others, particularly their role in child care and as mothers.

The chapter will focus on the following issues:

- The role of women in society
- Women as carers in society
- Cultural beliefs and the needs of women
- Women and the need to maintain privacy and dignity
- The effects of women's role and cultural beliefs on their health and health care

THE ROLE OF WOMEN IN SOCIETY

Events such as human-made and natural disasters (e.g. war, earthquakes), the increasing longevity of women and changing family structures have influenced the role that women play in their own cultural groups and in society. Consider, for example, the changing role of women in society in the United Kingdom. Owing to factors such as unemployment and increased divorce rates, many women in traditional UK culture have now become the main breadwinner, with more men adopting a child-caring role. However, traditional social norms still do not view this as 'normal' behaviour within a nuclear family structure. As a result of changing family patterns and the need for many men and women to move away from their locality during the past century, there are no longer the same extended family support networks. By contrast, in some other cultures, there are extended families that give women a great deal of support.

However, Schott and Henley (1996) pointed out that even this is no longer guaranteed, especially if families are separated geographically, and that a stereotype of extended family support could prevent adequate services being provided for different cultural groups. They cite an example from a Bradford study (Gatrad, 1994) which found that South Asian mothers who wanted and needed help from Social Services were less likely to receive it than English mothers. However, a recent report by the National Society for the Prevention of Cruelty to Children (NSPCC) notes that with regard to issues of domestic violence, this extended family (i.e. the women) will not always intervene or support the woman who may need help, encouraging them to stay in their abusive marriage rather than leave it (Izzidien, 2008). Izzidien (2008) states, however, that when the family condemned the actions of the perpetrator and sympathised with the women, they were a great source of help.

Kaur and Garg (2008) report on the same issue of domestic violence in India following the Protection of Women from Domestic Violence Act (2005) which states 'that any act, conduct, omission or commission that harms or injures or has the potential to harm or injure will be considered domestic violence by the law'.

This act also protects children. They point out that the act covers domestic violence against men or women but that in India it is women that are the main victims. The wider communities, however, are often reluctant to get involved in what are seen as family disputes and of course the victims are often ashamed to tell anyone even in their close family unit.

Hendry (1999) cited an example of the Pakistani community, where this extended family network includes a group of individuals known as the biradari, commonly translated as 'relations'. This group is a central support network for girls when they get married, and is reinforced by 'arranged marriages between members of the same biradari, very often between first cousins' (Hendry, 1999; see Chapter 9 for further information). For young British-Pakistani men in Bradford, however, 'biridari (clan) networks no longer had the centrality they once enjoyed, as there were now other ways to gain support, understanding and group identification' (Alam and Husband, 2006).

Reflective exercise

1. **Consider your own family structure. What kind is it?**
2. **Discuss with a colleague from another culture what kind of support networks exist in their family structure.**
3. **Compare the way in which women receive or give support to family members.**

Within society, motherhood is viewed as the natural role for women, and in the United Kingdom 'the status of mothers is generally low in comparison to some other cultures and countries' (Schott and Henley, 1996). However, Bowler (1993) does point out that our understanding of 'normal' motherhood is based on Western white middle-class behaviours. Phoenix and Woollett (1991), cited by Bowler (1993), believe that it is this view that has helped to ensure that when we talk about what is right or wrong about women's role in bringing up children, anything that does not fit into this traditional pattern is not 'normal'.

Marriage patterns are also linked to the role of women in society. Many couples marry their own choice of partner, but some cultures have arranged marriages and/or very strict

prohibitions about partners. For example, a student nurse from a Muslim culture gave the following history:

> **My parents are letting me do this course because I want to be a nurse and help people from my own culture. However, once I finish, I am expected to get married to someone they arrange for me to marry, and unless he supports me to carry on working I won't be able to.**

This student did in fact complete her course, but because of her marriage was unable to register as a qualified nurse. She subsequently divorced her husband and trained for another care profession.

This type of example was also seen in a study by Dyson et al. (2008), which explored the experiences of a group of South Asian student nurses. They found that 'negotiating marriage' was 'one of the most significant themes in the study' whereby 'students talked of negotiating with their parents, for the most part with fathers, to be allowed to study or work before returning home to be married' (Dyson et al., 2008, p. 169). They also highlighted the issue of 'not bringing shame' on their families and as one student explained:

> **If I find someone at University then he would have to be the same religion and the same caste and come from a good background – that's not a big issue – as long as he's the same religion. My parents would be disappointed if he wasn't because it's society – and they would talk and parents can't seem to handle that gossip and they care what people think. The biggest sin, as an Asian girl, would be to bring shame on your family.**
>
> *(Student 5, Dyson et al., 2008)*

Marriage across cultures is also discouraged by other societies. For example, Gypsy Travellers are not allowed to marry a Gorgio (an outsider or non-gypsy), as marriage relates to purity of the race and blood (Okley, 1983); neither are they allowed to marry first cousins. The latter prohibition is in complete contrast to other cultures. For example, in Islamic law, first cousins are allowed to marry one another (Henley, 1982). This is permitted by the Qur'an. The issue of first cousin marriages was a topic raised in the House of Lords in April 2008 in relation to genetic risks and the response to one question related to the role of health professionals and genetic counsellors:

> **Lord Darzi of Denham: My Lords, the noble Baroness makes an important point. I would like to put on record the Government's commitment to this. The role of the healthcare professional and of the Government is to provide support and advice to empower people to make informed choices based on clear information and advice. The healthcare professional's role is to allow the individual to assess these risks and to make their own decisions about what to do; it is not to tell them who they should marry. As a result the Government have made a significant investment in this field, not only in the training of genetic counsellors but in changing the curriculum of primary care colleagues with the collaboration of the Royal College of General Practitioners. We will see more and more genetic knowledge being disseminated through postgraduate education.**
>
> *(Parliamentary Business, Hansard, 21 April 2008; http://www.parliament.uk)*

(See Appendix 4 for further information on Islamic religious beliefs and practices.)

It is also important to understand the role that women play in marriage in different cultures. In Hindu culture women often undertake vows, the purpose of which is

> **to attain the grace of a deity for a specific objective – whether for the care, protection and well-being of the family or specific members by acquiring merit with God, for personal satisfaction and the 'goodness of God', through devotion and discipline, or to achieve a particular wish, often in times of family or personal crisis or during episodes of illness.**
>
> *(McDonald, 1997, p. 141)*

One such ritual is described as follows:

> **Jaya parvati vrat is a ritual performed by women for five years after marriage in order to ensure the health and longevity of their husbands, and to protect their own state as an auspicious married woman.**
>
> *(McDonald, 1997, p. 141)*

The annual ritual lasts for five days and consists of fasting and worship, with some variations according to beliefs of the community. For example, not eating food with salt nor wheat until the final day when a meal can be eaten with both of these. (See this Maher Community website for full details of the origin of this ritual: http://www.maheronline.org/religion/festivals/jaya-parvati-vrat, accessed on 16 March 2016.)

McDonald (1997) found that among the Gujarati women in her study, many still believed that they were subordinate to their husbands in certain aspects of their lives. If a woman had been widowed, she was traditionally viewed as bringing bad luck or being 'the cause of the evil eye' (McDonald, 1997), and it is still a tradition for a widow to remove all of her marriage jewellery. She may not put the vermilion mark in her hair parting or wear brightly coloured saris, as these are symbolic of her married status. A similar ritual is Sitala Satam, which takes place in July or August and involves both fasting and eating cold food (McDonald, 1997). Many childhood diseases are associated with the goddess Sitala, who, unless worshipped properly, brings illness into the community. The ritual is for the protection of children and to ensure their good health. Failing to worship the gods and goddesses is often viewed as the cause of illness and 'infertility in women' (McDonald, 1997).

Reflective exercise

1. Consider your own personal experiences. What role do women play within your family?
2. How is the role of women as workers, mothers and carers viewed in your culture?
3. If you are a woman, what role conflict have you experienced in relation to the above?

You may have concluded that in your culture men and women are considered to have equal status in the family and at work. In other cultures, the roles of men and women may differ from this, with women taking the major role in childcare and the home, and men having the major role as 'breadwinner'. However, in the United Kingdom this traditional male role is being taken on by

women in all cultures for economic reasons (e.g. male unemployment). This is often in addition to their roles as wife and mother, which can cause increased role conflict and stress for women as they try to manage both successfully.

WOMEN AS CARERS IN SOCIETY

Caring is traditionally viewed as the role of women, which Colliere (1986) believed was not considered to be valuable or of great necessity to society. Although this may appear to be a very sweeping statement, let us consider how nursing as a caring profession has been viewed in some societies since then. Most nurses are women, and Davies (1995) reported that in 1988 only 9% of nurses working in the NHS were men. In 1998, this number had increased to 10.5%: 44,557 out of a total of 421,749 (Department of Health, 1998). In 2006–2007, 90% of entrants into UK pre-registration nursing programmes were women (National Nursing Research Unit, 2009), and the policy report concluded that 'men could be a significant recruitment pool in the future if barriers to male recruitment could be overcome' (see Chapter 7).

Reflective exercise

1. Find out how many men are undertaking a nursing course in your own School of Nursing – you may ask your tutors for help with this exercise or choose it as one of your classroom projects. You may need to begin with your own classroom colleagues.
2. Find out if you can what Field of Practice (nursing speciality) men are most likely to pursue as a career. This can be from talking to your male colleagues in the classroom (during an appropriate classroom break) and also from undertaking a literature search.
3. Discuss the general findings with each other and decide whether you believe we need to encourage more men into nursing and why.
4. Some of you may be midwives reading this book chapter – indeed the same questions above also relate to the midwifery profession. Consider some of the issues about men in midwifery. (Access this article for both professions: https://www.nursing.vanderbilt.edu/msn/pdf/nmw_midwiferyformen.pdf.)

The image of nursing as a profession for women has tended to persist, even though the NHS has attempted to change this in order to aid the recruitment of nurses. The status of nurses and that of women in society has also been identified as being very closely linked (Davies, 1995). We can see this in Johnson's study (2010), which focused on the role of nurses in India when she told her about her mother's views:

> **Some discussions also revealed wider social attitudes towards nursing as a respectable occupation for women, particularly women from more affluent backgrounds. For my parents' generation in particular, nursing was not considered to be a suitable choice for girls from middle and upper-middle class families. For example, while reflecting upon my interest in**

> **studying Indian nurses, my mother remarked that nursing would not have been considered as an appropriate occupational choice for her. She recalled that her mother (who was reportedly very caste and class conscious) had expressly told her never to consider nursing as it was a job for girls from poorer families and too close to domestic work to be 'respectable'. Medicine, on the other hand, would have been an acceptable choice as this was seen as a prestigious profession, did not involve 'dirty work' and thus had none of the negative connotations of nursing.**
>
> *(Johnson 2010, p. 11: http://researchonline.lshtm.ac.uk/834552/1/550402.pdf. Accessed on 16 March 2016)*

This was also observed in a study by Mizuno-Lewis and McAllister (2006) on the issue of how Japanese nurses take leave from their work and the impact that their culture has on whether they do or not. They point out that there is gender inequality in Japan and that 'there remains a profound belief that the Japanese man should go out to work while the woman should stay home and look after the house and children' (Mizuno-Lewis and McAllister, 2006, p. 275). Although there is some change in this belief, men's careers are seen to be the priority but when women are working (i.e. nursing), their culture with its strong work ethic does not enable them to take sick leave nor many holidays (33% are reported to take less than five days annual leave a year). The paper reports on the case of a young female nurse who died of a subarachnoid haemorrhage and a dispute whereby there was an attempt by her parents to prove that it was caused by Karoshi (death by overwork). It appears that the nurse 'was allegedly forced to work more than 80 hours of overtime per month'. No final outcome was reported, but the authors concluded that there was a need for 'Japanese nursing … to benefit from preparatory education that teaches students about … emancipation of women and the need to change traditional values about not taking leave and the value of a balanced approach to work' (Mizuno-Lewis and McAllister, 2006, p. 279). Interestingly in relation to this issue of Karoshi, the *Guardian* newspaper in the United Kingdom (February 2015) published a short report about the Japanese government's intention to make it law that Japanese workers should take more paid holidays, and offered an interesting insight into the links between hard work and traditional cultural values: http://www.theguardian.com/world/2015/feb/22/japan-long-hours-work-culture-overwork-paid-holiday-law.

There is also a valuable insight into nursing and midwifery professions today in Japan by the Japanese Nursing Association (see these articles: http://www.nurse.or.jp/jna/english/pdf/nursing-in-japan2011.pdf and http://www.nurse.or.jp/jna/english/midwifery/pdf/mij2015.pdf). (Full links are provided in the websites list at the end of this chapter.)

Wolf (1986) found that there was also a relationship between nurses' work being regarded as sacred and profane. Nurses were perceived as being involved in both 'dirty work', such as handling body excreta with its pollution image, and sacred work, such as 'administering to the sick', with its religious symbolism (Wolf, 1986). These images have a major influence on the position and status of nurses worldwide.

In Japan, for example, nurses had a relatively low status because of their association with pollution and illness (Hendry and Martinez, 1991). According to Tierney and Tierney (1994), 'nurses in Japan are regarded as having a "3K" job – kitsui (hard), kitanai (dirty) and kiken (dangerous)'. Similar findings have been reported with regard to nursing in India (Nandi, 1977; Somjee, 1991). A study by Zaman (2009) reported that 'nurses in Bangladesh rarely touch the

patient; the relatives of the patient do all the "body work" and play the role of nurses'. It was also reported that:

> **The negative opinion of nursing also comes from the existing religious notions in Bangladesh. In this context, the nursing profession is considered socially low because of Hindu ideas about the caste system and because of Islamic notions about decent moral conduct for women.**
>
> *(Zaman, 2009, p. 373)*

Reflective exercise

1. How often have you heard the same kind of views being expressed about nursing in the United Kingdom? Ask some of your non-nursing friends how many of them would consider nursing as an occupation and why.
2. Ask your non-nursing friends what their image of female and male nurses is, and how both professional (nurses and other healthcare occupations) and lay (non-healthcare worker) caring is viewed.
3. Compare these with the earlier comments on Japanese nurses.

In Japan, as in the United Kingdom, there has been an increase in the number of women going out to work (Tierney and Tierney, 1994), which is now creating a problem with regard to care for the elderly in traditional extended families. Atkin and Rollings (1993) have reported on one of several studies which have examined this informal carer role within black and minority ethnic communities. A study by McCalman in 1990 cited by Atkin and Rollings (1993) found that of 34 carers living in the London borough of Southwark:

> **All the carers looked after a close relative; just over half [of carers] – a parent, step-parent or parent in law, one-third a spouse and just over an eighth a grandparent. Twenty-one carers were female.**
>
> *(Atkin and Rollings, 1993, p. 12)*

Atkin and Rollings also point out from their research that 'the supportive extended family network is largely a myth' and that there are many Asian people now living on their own (Atkin and Rollings, 1993). A study by Walker in 1987 also revealed that 'out of 15 Asian families caring for a child with severe learning difficulty – the mother always assumed responsibility for all aspects of care' (Atkin and Rollings, 1993). This predominantly female role was also identified by Poonia and Ward (1990), who discussed the value of such initiatives as the 'Give Mum A Break' service in Bradford or 'Contact a Family' in the London boroughs of Lewisham and Southall. These schemes ensured that women caring for children with severe learning difficulties, who are especially vulnerable to isolation and depression, are given a 'lifeline'.

In one case study, Davis and Choudhury (1988) analysed an Asian family and the ways in which healthcare professionals helped them. They demonstrate how their interventions reduced the possible plight of the woman carer. However, this Asian woman's situation was made doubly

stressful because she was from a different culture and was unable to communicate in the language of the caring profession.

Case study

The family lived in a fourth-floor council flat where the lift was frequently broken. This was intimidating, as is often the case in housing in inner cities. Mrs B was 45 years old and had two sons (aged 12 and 16 years) and a daughter with Down syndrome (aged 11 months) living with her. At the first meeting, Mrs B appeared bewildered, lonely, distraught and unable to cope with the problems facing her, including the recent sudden death of her husband, her daughter's Down syndrome, her own ill health, her inability to speak English, her fear of leaving the flat, her enforced separation from her other children in Bangladesh, the absence of a support system (family or friends) and her extreme poverty. (From Davis and Choudhury, 1988, p. 48.)

Reflection point

Imagine that you are a member of the community team who is assigned to help this woman. What cultural factors would you have to consider in order to establish an understanding of her situation?

Mrs B was helped over a period of 12 months, and she eventually became more independent and had started to make friends. The main source of help was a Parent Advisor Scheme set up to help the families of children with special needs (Davis and Choudhury, 1988). The scheme has trained counsellors who speak the same language as the families and can thus offer support through communication; it also involves a team of healthcare and education professionals. This planned support is based on trust and effective communication.

A report by the Foundation for People with Learning Disabilities (Towers, 2009), however, found that fathers of children with learning disabilities wanted more involvement in looking after their children but also recommended that more support was required for them to maintain their health and well-being where they were very involved in the caring role. (Further information on matters relating to minority ethnic communities and people with learning disabilities can be found in the websites list at the end of this chapter.)

One of these is a very detailed report (RCPSYCH, 2011) on the situation with regard to 'Minority Ethnic Communities and Specialist Learning Disability Services' in the United Kingdom, established through the literature and focus groups of experts that there were now new groups of people that had to be taken into consideration in relation to learning disability, and that was 'new migrants with learning disabilities with mental health issues'. The researchers offer many possible solutions and challenges for the future care of individuals and the communities in which they live, including one that is an integral part of this book, and that is there is a need to develop 'a culturally competent workforce that goes beyond providing diversity training'. They believe that it should be 'integrated both at the organisational and the individual practitioner level'.

It appears that in some situations there remain misunderstandings about beliefs and values of minority-sized communities that the Poonia and Ward (1990) example remains relevant to use in this chapter.

Poonia and Ward (1990) also highlight the fears of many parents of dependent children who may require additional care outside the home. These are especially focused on their concerns that the children's cultural needs will not be met. They cite the experience of Mr and Mrs Rafiq, who were unhappy that 'their son Nadeen was unable to pray during Ramadan as they would like when he attended a local scheme' (Poonia and Ward, 1990).

This scenario could apply to any parents from any culture, but it is clear from the literature that there is a perceived inequality in the services provided for families from minority ethnic communities (Ellahi and Hatfield, 1992; Rickford, 1992). Other studies and similar evidence can be found on the NHS Evidence–Ethnicity and Health website (see the website list at the end of this chapter).

An interesting study by Greenfields (2008) focuses on both consideration of education and training opportunities for Gypsy and Traveller communities which would enable those being trained to undertake different roles for that community such as midwifery, training in social care but also discussed the difficulties from the community members point of view, of prejudice and racism they face as well as having to travel and move their residences about.

Key points

1. **Caring for others is traditionally viewed in many cultures as being the role of women.**
2. **The status of nurses in society is very much linked to that of women.**
3. **The literature indicates that communication between carers and health and social care professionals has to be effective if care is to reflect multicultural needs.**

CULTURAL BELIEFS AND THE NEEDS OF WOMEN

An understanding of individual and cultural beliefs about menstruation, pregnancy and childbirth, for example, can be considered essential to an understanding of women's health care in a multicultural society.

In many cultures, women who are menstruating are considered to be polluted and 'dirty'. For example, Jewish law states that while a woman has any vaginal blood loss, and for seven days after the loss ends, touch between her and her husband is forbidden (Schott and Henley, 1996). There is no contact between Orthodox Jewish couples until the woman has had no bleeding for seven clear days, at which time they go to the 'mikvah' (a special bath-house attached to the synagogue) for a ritual cleansing bath. The couple can then resume contact. This belief that women are unclean during menstruation is also found in Muslim, Hindu, Sikh and Gypsy-Traveller cultures.

Muslim women are also considered to be unclean for 40 days after giving birth. During this time they do not fast, say their daily prayers or touch the Holy Qu'ran (Henley, 1982). Sexual intercourse during menstruation is strictly forbidden in all of these cultures. These beliefs could explain why many men do not touch their wives during labour (it is not because they are uncaring towards them). Japanese women do not bathe or wash their hair during menstruation, and 'there are beauticians who make sure their customers are not menstruating before they will agree to wash their hair' (Ohnuki-Tierney, 1984, p. 28).

The onset of menstruation is not only evidence that reproductive activity has started in the body but is also a symbol of having reached maturity as a woman. Helman (2007) cites a study undertaken by Skultans (1970), who found that some women in a South Wales mining village believed that menstruation and the 'monthly flow' had a positive value in terms of their health (i.e. that getting rid of 'bad' blood was a means of purging one's body). Standing (1980) also reported that many of the women in Skultan's study believed that menstrual blood was poisonous, even at the menopause, and that 'menopausal women were told not to touch red meat because it might go off or to make bread because the dough would not rise'. Gypsy Traveller women are considered impure or 'Mochadi' during both menstruation and pregnancy (Vernon, 1994). These are cross-cultural beliefs and an example illustrating this can be found in Wogeo Island, New Guinea, where any woman who is menstruating is kept in seclusion in her own hut and 'must not come into contact with people or property while she is in this condition, nor touch the food of her husband lest he die' (La Fontaine, 1985). A study of menstrual hygiene and management in adolescent school girls in Nepal (WaterAid, 2009) also highlighted the beliefs of the 'polluting touch' and the equally polluting potential of the 'menstrual cloth' but many of the girls were beginning to challenge the rituals surrounding menstruation. One participant offered the following explanation:

> **I grew up being told of what to do and what not to do. I know of what I am supposed to do … but then when no one is around I do everything that I am not supposed to … I touch water, I touch food in the kitchen, I enter every room … I have also touched many fruit trees and none of them have wilted so I think it is not true.**
>
> *(WaterAid, 2009, p. 11)*

Reflective exercise

Reflect on your own experiences of menstruation.

1. If you are a man, identify what you were told about the experience of menstruation and who told you. How has it influenced your care of women?
2. If you are a woman, identify how menstruation is viewed in your culture and how it has influenced your life.

Understanding the different cultural practices in relation to menstruation is important for any nurse, but it is essential for those working in women's health care. For example, to be able to offer advice to women who have had investigations for menstrual problems, knowledge of cultural beliefs and practices will be necessary in order to establish an effective nurse–patient relationship. Consider the following case study.

Case study

A 38-year-old woman from an Orthodox Jewish family is admitted to the hospital for a hysterectomy (removal of the uterus).

You are required to discuss with her the effects of the surgery.

continued

Case study

Points to consider

1. How may she view the fact that she will no longer menstruate?
2. Will this affect her relationship with her husband?
3. What knowledge of the Jewish religion and beliefs will be required for you to be able to discuss possible future health problems with her?
4. Consider the same scenario for women of different cultures. If you are working in a women's healthcare ward or department, you could develop a resource pack that focuses specifically on multicultural care issues. Although this could be perceived as a 'recipe' type approach, it remains one of the most effective ways of acquiring accessible information which can then be supported by other resources. (See Holland, 2008, for another case study of a Muslim woman who was admitted to hospital for a hysterectomy.)
5. Two articles to help you in developing a resource pack and understanding some of the possible concerns affecting the woman above are given here:

O'Flynn, N. 2006. Menstrual symptoms: The importance of social factors in women's experiences. *Br J Gen Pract.*, 56(533), 950–957.

Denny, E. et al. 2011. From womanhood to endometriosis: Findings from focus groups with women from different ethnic groups. *Diversity in Health and Care*, 8, 167–180.

Key points

1. Individual and cultural beliefs with regard to menstruation, pregnancy and childbirth need to be understood in order to offer women's health care that is culturally sensitive.
2. Women who are menstruating or who have given birth are considered to be 'unclean' and polluted in many cultures.
3. Many cultural practices with regard to menstruation, pregnancy and childbirth have a religious significance.

WOMEN AND THE NEED TO MAINTAIN PRIVACY AND DIGNITY

The way in which women dress can be linked to their relationship with men. For example, Muslim women wear clothes that cover their whole body except for their hands. This clothing is known as chador in Iran and parts of Arabia, and consists of a long black dress or skirt and blouse and a black veil. Many of these women also wear a covering to their eyes and nose. In Pakistan, women wear a shalwar (trousers), kameez (shirt) and a long scarf (chuni or dupatta) that covers their head and their mouth and nose. When women are waiting for an x-ray, for example, the exposure of their legs and arms can be very embarrassing and upsetting. It is important that both nurses and other healthcare professionals are aware of this in order to ensure that the woman's dignity is maintained. Consider the following case study.

Case study

A 40-year-old married Muslim woman is admitted to an intensive care unit (ICU) in a critical state. She is unconscious and receiving artificial ventilation. The other four patients in the unit are all men.

How would you ensure that her privacy and dignity are maintained while relatives are visiting her and the other patients?

Points to consider

1. The role of the nurse as advocate for the unconscious patient.
2. The needs of the relatives and of the healthcare team.
3. The position of women in Muslim culture.
4. The traditional dress and customs of Muslim women.

Gerrish et al. (1996) highlighted the lack of respect for maintaining dignity as perceived by users of healthcare services, which in many instances was caused by a lack of cultural knowledge on the part of the healthcare professionals. One example was related by a Gujarati women's group that was interviewed during this study:

> **Many women felt that there was insufficient privacy in getting changed or going for operations. One woman in hospital for suspected appendicitis had a finger thrust up her anus without explanation. She only found out later that this was a test for appendicitis. She was absolutely devastated, but the nurses just didn't seem to notice. When her husband came in later, she completely broke down (BG6).**
>
> *(Gerrish et al., 1996, p. 44)*

Nurses are bound by a professional code (Nursing and Midwifery Council, 2015), which stresses the importance of respecting the dignity of patients and clients. To ensure that this happens, nurses need to be aware of the potential cultural needs of all individuals in their care. To avoid cultural misunderstandings such as the example highlighted above, the nursing team on the ward concerned could have provided patient information explaining the investigations and treatment in relation to the patient's illness in different languages. Many nursing-focused information packages for patients are now written in different languages but it is important, regardless of the language involved, to ensure that patients are able to read it. Some healthcare organizations provide the information in different formats such as audio tapes or a CD-ROM to ensure patients have the information required.

Reflective exercise

1. Identify how you currently explain to any patient or client the nature of intrusive investigations or treatments to be carried out either by yourself or by others.
2. Following this, undertake a similar exercise but focus on the culture-specific needs of those patients and clients with whom you are in most contact.
3. Determine a plan of action to ensure that your care in relation to maintaining privacy and dignity is culturally focused.

THE EFFECT OF WOMEN'S ROLES AND CULTURAL BELIEFS ON THEIR HEALTH AND HEALTH CARE

The 'low' status afforded to women in some societies is reflected in how girl and boy babies are viewed and in some parts of the world 'infanticide of female babies still persists, especially in rural areas' (Helman, 2007).

Trevelyan (1994) reported that in societies where 'there is a strong son preference' the following trends are likely:

> **Girls get a smaller percentage of their food needs satisfied than boys do, and boys tend to get the more nutritious food. In one region of India, for example, girls are more than four times as likely to be malnourished as boys.**
>
> **Boys are breastfed longer. When the baby is a girl, the mother may interrupt breastfeeding to become pregnant and try for a boy.**
>
> **Boys are more often taken for medical care when they are sick and more money is spent on doctors' fees and medicine for them. According to UNICEF, for example, in one paediatric unit of a hospital in the North-West Frontier province of Pakistan in 1989, out of a total of 1233 patients, only 424 were girls.**
>
> *(Trevelyan, 1994, p. 49)*

Explanations for this preference stem mainly from cultural and economic sources, and Trevelyan (1994) cites the work of Smyke (1991), who creates a link with this continued devaluing of women's place because they are women. Smyke (1991) believes that this 'has a profound influence on many women's attitudes towards their own health and their bodies. They accept ill health, pain and suffering rather than finding out if there is something they could do about it' (Trevelyan, 1994, p. 50).

When women from different countries then find themselves living in Western cultures where they still adhere to such beliefs, it becomes clear why they may not use the available healthcare services.

A conflict sometimes arises between first-, second- and third-generation members of minority cultures when exposure to the 'main culture' enables women to consider alternative cultural views. Depression and suicide become common. Schreiber et al. (1998) highlight issues such as this in their study of how black West Indian women in Canada manage depression in a Eurocentric society. They were reluctant to seek help for their problems because of the strong stigma attached to mental illness.

One cultural practice that has had a major impact on women's health in some societies is that of female genital mutilation (FGM) (sometimes called female circumcision). According to Schott and Henley (1996) there are three types of FGM:

> 1. **Removal of the clitoral hood – this is the only type that can correctly be called circumcision.**
> 2. **Excision of the clitoris and part or all of the labia minora (clitoridectomy).**
> 3. **Infibulation – the most extensive form of FGM in which the clitoris and the labia minora are removed and the labia majora are reduced and then stitched together, leaving a small opening so that urine and menstrual fluid can escape. Occasionally infibulation is performed over an intact clitoris.**
>
> *(Schott and Henley, 1996, p. 213)*

Female genital mutilation is performed at different ages, from very young babies (e.g. in Ethiopia) to just before puberty (e.g. in West Africa). It does not appear to be an Islamic requirement, as it is not mentioned in the Qur'an (Trevelyan, 1994; Schott and Henley, 1996) and has no health benefits whatsoever. Trevelyan (1994) cites the severe immediate and long-term complications of this procedure. These include:

- Immediate complications: Severe bleeding and shock, infections, death
- Long-term complications: Recurrent urinary tract infections, chronic pelvic infection, painful intercourse, menopausal problems
- Complications during pregnancy and delivery: Vaginal delivery may be impossible, passing a urinary catheter is impossible

Consider the following case study.

Case study

You are working on a gynaecology ward and a young Somalian woman is admitted with severe right-sided abdominal pain. The doctor suspects that it is either appendicitis or an ectopic pregnancy, but the woman has refused to be examined by him. The link worker has obtained information from her mother that she is not married and has never had a 'proper period'. She has also found out that this young woman has had problems with passing urine since she arrived in the United Kingdom as a child. She is extremely distressed and in severe pain.

Reflection points

1. What are your priorities with regard to helping this young woman?
2. What knowledge would you need to be able to identify her potential problems?
3. Examine your own beliefs and feelings if it is discovered that she has had some type of female genital mutilation procedure performed on her.

The Royal College of Nursing in the United Kingdom has produced excellent guidance for nurses (Royal College of Nursing, 2006) which will help you to understand more about this problem and how to answer these questions and more (see also the website list at the end of this chapter). The World Health Organization (WHO) has other information related to this topic (see the website list at the end of this chapter).

The way in which health professionals project their own personal beliefs is crucial to the care that individuals and their families receive. Bowler (1993) undertook a small-scale ethnographic study of women's maternity experiences in a hospital in the south of England, and although it is acknowledged that this study is not representative of all midwives or nurses, it does illustrate an example of stereotyped images influencing care. She identified four main themes that stereotyped Asian women: 'the difficulty of communication, the women's lack of compliance with care and abuse of the service, their tendency to "make a fuss about nothing" and their lack of normal maternal instinct' (Bowler, 1993, p. 160).

These stereotypes resulted in inappropriate care. Because communication was problematic, given that many of the women did not speak English, some of the midwives told Bowler (1993) that 'they were unable to have a "proper relationship" with them, and that having a "good relationship" with a mother was reported as an important part of a midwife's role'. This example could apply to any care worker relationship in which the patient or client does not speak English.

The stereotypes that emerged from the midwives' perceptions of the women's lack of compliance with care stemmed from their ideas about family planning and fertility. The fact that many of the women did have large families led the midwives to believe that they were uninterested in contraceptives, yet it was clear to Bowler (1993) that many women did use them but were embarrassed to discuss the issues, or had language or translation difficulties. However, Parsons et al. (1993) stated that little information was available nationally about the contraceptive practices and needs of people in minority ethnic groups.

Reflective exercise

1. **Imagine that you are responsible for setting up a family planning service for a multicultural community. You will be expected to offer an advisory service for both men and women.**
2. **Identify the cultural issues that will need to be taken into account if the service is to be successful.**
3. **Identify which cultural and religious groups would not use this service.**

The theme that Bowler (1993) identified as 'making a fuss about nothing' is also a stereotypical image that will be familiar to some readers. When questioned by Bowler (1993) about the needs of different women, a typical response was 'Well, these Asian women you're interested in have very low pain thresholds. It can make it very difficult to care for them'. A phrase used by midwives in relation to the last theme of 'lack of maternal instinct' was that 'they're not the same as us', which was attributed in part to their 'large numbers of children and "unhealthy" preference for sons' (Bowler, 1993).

The latter issue is very significant to Muslim women, as male children are considered extremely important in Islamic culture.

This issue has already been highlighted by Trevelyan (1994), and it is important to remember that women who have just given birth to girl babies may be extremely distressed not only by the birth, but also by their fears about not giving birth to a boy.

The theme of 'lack of maternal instinct' can be seen in the following case study, and it also results from a lack of cultural understanding of 'bonding' practices among mothers who have just given birth.

Case study

A Vietnamese woman, after giving birth to a son, refused to cuddle him, but she willingly provided minimal care such as feeding and changing his diaper [nappy]. The nurse, feeling sorry for the baby, picked him up, cuddled him and stroked the top

continued

Case study

of his head. Both the mother and her husband became visibly upset. This apparent neglectful behaviour does not reflect poor bonding, but instead indicates a cultural belief and tradition. Many people in rural areas of Vietnam believe in spirits. They believe that these spirits are attracted to infants and are likely to steal them (by inducing death). The parents do everything possible not to attract attention to their newborn; for this reason infants are not cuddled or fussed over. This apparent lack of interest reflects an intense love and concern for the child, not neglect. Not only did the nurse attract attention to the infant, but also she touched him in a taboo area. Southeast Asians view the head as private and personal; it is seen as the seat of the soul and is not to be touched.

Reflective exercise

1. Reflect on your own experience of childbirth or that of a family member. Discuss with a colleague from another culture his or her experiences, and compare the two.
2. What similarities and differences were there? What were the cultural reasons, if any, for these?

Childbirth is associated with long-term health problems as well as those of an immediate nature. For example, a study conducted by Hagger in 1994 illustrates the way in which a change in cultural lifestyle has influenced patterns of health norms. There appeared to be an increase in the number of Bangladeshi women with continence problems following pregnancy and childbirth in the United Kingdom, whereas those women who had given birth to their children in Bangladesh and received traditional postnatal care often did not have these problems (Hagger, 1994). If the cultural reasons for this are examined, we can see that:

> **Traditional postnatal care involves 40 days' rest, during which time relations take over domestic duties, the diet is light, there is no sexual intercourse, breastfeeding is common and compression bandages are often used – also it is usual to squat over a hole to urinate. Squatting instead of sitting on chairs, and regular swimming, also help to strengthen pelvic floor muscles.**
>
> *(Hagger, 1994, p. 72)*

However, in the United Kingdom few of these traditional practices can be undertaken, with the result that there is now an increasing number of Bangladeshi women with incontinence problems.

Schytt (2006), in her study on women's health after childbirth, also found similar issues with Swedish women, together with a range of other problems such as perineal pain and sexual problems.

A study by Ross et al. (1998) of the way in which women in rural Bangladesh view their health priorities illustrates the need for improved understanding of women's cultural healthcare needs. The study found that, despite appreciating that their health problems could become chronic if left untreated, these women were reluctant to seek early treatment. Even when they did so, it was very often the traditional healers whom they consulted initially.

One example they referred to is described in the following case study.

Case study

A 24-year-old Bangladeshi woman had a persistent vaginal discharge. She believed that her husband was aware of her problem as he had once bought her medicine from a chemist in the bazaar. However, it was ineffective, and her health continued to fail during her second pregnancy because of her discharge. Her second daughter is now 4 months old. Her health has been even more compromised because, with the second pregnancy, she is experiencing paddaphul (uterine prolapse). This made intercourse very difficult, 'even more so than before' (Ross et al., 1998). Unfortunately, the woman's husband then left her and the children. However, the young woman continued to live with her mother-in-law.

Reflection points

1. If this young woman had been English (non-minority ethnic culture), how different would her experience have been?
2. How can the experience of this young woman be of value with regard to understanding the heath care needs of Bangladeshi women in the United Kingdom?

CONCLUSION

Being a woman in different societies has many similarities with regard to biological functions such as menstruation, pregnancy and childbirth. However, the influence of cultural beliefs on these life events ensures that they are unique not only to the individual but also to the cultural community. It is important that, when caring for women in a multicultural society, healthcare professionals are 'culturally prepared' in order to ensure that they provide non-discriminatory practice and understanding.

CHAPTER SUMMARY

1. A woman's health status has a major effect on the health and well-being of her family.
2. Women make a significant contribution to care as both professional and lay carers.
3. Menstruation, pregnancy and childbirth are 'normal' life events for women. However, the significance of each of these in different cultures will vary according to both health beliefs and religious practices.

FURTHER READING

Ahmed, S. 2009. *Seen and Not Heard: Voices of Young British Muslims*. Leicester: Policy Research Centre, Islamic Foundation.

This report highlights the lives of young Asian men and women in Britain, and in particular their views on issues such as gender and identity.

Davies, C. 1995. *Gender and the Professional Predicament in Nursing*. Buckingham: Open University Press.
This book explores the status of nursing as a profession in the context of gender and the status of women in society.

Department of Health 2014. Department for Communities and Local Government Adult Social Care in England: Overview (March).
This study reviews the current state of adult social care in England locally and nationally, and outlines the remaining challenges https://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

Phillipson, C., Ahmed, N. and Latimer, J. 2003. *Women in Transition. A Study of the Experiences of Bngladeshi Women Living in Tower Hamlets*. Bristol: The Polity Press.
This book focuses on a study conducted to consider the lives of women 'who had migrated to the UK during the 1970s through to the early 1990s from the Sylhet district of Bangladesh. It is a fascinating insight into their lives made more real due to the rich narratives throughout the findings.

Riska, E. and Wegar, K. 1993. *Gender, Work and Medicine*. London: Sage Publications.
A sociological account of the division of labour in medicine and its relationship with nursing and midwifery. (Although a dated book it still has relevance for critical discussion in this chapter.)

Schott, J. and Henley, A. 1996. *Culture, Religion and Childbearing in a Multiracial Society*. Oxford: Butterworth-Heinemann.
This book, although published in 1996, still offers health professionals a specific insight into the major issues related to childbearing and how culture and religion impact on this experience.

WEBSITES

http://globalhealth.org and http://globalhealth.org/resources/archived-publications/
This website is the Global Health Council where there is not only information and resources about women's health internationally but also a range of other topics such as sexual and reproductive health. It has a major archive of documents from the previous site.

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/International/AsylumseekersAndrefugees/index.htm (National Archive of material)
This website is the Health for Asylum Seekers and Refugees Portal and is a key resource site for healthcare professionals working with asylum seekers. This is an excellent site for women's health-related resources and information.

http://www.learningdisabilities.org.uk/
For information on matters relating to minority ethnic communities and people with learning disabilities (accessed 16 March 2016).

https://www.nspcc.org.uk/globalassets/documents/research-reports/i-cant-tell-people-what-happening-home-report.pdf (accessed 16 March 2016)

This is the direct web-link to a report by the report: 'I can't tell people what is happening at home', domestic abuse within South Asian communities: the specific needs of women, children and young people (Izzidien, 2008).

http://www.rcn.org.uk; https://www.rcn.org.uk/professional-development/publications/pub-004773, 2015 and https://www.rcn.org.uk/professional-development/publications/pub-004531, 2013 (accessed 16 March 2016)

The Royal College of Nursing has produced excellent guidance for nurses on genital mutilation which will help you to understand more about this subject.

http://www.who.int/mediacentre/factsheets/fs241/en/

World Health Organization information related to female genital mutilation. (Updated February 2016.)

http://www.dimensionsofculture.com/2011/09/the-role-of-religion-in-providing-culturally-responsive-care/

This is a very informative website and has a range of resources on all aspects of cultural life in a number of communities mainly in the United States

http://www.maheronline.org/

This site offers a rich resource into the history and life of people from the Maher people of Saurashtra, Gujarat.

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CHAPTER 7

Men and health care in a multicultural society

Karen Holland and Muwafaq Al-Momani

INTRODUCTION

Men's health care is acknowledged as being equal in importance to women's (see Chapter 6), and while in the past the impact of men's health problems may not have been as apparent, in today's society this is no longer the case. Men in many cultures, for example, are more involved in child care and in many instances women have taken over the man's traditional role as the main breadwinner in the family. At the same time, there has also been an increase in the number of men entering nursing and other healthcare professions, although nursing in the main remains a female-dominated profession.

This chapter will focus on issues in men's health care in a multicultural society, in the following areas:

- The role of men in society
- Men as carers in societies
- Men in nursing
- The effects of men's role and cultural beliefs on their health and health care

THE ROLE OF MEN IN SOCIETY

The society or country that you live in will have an effect on the role that men have, and considering that for many of us society is now multicultural, it is important that we do not take an ethnocentric view of this role. Traditionally, in the United Kingdom, the main role for men in society was that of the main provider or 'breadwinner', being responsible for earning the main income to support his family. Although this has altered owing to economic and political change, resulting in male unemployment for many, there still remains in many families the traditional scenario of men going out to work and women staying home to look after the children. This view in the 1990s was the cause of 'a great deal of discussion, debate and reflection on what it meant to be a "man" in the modern world and how this might influence health practices' (Robertson and Williamson, 2005). Robertson and Williamson (2005) concluded that it was not just being men that accounted for differences in 'men's health outcomes and practices' but that 'other aspects of identity, such as sexuality, disability, ethnicity and social class' were just as important 'if not more so'.

Men are socialized in many cultures to be masculine with expectations of behaviour associated with that status. According to White (2002) this issue of 'masculinity' is central to

the discussion of the current state of men's health and 'we need to consider the variety of ways in which masculinity is constructed in the course of day to day living'. Basically, he states that this is considered in terms of specific behaviours, whereby:

> **… men are meant to be stoical, unemotional, rational, virile, independent, sexually active and physically strong (as indications of their dominant social position and role) while women are presented as essentially fragile, emotional, irrational, dependent, sexually submissive and physically weak (and hence suited to their socially sub-ordinate position and role in society).**
>
> *(White, 2002, p. 274)*

Reflective exercise

Consider this explanation and how you view men and women in these terms. Are there any circumstances where you have seen this stereotype of men and women? Consider situations where the opposite has been the case.

For certain cultures these kinds of specific behaviours are more anticipated than others and this will have an impact, as we will see later, on how nurses and healthcare professionals engage with men in relation to their health behaviours and practices, as well as how they relate to the women in their lives (see Chapter 6).

So, how are men viewed in different societies? Rather than single out specific cultures in relation to the division between men and women, the differences will be illustrated throughout each section of this chapter as appropriate. The role of men in most societies is inextricably linked with their health-related behaviours and practices as well as how men view the health professions as possible employment opportunities. In most societies there is a division of labour between men and women in looking after children, working and the organization of family structures. In addition, there are cultures where men or women undertake both traditional roles in same-sex relationships, and in many developed countries this has had a major effect on many aspects of the health of men and women.

Despite the Civil Partnership Act 2004 (Her Majesty's Stationery Office, 2004) in the United Kingdom where significant changes were made with regard to legal responsibilities of partners, for example, State Pension entitlement, there remain areas of confusion in decisions about health issues. Ensuring being named as next of kin if a person is ill is one area where there is a change, and King and Bartlett (2006) pointed out that the discriminatory use of the term 'nearest relative' in current mental health law was also being addressed in a new Mental Health Act in the United Kingdom, important in decision making regarding the detention of individuals. Here is the link to the 1983 MH Act: http://www.mind.org.uk/information-support/legal-rights/nearest-relative/about-the-nearest-relative/#.VtCPDBinNP4. (A link to the UK Government Guide to the Act can be found in the websites list at the end of this chapter.) This 1983 Act was substantially amended in 2007. Here is a link to those changes that relate to 'the nearest relative' in the context of civil partners: http://www.legislation.gov.uk/ukpga/2007/12/contents.

King and Bartlett (2006) indicate that same-sex civil partnerships may also have a positive benefit on health through increasing stability in relationships and lessening contact with multiple partners with its associated risk of sexual infections. They also note that as 'same sex unions

constitute a new social form, which poses challenges for health staff', training may be required to enable staff to work effectively, especially, one assumes, in relation to the rights of partners in decision making.

Reflective exercise

Consider your own family structure.

1. What role do (or did) your parents undertake?
2. Was it any different from any of your friends and if yes in what way?
3. Who undertook the main employment role and how did that affect responsibilities for care roles?
4. Discuss with others their experiences and how understanding about various ways of living helps you to undertake your care role.
5. Read the following paragraphs and consider whether any of the issues raised were also found in your families.

Henley (1982) noted that in Muslim culture the family was central and that the man, especially a son, is 'considered responsible for the care and support of their parents as they grow older' and that 'when a son marries he and his wife often remain with his parents and bring up their children there'. Although shared decision making might occur within the home, 'in most matters outside the home a Muslim woman should always be under the protection and guardianship of a man: her father, her husband or her sons, if she is a widow' (Henley, 1982). This role requires understanding by the nurse, especially if a Muslim woman has to be admitted to the hospital or visit her GP, as she may be seen to defer to her husband at all times. Consider the following scenario described by Galanti (2008):

Case study

A 19-year-old Saudi Arabian woman named Sheida Nazih had just given birth. Her husband, Abdul, had been away on business during most of their 10-month marriage but brought her to the United States to have their baby. He moved into the hospital room with Sheida immediately after she gave birth. He kept the door to their room shut and questioned everyone who entered, including the nurses. The nurses were not happy with this procedure but felt they had no choice except to comply. Although Sheida could speak some English, the only time she would speak directly to the nurses was when Abdul was out of the room. Otherwise, he answered all questions addressed to her. He also decided when she would eat and bathe. As leader of the family, Abdul felt it was his role to act as intermediary between his wife and the world.

Although this scenario took place in another country with a different healthcare system (United States), it gives us an insight into the perceived role of the man in an Islamic country with regard to his responsibility to his wife. It is important to recognize this as a possibility rather than

consider that the man does not wish his wife to talk to the nurses about their relationship or home life. Galanti (2008) described another scenario where the husband was clearly abusing the wife, and that not letting her speak was a possible indication of not wishing the medical and nursing staff to find out. She cautions that 'health care providers should not jump to unwarranted conclusions based on that evidence alone' (Galanti, 2008). In another culture, Jordan, both male and female, will be in a position of being influenced by their families when talking about sensitive issues, particularly with male patients. One of female participants in a case study by Al-Momani (2011) on nurses' experiences in caring for men with sexual dysfunction, she attributed her own beliefs and those of the wider society, of not being able to discuss sexual health issues, to the way people are educated within their homes and schools, alongside society's expectations of how male and females should behave. Here is her view:

> **it is how parents teach their children and how to deal with things… this is right and this is wrong…when we were children we used not to be allowed to sit and talk to our male cousins for example about these issues… I think the culture is illiterate in this area (Suha_HH_F)**

Men's role in childbirth and child care is also an important area of family life where cultural differences predominate. However, even in cultures where traditionally it is seen as the man's role to earn income to provide for the family, there are some notable changes when it comes to helping with child care. A study by Turan et al. (2001) of men's involvement in perinatal health in Katmandu found that new fathers were now playing a more significant role in their child care than was traditionally the case. However, it remained the woman's role to undertake the housework as seen in this narrative:

> **now that we have a child, I take care of the baby when I come home from work so that my wife can easily do her housework … there is a little bit more sharing than before.**
>
> *(New father, Turan et al., 2001, p. 116)*

Social stigma in relation to helping their wives was identified in a study of Nepalese husbands' involvement in maternal health (Mullany, 2006), where husbands who did help their wives were made fun of by others in their community:

> **I know society criticizes me when I carry the water container and let my wife walk empty handed or let her stay in bed. When I bring my vegetables and help my wife my community makes fun of me saying that I work for a woman.**
>
> *(A 24-year-old service industry worker, Mullany, 2006, p. 2801)*

This same study raised many other issues which have an impact on men's role in perinatal health, and concluded that it was important to differentiate between situations where women required or expected the help of their husbands in communicating with health professionals as part of a loving relationship and that of men opting out of sharing as they considered it to be a woman's role. Hoga et al. (2001) used Leininger's theory of Culture Care Diversity and Universality (Leininger, 1991) to recommend to nurses how to integrate 'men's worldview of reproductive health values and lifeways' into care.

Leininger (1991) proposed three different kinds of action to guide decisions by nurses: cultural care preservation or maintenance, accommodation or negotiation and repatterning (or

restructuring). In relation to preservation, Hoga et al. (2001) recommended that nurses ensure that they take account of the man's views and beliefs about reproductive healthcare practices and not to 'assume an ethnocentric view'. They suggested that care of the women should 'target increased male participation' (cultural care accommodation) and offered the example of 'extending hours of home care services to accommodate men's work schedule'. In relation to re-patterning of reproductive health practices they suggested that men, once educated themselves, should be encouraged to be involved in 'teaching other men about sexuality and sex education' to alleviate the 'myths about vasectomy, condom use and STD [sexually transmitted disease] and HIV/AIDS transmission'. The education of men in relation to their role in society, concerning women generally and wives in particular, was also the focus of a successful programme on men's sexual and reproductive health in Northern Namibia (Mufune, 2009), leading to a change in many of the men's views of their wives 'not simply as appendages of their husbands and that women are not quite as inferior as their culture had taught them to believe'.

Key points

1. Men's role in society is traditionally viewed as the main provider or family leader.
2. In some countries men are able to enter into a civil marriage with another man.
3. It is important that nurses and midwives understand relationships between men and women in different cultures in order to ensure culturally appropriate care.

MEN AS CARERS IN SOCIETY

Men can be occupied in caring for others within their own families or others (informal or lay carer), or in professions which care for others in a formal way, such as a nurse or physiotherapist. According to Arber and Gilbert (1989) 'men make a larger contribution to caring than is often recognised' and this is borne out in the 2001 census data (see Box 7.1).

Box 7.1 Carers UK – Policy Briefing (January 2009)

The 2001 census shows that women are more likely to be carers than men. Across the United Kingdom there are 3,400,000 female carers (58% of carers) and 2,460,000 male carers (42%).

Women have a 50:50 chance of providing care by the time they are 59 years old compared with men who have the same chance by the time they are 75 years old. Women are more likely to give up work in order to care (It could be you, Carers UK, 2000).

Caring varies between ethnic groups. Bangladeshi and Pakistani men and women are three times more likely to provide care compared with their white British counterparts (Who cares wins, statistical analysis of the Census, Carers UK, 2001).

Although this census reports that there are more women than men carers, there is still a significant number of men carers. A reason given by Arber and Gilbert (1989) for the increase

was that there was an increasing number of men looking after elderly spouses or parents who may be severely disabled in some way. They did not focus on any particular ethnic group. A report published by the Afyia Trust for National Black Carers and Carers Workers Network (2008) highlights the distinct lack of 'baseline data available regarding the numbers, role and experiences of carers within black and minority ethnic communities'. The Afyia Trust also offers an excellent guide for people working with black carers (National Black Carers Network, 2002).

Reflective exercise

If you are a student nurse, how many male carers have you met during your clinical placements in a community setting? What was their role as carer? Were any of them child carers (i.e. caring for children)?

The 2001 census figures noted that there were 174,995 young people under the age of 18 years who provide care and 13,029 of these were providing care for 50 hours or more per week (Carers UK, 2009). Doran et al. (2003) conducted an analysis of some of this data to determine issues of carers' well-being. They found that many 'children and pensioners were not in good health themselves' and considered that this was of some concern. A report published by the Office for National Statistics (2013) makes the following key points in relation to male carers:

- In 2011, females were notably more likely to be unpaid carers than males; 57.7% of unpaid carers were females and 42.3% were males in England and Wales.
- Across English regions and Wales, females took on a higher share of the unpaid care burden than males in a similar proportion, regardless of the amount of unpaid care the region's usually resident population provided.
- The share of unpaid care provision fell most heavily on women aged 50–64; but the gender inequality diminished among retired people, with men slightly more likely to be providing care than women.
- The general health of unpaid carers deteriorated incrementally with increasing levels of unpaid care provided, up to the age of 65 (see: http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/fullstorythegendergapinunpaidcareprovisionisthereanimpactonhealthandeconomicposition/2013-05-16: accessed 15 March 2016).

EXERCISE

1. Obtain a copy of this report from the Office for National Statistics and consider the question in its title: *The Gender Gap in Unpaid Care Provision: Is There an Impact on Health and Economic Position?*
2. Read it and determine for yourself the answer to this same question.

If there has been an increase in the number of male carers in the community, has there been a parallel increase in men becoming professional carers in occupations such as nursing?

MEN IN NURSING

Whittock and Leonard (2003) point out that despite the historical position of men in nursing in the United Kingdom that 'numbers of registered male nurses have seldom exceeded 10% of the total'. In a UK Parliament (House of Commons) question time, the issue was raised of men entering the nursing profession as a career. A response from the Secretary of State for Health noted that there had in fact been an increase between 2004 and 2006 (see Table 7.1). Whittock and Leonard (2003) provided preliminary evidence of key themes as to why men chose nursing as a career, such as influence of family members who were in the same career and having 'experienced some form of caring situation, usually in a family capacity', but concluded that careers advice was lacking for young men with regard to nursing. The NHS Careers website (see the websites list at the end of this chapter) has three life stories of men in nursing and reflects the drive to encourage more men to make nursing a career. Duffin (2009), in a recent opinion-seeking paper on the benefit of male nurses to the profession, found that there were still concerns by some organizations, The Patients Association being one, and cite the director of that organization as saying that:

> **Many older female patients would feel vulnerable and uncomfortable if there were only male nurses on a ward, especially if there were gynaecological issues.**
>
> *(Duffin, 2009, p. 13)*

This comment is also reflective of cultural concerns generally in relation to being cared for by both male and female nurses when sensitive issues need to be discussed. However, in support

Table 7.1 Qualified Nursing, Midwifery and Health-Visiting Staff – Broken Down by Gender

2006	Percentage				
	Male	Female	Unknown	Male	Female
All qualified nursing, midwifery and health-visiting staff	38,242	304,942	31,354	11.1	88.9
Nurse consultant	136	654	–	17.2	82.8
Modern matron	204	1,767	11	10.4	89.6
Manager	1,303	5,707	148	18.6	81.4
Registered nurse – children	531	11,710	955	4.3	95.7
Registered midwife	176	22,937	1356	0.8	99.2
Health visitor	176	11,507	351	1.5	98.5
District nurse (1st level)	418	9,239	351	4.3	95.7
District nurse (2nd level)	65	1,101	96	5.6	94.4
School nurse	9	1,100	20	0.8	99.2
Other 1st level	34,283	229,596	26,690	13.0	87.0
Other 2nd level	921	9,279	1,375	9.0	91.0

Table from Hansard (House of Commons Daily Debates) 21 May 2007 (Written Answers – Health – Nurses). See the websites list at the end of this chapter for source URL. (Reproduced with permission from the Office of Public Sector Information 2009: www.opsi.gov.uk.)

of more men in nursing he stated that the union Unite had recently 'submitted evidence to the Prime Minister's Commission on the Future of Nursing and Midwifery drawing on the under-representation of men in the profession' and that it hoped that 'the Commission will suggest that the image of men in nursing needs a boost when it reports its findings next year' (Duffin, 2009).

A recent study by O'Connor (2015) on this issue of men choosing nursing as a career found that:

> **The findings indicate contradictions and difficulties for men in identifying with the profession and as men. Little encouragement is given to men to join the profession, and for men who have chosen to nurse, there is an attempt to distance themselves from traditional motivations for choosing nursing such as caring and vocationalism. This has implications for the recruitment and retention of men into the profession and also points to a need to examine the relationship of nursing to gendered concepts.**
>
> *(O'Connor, 2015, p. 194)*

Entwistle (2004) explored the place of men within nursing in New Zealand and among his conclusions was the fact that 'men who choose nursing as a career risk challenging the traditional roles of their gender stereotype'. Loughrey (2008) also considered gender issues in his study in Ireland, which was aimed at obtaining data to help recruit more men into the nursing profession. Although it was a small study it did indicate that there was more of a tendency towards traits considered female in the men but 'considering that gender is strongly influenced by culture' deemed it important to undertake further study into men in caring roles in order to influence future policy. A study carried out in Israel (Romem and Anson, 2005) to determine why men choose nursing as a profession found that 'it seems that nursing appeals more to men who do not belong to the mainstream of the Israeli society, that is, immigrants and ethnic minorities'. They concluded that because these two groups found challenges and difficulties in 'the educational system and labour market' that the 'nursing profession enables them to obtain an academic degree which is highly regarded in Israeli society, ensures steady job opportunities and steady income'.

The theme of 'guarantee of work' was also predominant in a study of Turkish male nursing students (Kulakac et al., 2009), as was the fact that in Turkish culture caring was traditionally a woman's role.

Objections to male nurses caring for women patients together with perceptions by others that male nurses must be homosexual (Evans, 2002; Kulakac et al., 2009) are two other areas that are predominant in the literature on men in nursing. Kulakac et al. (2009) found that some of the male student nurse participants in their study 'indicated that they would reject a male nurse who would attempt to care for their female relatives', and that this objection, as in Evans' (2002) study, was based on the fact that they considered male touch to carry sexual connotation when applied to women. Keogh and Gleeson (2006) in their study on male and female student nurses found that this was a major concern in caring for both adult and mental health patients. They offer examples of the students' concerns:

> **Obviously the big thing that I am highly aware is the gender of the patient … I steer clear of female patients because I am just very aware of allegations … it's just something that I am very uncomfortable if I am left on my own with a female patient (RPN 3).**

> **It makes no difference because anything, a touch, can be interpreted in the wrong way so I would always have someone with me … and I'll be very careful of that because in this day and age you just have to watch yourself (RGN 2).**
>
> *(Keogh and Gleeson, 2006, p. 173)*

Inoue et al. (2006) also found that 'providing intimate care for women clients was a challenging experience for male nurses' and concluded that 'nurse educators should assist male nurses to be better prepared to interact with women clients in various settings'.

However, male nurses' preparation to care for female patients may not be possible due to cultural issues where same gender preference is influenced and determined by the culture of the society. For example, in Jordan, traditionally, female nurses communicate with female patients in one ward. From nurses' perspective, the doctorate study by Al-Momani (2011) showed that more than 80% of nurses (males and females) supported same-gender preference in Jordan and nurses preferred not to talk to a patient from the opposite gender especially about sensitive issues such as sexual health needs with more agreements by females, which indicates that female patients would not be able to talk to male nurses even if they were trained to do so. So, being a male in society appeared to be more of a priority than being a nurse. Two female nurses support this and said:

> **…my nature as a female this is not to be discussed with males unless there is a problem and this problem is too clear and threaten the patients health…when the patient asks me a question like this I automatically may reflect it and forward it to the doctor or any male nurse…but one would imagine why me to answer and not anybody else? I mean male to male which could be better as you may feel guilt when you talk. (Amany_JH_F)**
>
> **…nurses and patients were taught that all these things are taboo and not supposed to be discussed with female nurses so in our culture we find it more comfortable to discuss things male to male and female to female even not sexual issues. (Suha_HH_F)**

Given the worldwide need for an increase in the number of nurses in the future, owing mainly to the ageing workforce, there are already indications of increases in the number of male nurses internationally. It is, however, important to consider the effect of this on the nature of caring interventions they may be required to undertake and the possible educational implications for nursing curricula in the future.

Reflective exercise

1. Consider the issues raised in this section on men in nursing. What have your experiences been during clinical placements?
2. If you are a male student nurse, which field of practice (branch) are you undertaking and why did you choose that one? How do you think your chosen field of practice is portrayed in the media or literature?
3. If you are a female student nurse, answer the same questions, then discuss with your male nurse colleagues their experiences of being a male nurse caring for female and male patients.

Key points

1. There has been an increase in the number of men in caring roles within the community in the United Kingdom and other cultures outside the United Kingdom.
2. The number of men choosing to register as qualified nurses has more or less remained around 10% of the total nursing population in the United Kingdom.
3. Although men are still choosing nursing as a career, there remains a need to keep promoting it as a career for men worldwide.
4. Similar to male nurses caring for female patients, female nurses may also need training and justifying the need to care for men in different cultures like Jordan.

THE EFFECTS OF MEN'S ROLE AND CULTURAL BELIEFS ON THEIR HEALTH AND HEALTH CARE

It is recognized that in many countries the life expectancy of men is lower than that of women (Sun and Liu, 2007; Nuttall, 2008; Men's Health Forum, 2009) and the reasons for this are varied. White and Cash (2003) noted that there were differences between countries in Europe 'in the impact of the various health issues on their male population'. This is an important point as it indicates that there are national and regional variations to be considered as well as those related directly to the issue of 'being male' or individual cultural beliefs. The environment is one such variable that could have an impact on men's health, as is evident when considering the rate of suicide in men living in Finland – 4% of all male deaths as opposed to 0.6% in Greece (White and Cash, 2003). This link between suicide and seasonal variations has been reported in many international studies and Bjorksten et al. (2005) found that most suicides in West Greenland were men. They considered a link to the long periods of daily sunlight in the summer months which affected mood and violent tendencies, which manifested in the way the men committed suicide.

Men's health and health care in the past has reflected the gender variations in life expectancy, with more focus on women rather than men. However, this is now changing and, in the United Kingdom, organizations such as the Men's Health Forum have made a significant step towards having the health needs of men of all cultures taken seriously by the Department of Health.

White (2001), who was also the world's first professor of men's health, made the following key points in relation to men's response to illness:

1. **Men do not manage their health well and solutions need to be found to redress the current inequality in health.**
2. **Most men, especially in patriarchal societies where men are dominant, do not see their bodies as having problems and may need to be persuaded to visit the doctor when something does go wrong.**
3. **Health services are perceived as being less accessible to men and simply visiting the health centre may involve negotiating time off work.**

4. **By making services more male-friendly and accessible, men are more likely to seek advice and take an active role in managing their health.**

(White, 2001, p. 18)

Reflective exercise

From your experience, how true are these statements today? Consider what additional health services are available for men specifically where you live and the kinds of information available. Discuss and share your findings with colleagues.

An excellent article to obtain some up-to-date information on the above points is that by the Men's Health Forum in the United Kingdom (see the website list at the end of this chapter), which is a policy briefing paper prepared for National Men's Health Week in 2009. In this paper they offered numerous facts and figures with regard to men's health problems, men's use of services, why men do not seek help and where services for men are up to in terms of additional provisions for men. These are considered briefly (in the report) in relation to men generally.

A new study by Hosegood et al. (2016) focused on men's health and fatherhood in rural South Africa. They reported that:

> **Three themes related to men's health emerged from the analysis of transcripts: (a) the interweaving of health status and health behaviours in descriptions of 'good' and 'bad' fathers, (b) the dominance of positive accounts of health and health status in men's own accounts and (c) fathers narratives of transformations and positive reinforcement in health behaviors. The study revealed the pervasiveness of an ideal of healthy fathers, one in which the health of men has practical and symbolic importance not only for men themselves but also for others in the family and community.**

(This paper can be found in the Further Reading section)

In Jordan, traditionally, men have been socialized into a male focused environment, and evidence indicates that health problems of these men and seeking help could be denied because they were perceived by the family, peers and Jordan society itself as a sign of men's weakness which may show a detrimental effect of masculinity on men's physical and mental well-being.

Al-Momani (2011) found that both male and female nurses agreed that sexual dysfunction is important to men's quality of life, and in Jordan it is not just a physiological impact but nurses recognised the psychological impact as a result of the pressure society places on such a function, indeed patients may pay anything to get a problem resolved. Here are two participants offering their view:

> **…Yes because they are affected psychologically and sometimes have depression. (Amany_JH_F)**
>
> **…sexual dysfunction is likely to be a social problem and the patient could pay anything to sort it. (Ibrahim_HH_M)**

Within Jordan where the condition is not accepted in men's views, some men pretend the problem is not theirs and seek help for a fictitious friend who has a problem rather than exposing themselves; however, it is clearly important to some men to seek help directly by attending a clinic, as explained here:

> **… Oh yes, yes, if he is not concerned about the problem he will not ask friends separately for tablets for sexual activity… instead of going to doctor. It was approved that some patients go to our colleagues and ask for tablets for sexual activity and say, 'can you give me tablet for this and this and it is for my relative' and in fact, it is for himself. He tries to hide this defect and hang it to some body else in indirect way. (Shams_HH_M)**
>
> **…yes it is important…men sometimes talk and ask for medication and pretend that these medications are not for them but for someone else in the family like his father or brother but it is for himself. (Karam_HH_M)**

MEN'S HEALTH PROBLEMS AND SEEKING HELP

There are many health problems that both men and women experience but for men their incidence may be higher or the outcome very different. Men also respond to illness differently.

In Jordan, an Arabic country, Al-Momani (2011) found that discussing a sexual health problem such as sexual or erectile dysfunction could jeopardise men's position in society. Indeed men with sexual dysfunction in this country often suppress their needs and emotions refusing to disclose the problem even to doctors or nurses because they believed that it may diminish them in front of female nurses they work with or even their families.

Jordan is a structured society with more related social and family networks, and men living there were extremely likely to meet relative male nurses in places they go for treatment. This may be sufficient for them to stop and think before seeking advice from health professionals believing that their problem would not remain confidential, that nurses (if relatives) would tell others in the family of their problems. Because of this belief, nurses in the study believed that men in Jordan may be willing to pay with everything they have to sort out their sexual health problem or at least to find someone who is trustworthy in their opinion to talk to them and keep their problem confidential.

Sun and Liu (2007) discuss problems that Chinese men experience in relation to sexual health. In particular, they discuss the issue of erectile dysfunction and the fact that although it is common, it is undertreated. They note that for Chinese men to ask for medical help is to 'lose face' or 'being undignified', especially as the issue of sex for many Chinese people generally is 'considered dirty or abusive and the majority of ordinary people are unable to express their own sexual feelings or evaluate their sexual behaviours'.

They also note that many men with this health issue suffer from additional problems, such as diabetes or heart problems, which are associated with erectile dysfunction. Another major male health problem in China, as in other countries, is prostate cancer which 'is the fourth most common cancer in men in the world' (Sun and Liu, 2007).

Halbert et al. (2009) explored the reactions of African American and white men to being told they had prostate cancer, and in particular whether their cultural beliefs and values made a difference. They did not find any significant difference between the two groups in terms of these issues but concluded that their coping mechanisms for the stress associated with the diagnosis

were more likely to be related to their being men generally. Cultural differences in men of different ethnic origin were also the focus of a study by Hjelm et al. (2005) where they considered beliefs about health and diabetes in Sweden. The participants were mainly Arab, former Yugoslavian and Swedish men and all had a diagnosis of diabetes. Beliefs about health were found to vary and were clearly linked to issues of men's role in the family, as discussed earlier. For example:

> **Swedish men stated the importance of a healthy lifestyle, with what they considered to be healthy food (low in fat and rich in fibre) and exercise. Non-Swedish men talked about the importance of employment to avoid mental strain: 'having a job is very important. It affects your general well-being. It affects the relationship between man and woman'. They described their frustration about being unemployed and not being able to have the 'natural' role of breadwinner; this often led to conflicts within the family and thus increased blood sugar levels.**
>
> *(Hjelm et al., 2005, p. 51)*

With regard to health and illness, Muslims are generally highly religious in the way they deal with and treat sexual health problems. They believe that health and illness are determined by God (Allah) although they try to treat these health problems through doctors and health centres. The vast majority of Muslims believe in fate, which attributes all life events to the will of Allah as the supernatural power.

> **…for each population is a fate and if their fate came they will not be late for hour nor being forward**
>
> *([Qu'ran], chapter 7 [Al-Araf surah], verse 34, p. 154)*

With all of this, men in Jordan as Muslims are still reluctant to seek help from nurses or even from doctors for sexual health problems. Instead, they turn to other religious beliefs, which appreciate Muslim patience on illness and coping with the disease without seeking help. These beliefs indeed place value on the individual's patience with all life's difficulties and illness, but again still encourage Muslims to look for treatment and achieve a healthy lifestyle. Beside treatments, Muslim patients could recite the Noble Quran, praying or even go to other religious persons asking for further help.

In his research study Al-Momani (2011), talked to one female nurse who believed that sexual dysfunction is something from God and patients have to accept it anyway. She said:

> **…Usually patients consider this as from God and they should be satisfied with it…they say I can't make babies and that is it, rather to go for treatments. (Feda_JUH_F)**

Hjelm et al. (2005) also reported on men's beliefs about illness and how some of them even saw it as 'the will of God' (Arab men). Issues around sexual function were also considered, with the younger men of all cultures concerned about their sexual capability.

It is important for nurses and health professionals to take account of these views in order to help men manage their diabetes. Consider the following case study:

Case study

A 45-year-old Muslim man, married with three children, has diagnosed diabetes. He has been taking insulin for 20 years. He has come for a reassessment of his health needs and a note from his GP to the diabetes specialist nurse states that he has been to see the GP with regard to some erectile dysfunction problems.

Reflective exercise

You meet the man for the first time at the Diabetes Clinic where you are undertaking a 2-day clinical placement experience. What would be the key questions the nurse would ask him during the initial assessment of his needs for long-term care?

Using an assessment tool such as that based on Roper, Logan and Tierney's model of care (Holland et al., 2008) may be helpful in terms of gaining a holistic picture of his healthcare needs. In particular would be the activities of living related to sexuality and eating and drinking. Use the other chapters in this book to assist in this exercise as well as the information in this chapter. Diabetes UK is an excellent website that can help you: http://www.diabetes.org.uk/Guide-to-diabetes/Living_with_diabetes/Sex-and-diabetes/.

You could make this kind of learning exercise part of a wider project during your course of study, such as developing a teaching/information package for men of different cultures who have diabetes – explaining about their illness, their future health behaviours, what they can do during periods of fasting during Ramadan and how to manage any additional health problems that may arise, such as impotency.

Key points

1. In many countries the life expectancy of men is lower than that of women and reasons for this vary.
2. The specific health needs of men are becoming more important on the health care agenda in different countries of the world.
3. Men respond to ill health differently than women do.

MEN'S HEALTH-RISK BEHAVIOURS AND THE USE OF HEALTH SERVICES

Galdas et al. (2005) in an extensive literature review on men and health help-seeking behaviour found that there was much inconsistency in the international evidence and that there was more than the issue of gender in why men do not seek help if ill. These other issues were: 'occupation, socioeconomic status and age'. They believed, however, that if nurses were to play a significant part in addressing the reasons men did not seek help, it was important that their practice should be 'informed by an understanding of men's beliefs, values and reactions to health services and ill health'.

The attitudes of men towards health, according to Peate (2004), do have an effect on nursing care. In particular is the need for nurses and other healthcare professionals to understand the risk-taking behaviours associated with men's health problems in order to be able to offer advice on discharge home from hospital or as part of health-promotion activities generally. These were linked to 'traditional masculine norms' and included:

- **Increased alcohol consumption;**
- **Increased sexual risk-taking;**
- **A need to deal with problems alone;**
- **A reluctance to access health services.**

(Nuttall, 2008, p. 540)

However, some of these do not apply to all cultural groups. Substance abuse in the form of increased alcohol consumption is one such health-risk behaviour that the majority of religious Muslim men would not consider. A study by Bradby (2007) explored how young British Asians (men and women) experience identity and substance abuse. In relation to drinking and identity she notes that:

> **Respectable Asian women did not drink, as a woman thought to be a drinker was dishonoured and her morality called into question. Taking alcohol would amount to forfeiting one's claim to being Muslim: for non-Muslim men, however, there was greater leeway to experiment with alcohol without jeopardizing a religious or ethnic identity. Providing Sikh and Hindu men did not indulge in the regular, sustained drinking associated with the ethnic majority, occasional and discreet celebratory drinks supported a worldly, manly image. Teetotal Sikh men demonstrated their religious devotion and a principled masculine strength.**

(Bradby, 2007, p. 663)

It is interesting to note that smoking as a risk-taking behaviour elicited a very different response and that smoking was more tolerated by Asian groups in her study. She notes that:

> **'Smoking is bad, but at least it's not drink' was the Muslims' explanation of their elders' tolerance of cigarettes and non-Muslims said, 'Muslims smoke because they can't drink' … Adult Muslim men hid their drinking but not their smoking because 'smoking is not intoxicating,' 'it doesn't do anything to your mind … you're still in control' so you do not lose sight of God's laws. However, a religious obligation to guard one's health and to steward one's finances was acknowledged to mean that ideally Muslims should avoid cigarettes as well as alcohol.**

(Bradby, 2007, p. 664)

There are many other health problems that affect men specifically, in particular testicular cancer. It is noted, however, that this type of cancer is more common in white men rather than African–Caribbean or Asian men (Cancer Information+: see the website list at the end of this chapter). Regardless of the nature of health problems affecting men in particular (i.e. gender specific), most other health problems are non-gender specific but when affecting men they need to be addressed as such. A report by the European Men's Health Forum (Wilkins and Savoye, 2009), which considered men's health in 11 countries, highlighted this issue of men's health as related to male-specific actions and used this definition for a men's health issue:

> **A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or necessitates**

> **male-specific actions to achieve improvements in health or well-being at either individual or population level.**
>
> *(Wilkins and Savoye, 2009, p. 9)*

This makes an important distinction for those creating health policies but also for nurses and other health professionals who need to consider its meaning when developing any local services or care practices. The report states that it is about ensuring that services will need to be male-specific and not part of a wider 'men and women approach'. The definition above is clear about the fact that men's health is not just about the biological differences but also cultural and social differences, taking account of various health beliefs and the issues of masculinity that were discussed earlier in the chapter (Wilkins and Savoye, 2009). This is highlighted very well in Peate and Richens' (2006) paper on being a male refugee or asylum seeker (see Chapter 11), not only who have to contend with a new culture but also the impact of why they have arrived in another country. This is often as a result of war or persecution and may also have resulted in their losing their families. If one considers that in most societies the man is seen as the provider for the family, the possible traumatic loss of their family structure could lead to feelings of isolation and psychological stress. This is not to belittle similar events for women, but using the definition for male health issue it is clear that for health professionals in contact with men who are in these circumstances, a male-specific action would be essential to their self-respect and self-esteem.

CONCLUSION

Being a man in any society is influenced by cultural and religious beliefs but also, and most importantly, the way in which men relate to each other and to women generally. In this chapter we have tried to establish the basic principles and current evidence in relation to men's health in a multicultural society but realize that we could have written a whole book on this subject alone. The work being undertaken by the Men's Health Forum in the United Kingdom and Europe is raising the agenda of men's health internationally. It is clear, however, that although there is more nursing and health-professional care practice evidence in relation to men and men's health generally, how to engage with the cultural aspects of men's health care in practice is not as evident. This is an area for further development if men's health is to achieve the importance it deserves at the point of contact with healthcare services.

CHAPTER SUMMARY

1. The role of men in any society has an effect on their health behaviour and that of their families.
2. Men's health is influenced not only by their biological and physiological attributes but also their cultural background and religious beliefs.
3. Men are less likely than women to seek help in relation to their health and some groups such as asylum seekers and refugees are particularly at risk of not doing so.

FURTHER READING

Harrison, T. and Dignan, K. 1999. *Men's Health: An Introduction for Nurses and Health.* Edinburgh: Churchill Livingstone.

Hosegood, V., Richter, L. and Clarke, L. 2016. …I should maintain a healthy life now and not just as I please …..' : Men's health and fatherhood in rural South Africa. *American Journal of Men's Health*, 1–12 (downloaded from jmh.sagepub.com. 12 October 2015).

O'Connor, T. 2015. Men choosing nursing: Negotiating a masculine identity in a feminine world. *Journal of Men's Studies*, 23(2), 194–211.

Wilkins, D., Payne, S., Granville, G. and Branney, P. L. 2008. *The Gender and Access to Health Services Study.* London: Men's Health Forum and University of Bristol, Department of Health, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092042 (accessed 11 October 2009).

Wilkins, D. and Savoye, E. 2009. *Men's Health Around the World: A Review of Policy and Progress in 11 Countries.* Brussels: European Men's Health Forum.

WEBSITES

www.nbta-uk.org/partners/afyia-trust (accessed 5 April 2017)
This is the website of the Afiya Trust which has as its aim 'reducing inequalities in health and social care for racialized groups'.

http://www.cancerinfoplus.scot.nhs.uk
Cancer Information+ website.

http://www.carersuk.org/Home
This website offers information for both carers and professionals with regard to support and training opportunities together with a range of resources.

http://www.emhf.org
This is the European Men's Health Forum website with a number of international focused reports and resources related to men's health and well-being.

http://www.equalityhumanrights.com/
This is the Commission for Equality and Human Rights website, which replaced some other organizations such as the Equal Opportunities Commission. There is useful information on men and caring roles and ethnicity.

http://www.in-practice.org/sexualhealth/index.php
This website offers an introduction to sexual health matters for nurses and healthcare workers, including a paper on ethnic and cultural differences in sexual health needs.

http://www.menshealthforum.org.uk

This website has factsheets and resources on all aspects of men's health.

http://www.nhscareers.nhs.uk/nursing.shtml#

The NHS Careers website. This has three life stories of men in nursing and reflects the drive to encourage more men to make nursing a career.

http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm070521/text/70521w0023.htm#07052133000102

This is the Parliamentary website for the Hansard debate on men in nursing.

https://socialwelfare.bl.uk/subject-areas/services-client-groups/asylum-seekers-refugees/index.aspx (checked 11 April 2017)

This is the Health for Asylum Seekers and Refugees Portal and is a key resource site for healthcare professionals working with asylum seekers. This is an excellent site for men's health-related resources and information.

https://www.carers.org/sites/default/files/male_carers_research.pdf

This is report of a study undertaken in 2014 into male carers in the United Kingdom. This is a very well informed and comprehensive snapshot of the lives of male carers today.

http://gamh.org/

Global Action on Men's Health states it is about putting men and boys on the gender agenda aspects internationally when it comes to men's health. They have a number of links from this site to some excellent policy reports and one site is the European Commission Public Health site where you will find the 2011 report on the State of Men's Health in Europe (http://ec.europa.eu/health/population_groups/gender/index_en.htm: accessed 15 March 2016).

CHAPTER 8

Child and family centred care: a cultural perspective

Angela Darvill and Moira McLoughlin

INTRODUCTION

From the day children are born, culture plays a part in their lives. Consider the following ritual in Islam:

> **A Muslim welcomes a new baby into the ummah (the family of Islam) as soon as it is born, by whispering the call to prayer (the adhan, beginning 'Allahu Akbar!') into the baby's right ear, and the command to rise and worship (the iqamah) in its left ear, sometimes using a hollow reed or tube. Thus the word 'God' is the first word a baby hears.**
>
> *(Maqsood, 1994, p. 173)*

We can see here that cultural practices and cultural influences are evident from birth. In Islam, as seen above, it is decreed that the first sound children hear should be from a Muslim. This is so they are introduced to the faith as soon as possible.

In all societies, birth is accompanied by ritualistic practices that are influenced by culture. It is important that healthcare workers provide culturally sensitive care rather than misunderstanding and conflict (Galanti, 2008). In the United Kingdom, most babies are born in a hospital with the partner present as well as the midwife or doctor, who assists in the birth process (Hollowell et al., 2011). It is common practice for a woman to be discharged home (whatever her circumstances) soon after the birth. This may be within a matter of hours if she has had a normal delivery and within a few more days if she has had a complicated birth with or without a Caesarean section.

There are cultural differences in response to pain during birth. In a study of a comparison of cultural differences in child delivery between Jewish and Arab women, Rassin, Klug and Nathanzon (2009) found that most Jewish women verbalised pain by moaning and some cried. In comparison, more than half of the Arab women participants signified pain through screams.

Children's introduction to the world, regardless of any one country, is surrounded by customs and rituals. When a Hindu baby is born, a part of the Jatakarma ceremony which welcomes the child into the family, a family member with 'virtuous qualities' may write 'Om' (a mystical symbol that represents the supreme spirit) – see Figure 8.1 – on the baby's tongue with honey or ghee in the hope that the person's good qualities are passed on to the child (Gatrad, Ray and Sheikh, 2004).

Cultural beliefs form the basis and foundations of people's lives. This premise is stressed here by Mead (1953):

> **Culture encompasses the overarching institutions in society and the small intimate habits of daily life, such as hushing a baby to sleep.**
>
> *(Mead, 1953, p. 10)*

Figure 8.1 Om – a Hindu sacred symbol.

Cultural practices and customs are subtle and often taken for granted, and individuals may be unaware that these practices and customs are unique to their own culture. As Mead stresses, they are apparent in the small intimate habits, so simple but universal, tasks such as hushing a baby to sleep may be undertaken in many different ways.

Cultural beliefs and attitudes are assimilated as babies and children. Children are therefore continually learning and assimilating culture as they grow and develop. The games they play, the food they eat, and the care and explanations that they are given when they are ill are all culturally determined. Cultural norms and values are a central part of a child's life, wherever they live. Thus, when a child is accessing healthcare services, it may be the first time that they have encountered another culture, and they may therefore find the experience daunting and bewildering.

Children learn their beliefs about health and illness first from their family and later from their peers. Thus, perceptions about health care should always be considered within the context of the family group. However, families do not live in isolation from external influences and sources of information. There are other significant influences, such as social and economic factors, that may play a large part in the development and health of a child, and it is imperative that these are borne in mind when considering the health of the child as a whole. Brofenbrenner's (1977) ecological systems theory identified that the values, customs and attitudes of the cultural group to which the child belongs will affect their development. Thus, the health care delivered to the child must be by culturally sensitive and competent practitioners.

This chapter will focus on the following issues:

- Culture and the family
- Child-rearing practices across cultures
- Language and communication
- Patterns of illness and disease
- Good practices when caring for children

CULTURE AND THE FAMILY

The family is a central issue when considering the health of a child, but even more so when the child is of a different culture from the majority population. Individuals have different ideas and beliefs about family life and family norms: for example, their size, how to behave with other family members, and indeed what actually constitutes a family. In the United Kingdom in the twenty-first century, the stereotype of 'normal families' is a group of people 'tied with emotional bonds,

enjoying a high degree of domestic privacy occupied with the rearing of children' (Giddens and Sutton, 2013).

This scenario is often reflected in advertisements on the television. In reality, the family may take on many different forms, for example, lone parent families, step families and families headed by same-sex couples (Giddens and Sutton, 2013).

All families are different. Traditionally, in nuclear families parents shared responsibility for their children. In general, couples are financially and emotionally independent from their parents, although they may have frequent contact and live in close proximity to their extended family. In the nuclear family, home is regarded as a base and a place of independence. This reflects the Western notion of the value of the individual. For example, child-rearing practices in Western cultures encourage independence. Children are taught to 'think for themselves', and personal autonomy and independence are highly valued. These values also pervade health belief systems. For example, promoting health education and encouraging people to take responsibility for their own health.

The responsibilities in families for decision making, family roles and undertaking certain roles (e.g. child-rearing) may vary across cultures. Respect for patient autonomy is a cornerstone of contemporary healthcare practice (Beauchamp and Childress, 2009). It is evident that in clinical practice there is value in engaging children in decisions concerning them (Racine et al., 2013). However it is also important to consider how decisions are made in the context of the family when involving children in decision making. These issues may change and develop over time, being constantly negotiated between individuals in interaction, in a mutable, adaptive and creative way (Costa, 2013).

The Children's Act (Department of Health, 1989) in the United Kingdom stresses that help provided for the family and regard and attention should be paid to the different cultural groups to which the child and family belong. The Children Act (1989) and the UN Convention on the Rights of the Child (1989) required that those who work with children should consider fully the wishes of all children in the decisions that are made about their care. However, this may be in contrast to the perceptions of parents and families, who may regard their child as vulnerable and incapable of voicing their views and making decisions about their care. Yet, children's views about their health are influenced by their family and peers.

Reflective exercise

1. **Who are the members of your family?**
2. **Describe your family and the relationships you have with them.**
3. **How often do you have contact with them?**
4. **Who makes the decisions in your family, and why?**

However, culture is dynamic and Helman (2007) believed that people will change and become acculturated as they adapt to any new circumstance. Yet, to expect children and young people to become free and independent thinkers may cause great anguish not only among their elders but also among their peers and siblings.

For example, recently a Nigerian student nurse shared her view about the involvement of the family in decision making. Other family members would be consulted about any decision making and usually the Egbe (the senior male in the family) would make the decision and not the individual. Family members work closely together to discuss issues that require decisions (Ada Ogbu, 2005). Nigerian people may see themselves not as individuals, but as a component of a family. Consequently, decision making may automatically be referred to another member of the family, and older members of the family may be consulted regularly.

Some minority communities (e.g. South Asian and traditional Chinese) may find the pursuit of independence to be disrespectful and shocking. It may be misinterpreted as undesirable, selfish or a sign of coldness by the family, and a threat to traditional values and beliefs. A three-year research project undertaken by the University of Leeds in collaboration with Barnardos, which explored the values among families of Pakistani origin, found that young people and their families expressed ideas about white families. The typical white family was perceived as being individualistic and had values that encouraged them to defy their parents. It is important to note that this was a stereotypical view and not based on any direct experience (Chattoo, Atkin and McNeish, 2004).

Young women in particular may find this conflict stressful. Feeling caught between two cultures, at home and at school, they may experience divided loyalties between the roles and behaviours that they are expected to assume. However, inter-generational conflict occurs in all cultures. It is normal for teenagers to rebel and establish their own identity, and occasionally to cast their parents in the role of villains and oppressors.

However, in certain cultures people feel the ties of the family more so than in others. Strong family ties were evident in Roma Gypsy Travelling families in a study by Parry et al. (2004). One woman noted 'we come from a big family community … and we're all very close'. Participants in this study placed great value on close family life and discussed how welcome children were. One respondent noted 'kids are everything to Travellers, that's why they get married … it's to have kids and rear up children'.

In the United Kingdom, Gypsy Travellers is an umbrella term for Welsh and English Romanichal or Romany Gypsies, Scottish and Irish Travellers and more recently European Romanichals or Roma. Other travelling communities include Fairground or Showmen, New Travellers and Bargees (Francis, 2010).

Some children and young people may belong to a large family network – the extended family – where the welfare of one member is seen as dependent on the welfare of the whole family and all of its members. Families may live in large multigenerational homes or in close proximity to each other. Children may be raised by a number of female relatives, aunts, grandmothers and cousins. The roles of men and women are clearly defined, and they may lead separate lives, but above all else the support and centrality of the family are of greatest importance. People might also be conscious of the role they play in maintaining the good name and honour of the family. Marriage is often celebrated as a bond between two families. A couple remains part of a large family unit, both emotionally and physically, for all of their married life. The role of individuals within the family has implications for health care.

For example, the care of a child in the hospital may be undertaken solely by the mother, but any major decisions may be taken by the father, who may consult other male family members

(e.g. his brother or father). The child and mother may not be consulted, which some healthcare professionals may find difficult to accept. The roles played by men and women may also be different, as they may have different responsibilities and areas of authority. In some communities, for example, women may take sole care of children and bring them up alone or with other female relatives. The worlds of men and women may be much more segregated and separate.

Key points

1. The concept of family is culturally bound.
2. 'Western' family life may put emphasis on the value of the individual.
3. 'Eastern' family life may place the family at the centre of society at the expense of the individual.
4. In some cultures men and women may lead separate lives.

CHILD-REARING PRACTICES AND DAY-TO-DAY CARE OF INFANTS AND CHILDREN

In this section, consideration will be given to the day-to-day care of infants and children, and to the ways in which culture and health beliefs influence child-rearing practices.

Child rearing is a universal occupation and child-rearing practice is a generalised term used to refer to characteristic ways of handling or dealing with one's children. Any method of bringing up children will be dependent on the parents' values and the circumstances in which they live. Professionals working across cultures will encounter many different approaches to child-rearing often based on age-old customs and beliefs (Korama, Lynch and Kinnar, 2002). Raising children is a very personal and individual issue. The role of the nurse is therefore to support and help families in the way in which they wish to bring up children. Values and beliefs about child rearing need to be respected and valued, not judged or criticised. As Purnell (2013) identifies, one culture is not better than another culture; they are just different.

Carrying and settling children and babies

As Mead (1953) indicates, it is the small, intimate habits of daily life that are beacons of an individual's culture. One example is the way in which people carry babies and children. In the United Kingdom, Europe and North America, it is common to see babies and small children being pushed in a pram. These child-rearing practices may be a reflection of social and economic circumstances. Christine reflected, 'when my first baby was born, I was aware that I was to return to work in a few months, so I made a conscious effort to ensure that the baby was ready to be with other caregivers. This practice was reinforced by the health visitor, who once reprimanded me for "holding the baby too much"'.

It is also interesting to consider babies and children with regard to sleeping arrangements. In some Eastern and African cultures, bed-sharing may be a common practice as parents may feel that they need to look after the child while sleeping or that the child may be seen as too young to sleep alone.

The practice of keeping the baby with the mother at all times, and carrying on daily life alongside her is the norm in some cultures (Hooker et al., 2001). Within Nigerian culture, for example, the new mother will be with the baby constantly and carry the baby on her back. The infant will sleep with the mother and family members will hold the baby constantly and not allow him or her to cry (Ada Ogbu, 2005).

However, in the West traditionally infants were isolated and expected to sleep in a cot often in a different room (Hooker, Ball and Kelly, 2001). In Western cultures, bed sharing may be frowned on as it may be seen as fostering dependence and linked to sudden infant death syndrome. However, this link has been refuted. Ball et al. (2012) in a study of infant care practices in Bradford, UK, found that infants of South Asian parents have a lower rate of sudden infant death syndrome (SIDS) than white British infants. This was due to a number of risk factors including smoking, alcohol consumption, sofa sharing and solitary sleep. The study found risk reduction factors included keeping the baby in the parental room. Pakistani mothers were more likely to bed-share than white British mothers, and so these data do not support the contention that bed-sharing is a SIDS risk under all circumstances. White British mothers were more likely to sofa-share for sleep with their infants.

Hygiene practices

Good hygiene practices are essential for health and comfort, but are culturally influenced and often linked to health beliefs. Practices may therefore vary, but should not be interpreted as standards, so judgements must not be made.

Practices may vary both between different groups and over time. For example, in the United Kingdom in the 1920s parents would bathe their children once a week in a bathtub in front of a coal fire. This was usually on Saturday night, prior to church on Sunday. However, in many cultures bathing is considered to be poor hygiene practice (Galanti, 2008). People in Scandinavia may prefer to take a sauna, and it is common to see saunas in nursing homes. Many cultures prefer to shower or use running water to wash, so that dirt can be carried away in the water flow.

Toileting practices may also differ. Hindus and Muslims may prefer to squat when excreting, and to wash in running water after using the toilet, instead of using toilet paper. The left hand only is used for this purpose. The right hand is kept pure for handling food and other clean things. (See the Appendices.)

Feeding and nourishing babies and children

Food is an extremely important part of culture, and is as important to children as it is to adults. The acquisition and preparation of food are universal occupations, but again these are culturally determined and influenced. Children learn about food, and choices and preferences for food may be formed in childhood. Food plays a large part in religious festivals and rituals, but it is also influenced by trends and fashions. For example, the feeding of babies and children has changed considerably in the last 100 years. In the early part of the twentieth century, breastfeeding was a working-class practice, mainly because it was cheap. It was not until relatively recently, in the 1960s and 1970s, that solids were recommended at an early age – that is, from around 6 months according to current Department of Health guidance which is based on the WHO recommendations on infant feeding (http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/ and http://www.unicef.org.uk/Documents/Baby_Friendly/Leaflets/weaning_leaflet.pdf).

This issue of when to introduce more 'solid' food into an infant's diet remains an ongoing issue of differing views in the United Kingdom, for example, and at the other end of the discussion we will find, however, that in many developing countries babies may be weaned later than is current practice in the United Kingdom.

Food is a very important issue in Gypsy (Roma) and Travelling families, for example. In Parry et al. (2004), one respondent noted that 'travellers love fat children' and others mentioned the importance of giving children tonics to stimulate a good appetite. Food and being a good parent were also closely associated.

During the Muslim holy month of Ramadan (or Ramzaan), young children are exempt from fasting. Children are usually encouraged to fast for a few days from the age of 7 years, and they may fast with their parents on Fridays and at weekends. Between the ages of 12 and 14 years, they begin to fast for the whole month (Schott and Henley, 1996). People who are ill are exempted from fasting. However, this is an individual decision and many people prefer to fast for spiritual reasons. (See this short video of a child fasting for the first time at Ramadan. It is an interesting perception from a child's viewpoint and is from a series of different stories from children: http://www.bing.com/videos/search?q=children+and+fasting+in+ramadan+you+tube&&view=detail&mid=9F0F4B0D192DD57C2BDA9F0F4B0D192DD57C2BDA&FORM=VRDGAR.)

In Judaism, most devout Jews adhere to the Jewish kashrut or dietary laws. As in Islam, they are part of a code of discipline. Jews may not eat pork, pork products or anything that contains or is made with these. Shellfish and any fish without fins are also prohibited. Jews may eat meat from other animals, but it must have been killed in a certain way, that is, kosher (meaning fit). Milk and meat may not be used together in cooking. (Here is a short clip for children [through song] on what Kosher means. It is part of a religious education programme and there are additional videos on the Jewish faith and way of life: http://www.bbc.co.uk/education/clips/zqwmpv4.)

Hindus are not permitted to eat beef and beef products, as cows are considered to be sacred animals. Hindus believe that all of God's creatures are worthy of respect and compassion and thus Hindus are encouraged to be vegetarians. Alcohol is generally forbidden, and fasting is commonly practised.

Sikh dietary restrictions are similar to those for Hindus. Few Sikhs eat beef or halal food, and alcohol is forbidden. Pork is generally avoided by both Hindus and Sikhs, as pigs are regarded as dirty scavenging animals.

In South Asian cultures, food may be eaten using the hands rather than cutlery. The right hand is considered to be clean and is used for eating purposes. The left hand is reserved for 'dirty' functions such as cleaning and washing the genital areas.

Reflective exercise

1. Think back to the last time you were ill. What did you eat? What were you advised to eat by your family or friends?
2. Do you eat different foods for different illnesses? Do you 'feed a cold and starve a fever', for example?
3. What did you eat as a child when you were ill?
4. If you are a parent, what do you give your children to eat when they are ill? Why?

A study by Piko and Bak (2006) explored children's views about health and illness. It emerged from the study that children describe the causes of illness as processes of contagion and contamination. Most children emphasised a healthy lifestyle and specific behaviours, for example, sport, activities, food and nutrition and understood harmful eating habits. There may be cultural variations regarding beliefs about health and illness; for example, Muslims may believe that illness is considered to be God's (Allah) will (Lawrence and Rozmus, 2001). Sutherland (2005) discusses Roma attitudes to health and illness and identifies that these are as a result of spiritual and moral cleanliness.

It is apparent that food preference is culturally determined and that food has properties for curing and helping illness. Food and nutrition are extremely important. Understanding and respecting food and eating habits is important if healthcare professionals are to help children feel comfortable and accepted. It is also vital to plan appropriate and adequate care.

Dressing babies and children

The clothes individuals wear and the way in which people present themselves are all signs of cultural orientation. Style of dress is often related to our climatic conditions, but clothes also signify or preserve modesty.

Reflective exercise

1. Describe the clothes you are wearing today.
2. Which clothes shops do you buy from, and why?
3. Why have you chosen to wear these clothes?
4. What types of messages do they send out about you?
5. If a parent, how does your choice of clothes influence what your child wears?

In many cultures, strict attention is paid to female modesty (e.g. covering the limbs and hair). This may also be applicable to small children. Modesty is an extremely important issue for South Asian cultures. For example, Muslim girls may be encouraged to preserve their modesty at all times and, therefore, parents do not like to see the child's body exposed. Instead, they may prefer to have just one part of the body exposed. In non-urgent examinations it may be preferable for Muslim girls to be examined by a woman. Nudity may be considered improper. (See this archived but accessible video about the Hijab at: http://www.bbc.co.uk/religion/religions/islam/beliefs/hijab_1.shtml.)

Modesty and the need for privacy were also indicated in the study by Parry et al. (2004). In this research, Gypsy (Roma) and Travelling families discussed their need for privacy and their embarrassment when receiving physical personal care or needing to undergo intimate examinations. Some people noted that this was linked to upbringing: 'It's our kind of shyness and embarrassment'. This may prove a difficult issue for young people in particular, who may avoid lessons about sexual health issues. In hospital care it may result in some children and young people being hesitant, shy or reluctant to discuss intimate issues in relation to health care. Some young women may prefer to avoid using ordinary day-to-day language such as 'periods' for menstruation and may resort to using euphemisms such as 'monthlies' or the 'curse' (http://

www.romaniarts.co.uk/tag/a-review-of-gypsiesromatravellers-and-the-arts-in-wales/ and the report by Yvonne Cheal: http://www.romaniarts.co.uk/wp-content/uploads/2012/12/Beyond-the-Stereotypes.pdf).

Cheal (2012) offers the following information about menstruation and childbirth:

> **Menstruation is considered impure and a woman may not cook, wash up or handle food during this time. She must not step over a fire, a man sitting down, or anything else that may become defiled.**
>
> **She must pass behind rather than in front of a man. She must not step over or cross a stream with running water.**
>
> **Childbirth is an impure event and should take place outside the camp. This makes it acceptable for childbirth to take place in a Gadjé hospital, which is already impure.**
>
> **The mother and child are isolated for seven days, followed by 33 days of semi-isolation. During the 40 days of a woman's child-bearing and recovery (purification), she cannot touch any pure items or perform an activity such as cooking. She is allocated separate crockery which is destroyed at the end of the 40 days. Clothes and beds used during the 40 days are also destroyed.**
>
> *(Cheal, 2012, p. 17)*

It is also customary for some children to wear adornments or religious symbols. Christian children may demonstrate their religion by wearing a cross or medallion bearing the picture of a saint. Muslim children may wear a chain or piece of string around the neck or wrist, bearing a pendant inscribed with verses from the Qur'an. Sikh children may wear a kara (a steel bracelet) and both boys and girls may have their hair held up on top of their head with a small handkerchief. The hair of Sikh boys must not be cut. Sikhs may also wear the kaccha (special shorts or underpants). (See Appendix 6.)

The way in which people present themselves to the outside world provides messages about their identity. The above examples are externally worn symbols, and they may be used to signify good luck, good health or protection for children. It is important that they are valued and respected and not removed or thrown away. In preoperative and postoperative care, for example, care must be taken to recognise and respect any religious objects that the patient is wearing.

Giving names

Naming systems generally reflect how family and community life is organised, and this varies widely around the world. Nurses have a professional and legal duty to address people correctly and to ensure that they receive the appropriate care (NMC, 2015). Being aware of the established naming systems of a cultural group can provide better understanding, but it should not be assumed that everybody from that group would follow the same rules.

Names also play a major part in a child's social and cultural identity and heritage. Children are named in different ways in different cultures. For example, in African cultures personal names may have a meaning such as 'child of my dream', 'gift' or 'joy' and they do not denote gender differences. Some names are associated with days of the week. In Ghana, for example the name Kofi means male Friday, while Ama means female Saturday.

Hindu names may have three parts: a personal name and a complementary name (which are often used together), followed by a family name (Land Registry, 2002). The most common female complementary names are Behn, Kumari and Rani. The most common male complementary names are Kant, Kumar and Chand. In Hinduism parents give their child's name from a priest on the 10th–12th day (Gatrad, Ray and Sheikh, 2004).

Naming systems in Sikhism are based on religious rules. This requires people not to use a family name but to use only a first name together with a male or female title. These are Kaur (meaning 'princess' for females) and Singh (meaning 'lion' for males). Most women take their husband's family name when they marry.

Arabic names may consist of five parts, which follow no particular order (Notzon and Neson, 2005). Arabic or Muslim names are names used in the Arabic-speaking and Muslim worlds, which closely coincide. The full Arabic name can consist of a given name (called the *ism*), nicknames (*laqab*), and patronyms (*nasab*) and/or a family name (*nisba*). Sometimes these names are preceded by a *kunya*, which refers to the person's firstborn son.

Chinese names do not reveal whether a person is male or female, like many European names. The family name comes first, followed by the personal name. This can cause confusion with European systems that are the other way around. The most popular family names are Zhang, Wang, Li, Zhao, Chen, Yang, Wu, Liu, Huang and Zhou (Land Registry, 2002).

It is important to note that people may adapt their names in order to 'fit in' with the UK system. It is also worth noting that some people might not know their date of birth or their age, as in some developing countries births may not be registered.

Reflective exercise

1. Tell someone your names and describe to them how you came to have these names.
2. Explain the meaning of your names.
3. How do you feel about your names? For example, what do they say about you?
4. Have you ever had your name changed, or do you get called by nicknames? If so, how do you feel about this?
5. Is there anything you would change about your name? If so, why?

Most of us have a story to tell about our name, and these stories are often deeply significant. For example, children may be taunted about their name, and many of us dislike our given name being mispronounced or misspelled.

Playing and developing

Play is essential for helping children to grow, develop and understand the world in which they live. It is important not to impose Western culture bound views regarding play on the rest of the world (Lancy, 2007) According to Gosso (2010) children in all cultural groups engage in some type of playful consumption. As Lancy (2002) noted, children engage in playful activities whatever the culture in which they are socialized. Play is both a universal and culture-specific activity (Lancy, 2007).

Culture is a key factor in determining how people in different cultures view play (Izumi-Taylor et al., 2010). This is true whether cultures acknowledge, condone, support and set aside time for play. However, cultural variability in play also exists (Lancy, 2007) and empirical evidence clearly supports a relationship between play and culture (Holmes, 2013). In play, children acquire cultural values, skills and abilities which are embedded in children's everyday experiences.

It is important not to impose culturally bound views regarding play on others. In healthcare settings play, which is accessible and encouraged, should be an integral part of daily living patterns of the child's own cultural environment.

A study by Singer et al. (2009) on the role of play included children in Argentina, Brazil, China, France, India, Indonesia, Ireland, Morocco, Pakistan, Portugal, South Africa, Thailand, Turkey, the United Kingdom, the United States and Vietnam. They found agreement among mothers – despite well-known differences in language, geography, culture, history and religion – in their descriptions of their children's activities and in their concerns about play.

Concerns that parents reported was the lack of safe play spaces in their neighbourhoods. They found that when children were given the opportunity to play and get dirty, mothers in most countries accepted it. Mothers in developing countries, however, expressed the greatest concern about dirt and germs. This fear about outdoor play may be realistic in these countries but may also reflect the disease-prevention messages that are aimed particularly at developing countries. Mothers in only three countries – the United States, Great Britain and Ireland – mentioned imaginary pretend play as a frequent activity of their children.

Child-rearing in a racist society

Black and minority ethnic children are often aware of negative attitudes at an early age. Even from the age of 2 or 3 years, children are able to distinguish between different racial groups. Children from black and minority ethnic groups may soon harbour the idea that white people are naturally superior. It has been demonstrated that children may soon start to show an adherence to, or preference for, the dominant cultural group. There are documented cases of children trying to scrub or bleach their skin white because they wish to reject their black skin and identity (Milner, 1975).

Some children are subjected to racist attacks or remarks or negative attitudes at school. Parry et al. (2004) note that for Gypsy (Roma) and Travelling communities, children's education at school may suffer as families may move sites. Some people noted the difficulty in getting their children into a chosen faith school and many parents noted children being discriminated against or bullied in school. In a study by Williamson et al. (2009) direct prejudice was also noted by a female Traveller:

> **When my little brother was ill, he was only three, and we were in a different place and the doctor refused to see him because he was a gypsy. So we then had to go to a different town, 20 or 30 miles to a different town, because there were no walk-in-centres at that time.**
>
> *(Williamson et al., 2009, p. 39)*

Although many children have a strong sense of pride and self-esteem, some experience periods of self-rejection and self-dislike. They may be constantly aware of 'being different', and these negative messages may be reinforced by health workers. Some parents are bewildered and hurt

when their children reject their culture in favour of the dominant white culture. This might take the form of rejecting food or being ashamed of the parents' language or style of dress, for example.

(See http://www.teachingforchange.org/anti-bias-education-articles for a wide range of resources for education of children about racism and other related issues. A series of free articles is included. It is mainly set up for children in the United States but has relevance worldwide.)

LANGUAGE AND COMMUNICATION

Language and communication are central issues with regard to caring for children and their families. The way people and children talk, the words used, dialects and accents all convey messages and impressions about them. Language is acquired as babies and children, and the influence of parents is paramount in the early years. As children grow older, they are more likely to be influenced by the education system or peers.

Command of language and ease of expression are essential not only for safety and meeting basic human needs, but also for social fulfilment.

(See this excellent site from raisingchildren.net.au – an Australian parenting website which has a number of short videos about communication and talking in multicultural and often bilingual play http://raisingchildren.net.au/articles/different_cultures_play_video.html.)

Children in particular are sensitive to language and communication problems. The inability to express oneself can be frightening and anxiety provoking. Parents may be able to act as interpreters for children, but if the parents cannot speak English, other methods may have to be found (Galanti, 2008). These might include interpreters, toys, books and picture boards. It is not acceptable to use siblings or the child to interpret for their parents.

Ways of communicating distress and pain may also vary across cultures. In cultures that value stoicism and fortitude, suffering silently when in pain may be viewed as appropriate and mature behaviour. This is particularly relevant to white British cultures and is described as 'maintaining a stiff upper lip'. However, in other cultures (e.g. Jewish and Italian) it may be appropriate to display distress 'outwardly', that is by expressing pain and suffering verbally (Helman, 2007; Galanti, 2008).

Even when people do speak a little English, they may experience problems in using healthcare services. For example, some parents may speak English well but do not understand the technical jargon, slang or dialect that is used in the hospital setting. They may experience humiliation in public situations where they do not understand others or are unable to make themselves understood. They may also be made to feel stupid and uneducated even though they have skills in other languages (Bradby, 2001). (Children from refugee and asylum seeker families may find this to be of particular significance. This issue is explored in Chapter 11.)

This can lead to parents feeling invisible, and they may be reluctant to stay in the hospital for fear of being humiliated or judged. This is sometimes interpreted as an uncaring or disinterested attitude towards their children. Families need access to good interpreting and translating services that are sensitive to the needs of both children and their families.

Key points

1. Child-care practices are culture bound and may change over time.
2. Parents have a right to raise their children in the way that they feel is appropriate.
3. Children and their families may be particularly sensitive and vulnerable to criticisms about their lifestyle, so care must be taken to understand and acknowledge cultural differences.

PATTERNS OF ILLNESS AND DISEASE

There are important variations in the patterns of illness among different ethnic groups in the United Kingdom. Some conditions that affect specific minority ethnic groups are described here.

Sickle-cell disease

Sickle cell disease (SCD) is a severe haemoglobin disorder which is classed as the most common genetic disease in the African region (World Health Organisation, 2011) and an estimated 300,000 babies each year globally are born with SCD. SCD is now the most common serious genetic disorder in England, affecting over 1 in 2000 live births (Dick, 2010). In Britain, SCD is most common in people of African and Caribbean descent (at least 1 in 10–40 have a sickle cell trait and 1 in 60–200 have SCD). However, SCD not only affects people of African origin, but also Afro-Caribbean, Mediterranean, Asia and Middle Eastern (Sickle Cell Society, 2008). It is estimated that there are over 6000 adults and children with SCD in Britain at present.

This condition leads to shortened red blood cell survival, and subsequent anaemia (often called sickle cell anaemia). SCD is characterized by a modification in the shape of the red blood cell from a smooth, donut-shape to being shaped like a sickle. The abnormality in the shape of haemoglobin results in 'sickle' shaped cells that are inflexible, rigid and fragile, which can get stuck in tiny blood vessels, therefore starving the body of oxygen which is the primary cause of pain, known as 'vaso-occlusive crises' (Anie et al., 2007). Poor blood oxygen levels and blood vessel blockages in people with SCD can also lead to chronic acute pain syndromes, severe bacterial infections and necrosis (tissue death). This can result in intensely painful vaso-occlusive events, which are known as crises, where the cells are being damaged. The lack of blood supply can lead to organ damage, necrosis of bones and also strokes. Diseases can cause episodes of acute pain (crisis), anaemia, increased risk of infections, and chest problems. The condition can be life threatening, particularly for young children (NHS Sickle Cell and Thalassaemia Screening Programme, 2014). Patients with SCD suffer from all the signs of anaemia such as tiredness, shortness of breath and a vulnerability to infection (Dick, 2010).

(See http://www.nhs.uk/video/Pages/Sicklecellanaemiarealstory.aspx and https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408029/Sickle_Cell_A_ParentsGuide_2013.pdf for a deeper understanding of caring for children with this health problem.)

Thalassaemia

Thalassaemia is a genetic disorder that affects the production of haemoglobin. It is inherited as an autosomal recessive pattern (UK Thalassaemia Society, 2008). When there is not enough

haemoglobin in the red blood cells, oxygen cannot get to all parts of the body. Organs then become starved for oxygen and are unable to function properly.

In the United Kingdom, the main groups at risk of inheriting thalassaemia are people from the Mediterranean, Cyprus, Italy, Spain and Portugal and individuals from the Indian subcontinent, Middle East and the Far East (UK Thalassaemia Society, 2008).

Thalassaemia usually becomes evident in children between the ages of 6 and 12 months. If the child becomes severely anaemic, he or she may die of cardiac failure or infection. The child may require monthly transfusions or daily subcutaneous injections.

(See a child talking about experiencing this condition: http://www.nhs.uk/video/Pages/thalassaemia-test.aspx.)

Rickets

There is a higher incidence of rickets in children from minority ethnic groups with dark skin being an indicator (Elder and Bishop, 2014). Rickets is caused by a lack of vitamin D, which is normally obtained from diet and by exposure to the sun. Rickets is characterised by bony deformity and stunted growth and lower limb deformities. Long-term effects on skeletal health can occur with reduced bone size and mass predisposing to osteoporotic fracture later in life (Elder and Bishop, 2014). Childhood data for the frequency of clinical rickets in infants who present with vitamin D deficiency are scarce.

(See: http://www.nhs.uk/Conditions/Rickets/Pages/Introduction.aspx.)

GOOD PRACTICES WHEN CARING FOR BABIES AND CHILDREN

Healthcare practices often reflect Western ethnocentric views (Chattoo et al., 2004). Black children and families and those from ethnic minorities face many problems when they access healthcare services. Chattoo, Atkin and McNeish (2004) argue that support for families is needed as often inadequate and inappropriate referral to community and specialist support services occur due to assumptions about culture and family life. Nurses need to develop partnerships with families and acknowledge that family members provide care on an ongoing basis.

Family centred care is described by Shields et al. (2006) as 'a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child and in which all the family members are recognised' and at the centre is the child. Anything that happens to this child affects all members of the family and so the health care the child receives must be planned around the whole family (Shields et al., 2006, 2007).

Good practice in the care of sick children therefore centres on shared care between the child, parents and healthcare staff. Parents may feel reluctant to stay in the hospital, as they may feel either that they are not welcome or that the hospital does not have adequate facilities related to their cultural or religious needs (e.g. somewhere to pray). Some parents are stigmatised as uncaring when they leave their children unaccompanied in the hospital. However, it is important to remember that parents may have pressing commitments to other children or family members.

It is imperative, therefore, that the child and parents are given adequate information about the services available as well as about the care of the child. This should include information not just about the diagnosis, treatment and prognosis of the child, but also about the routines involved and the facilities for the family.

Information-giving needs to take into consideration issues such as language and literacy skills. Families who are unable to read in their own language may find videos and posters useful. Children are also more receptive to visual information and this should be taken into account when giving them information about their care.

Play facilities in hospitals need to reflect the cultural and ethnic diversity of children and multicultural toys should be available. These could include signs and books in dual languages, jigsaw puzzles, black dolls and toy fruits and vegetables that represent foods eaten by black and minority ethnic children. It may also be useful to provide toys that are appropriate to the traditions of the culture, such as domestic tools and utensils.

Nurses also need to familiarise themselves with the relevant customs and festivals of the local communities, such as Ramadan and Diwali (see the Appendices). It might be useful, for example, to plan celebrations with children. Parents and siblings may also welcome facilities for prayer and worship.

Nurses should ensure that children and their families have appropriate washing and toilet facilities (e.g. showers, running water). For example, Muslims may prefer to wash before praying (Lawrence and Rozmus, 2001). If it is not possible to move the patient physically, they may appreciate having a bowl brought to them and the bed curtains being pulled round.

Many children from black and minority ethnic families eat British food or an amalgam of family and British food. However, in some families it is customary to eat British foods while adhering to religious or cultural rules. People may develop a taste for British type food but insist that it is cooked according to religious rules (e.g. no animal fat). However, it is important to show sensitivity in the way that food is handled and presented to children and their families. For example, it is important to separate food utensils when handling food, to ensure that prohibited foods are not mixed. It is also important to note that, in the absence of their parents, some children may request food that is prohibited. This may be because of the child's curiosity, a desire to be like other children or rebelliousness, but nurses should always be aware of the anxiety of the parents and respect their wishes as well as ensuring that the child receives adequate nutrition.

Visiting may cause staff tensions, and it should always be borne in mind that cultural expectations of care may differ between families. For example, it may be the norm for the close extended family to be present (Lawrence and Rozmus, 2001) (especially the female family members) and for decisions to be made by the male family members. Female children in the hospital may cause their parents a great deal of anxiety. Families may object to girls undressing in front of others, especially male staff. Care and sensitivity are paramount here. For example, it is practical only to expose the area that is to be examined. Some families may prefer their daughter to be cared for by a female doctor or nurse, and these wishes should be respected wherever possible.

Consider the following case study.

Case study

Rachel is a 7-year-old girl admitted to the ward for myringotomy and insertion of grommets. She has glue ear. Rachel belongs to an Orthodox Jewish family and is accompanied to the ward by her father. Her mother is at home with their 6-month-old baby. She is admitted on Friday afternoon and is due to go to theatre on Saturday morning. Rachel's father is to be resident.

continued

Case study

How would you ensure that Rachel's cultural and religious needs are met?

The following information would help you to make informed decisions when caring for Rachel.

- Giger (2013) emphasised that Jewish parents, like many others, may be very protective of their children and vocal about their feelings and anxieties. This should not be misconstrued by nursing staff as the father and child being aggressive, 'difficult' or a 'problem patient'.
- Rachel will require a kosher diet and care must be taken to ensure that the food is individually wrapped and not unwrapped until it is ready to eat. Broadly, the diet contains food types that cannot be eaten, such as pork and shellfish. Meat and milk may not be eaten or cooked together (e.g. do not offer milk to drink with a meat dish). These meals come prepared with plates and cutlery. (The family must unwrap the meal.) (Collins, 2002)
- Rachel's father may prefer to let her use her own plastic cup.
- Medication may be an issue. The family might not wish Rachel to take certain analgesics and other medicines unless they are kosher. These include Disprol and Calpol suspension. It may be necessary to consult the pharmacy department about this.
- Rachel's father may consider some children's activities (e.g. watching videos) to be unsuitable for his daughter.
- The Jewish Sabbath (Shabbat) begins at sundown on Friday and finishes at nightfall on Saturday. It is a major festival and a day of rest. Orthodox Jews do not work, and they also avoid activities For example, they cannot drive, cook, use electricity/telephones (including using the patient buzzer), watch television, bath or write and sign official documents on the Sabbath. This factor needs to be borne in mind when signing consent forms. However, this consideration may be waived if life or health is compromised.
- Modesty is very important in Jewish cultures, especially for females. The family may be protective of their daughter and wish to avoid any unnecessary exposure. This should be considered when examining Rachel, and it might be necessary to provide female staff.
- Rachel's father may wish to pray when he is staying in hospital, and a suitable room or a quiet area should be provided, if possible, on the ward. Alternatively, the curtains may be drawn around the bed area.
- Some Orthodox Jewish men avoid all contact with unrelated women and therefore may not shake hands or make eye contact.

CONCLUSION

Culture influences all aspects of a child's physical and psychosocial growth and development. For some children, admission to the hospital may be the first time they encounter a new culture,

particularly if they are under 5 years old. Hospitals can be frightening, stressful places, but these fears are compounded in children who may not understand the language or the customs and rituals of hospitals. However, children and families may face a host of problems when they access health services, and they may find that the services provided are either not sensitive to their needs, or that they do not understand what is happening to the family member. Services for children need to take into account not only the individual needs and circumstances of the child, but also those of the family, and that often this needs to include the extended family. Caring for children from different cultures sometimes requires healthcare professionals to set aside their preconceived ideas about child-rearing and the norms and values with which they have grown up.

CHAPTER SUMMARY

1. Children need to be understood within the context of their families and their environments.
2. Beliefs about child care and child-rearing practices are valued and protected in every culture.
3. Children and their families are particularly vulnerable when they are receiving health care, and extra care and attention may be needed with regard to issues such as communication and provision of information.

FURTHER READING

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This is a book where there is cultural miscommunication about the health and treatment of a Humong child which ends in tragedy. It is a beautifully told story.

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This work is a comprehensive study of the complex issues in relation to child development and children's health.

Syal, M. 1997. *Anita and Me*. London: Harper Collins.
A very entertaining and funny novel, which depicts the life of Meena, the only daughter of a Punjabi family, as she is growing up in the Midlands in the 1960s.

Wilson, P. 2005. Jehovah's Witness children: When religion and the law collide. *Pediatric Nursing*, 17(3), 34–37.
This article examines the complex legal and ethical issues involved in making decisions when religious law is in conflict with civil law.

WEBSITES

http://www.borninbradford.nhs.uk
Born in Bradford is a long-term study of a cohort of 13,500 children, born at Bradford Royal Infirmary between March 2007 and December 2010, whose health is being tracked from pregnancy through childhood and into adult life.

http://www.sicklecellsociety.org/
Sickle Cell Anaemia. This website has a range of resources and information about sickle cell anaemia.

http://www.ukts.org/
Thalassaemia. UK Thalassaemia Society. This website has a range of information about this disease including a set of standards for the clinical care of children and adults with thalassaemia.

CHAPTER 9

Care of older people from black, Asian and minority ethnic groups

Elizabeth Collier and Prem Conhye

INTRODUCTION

Over the next 50 years, the number of older persons in the world will grow from about 600 million to over 2 billion (UN, 2005). Today, one person in ten is aged 60 and over. By 2050, this will be one person in five and by 2150, one in three.

This is a triumph rather than a burden, as often conceptualised (Oliver, 2014), but such a major demographic change does present challenges. In some cultures which organise ageing around economic roles, challenges of growing older might include retirement, loss of role and status and reduced income. The risks of physical ill health increase as we get older, and some people may find themselves facing loneliness or isolation as well as feeling excluded and undermined by ageist attitudes. For people from black, Asian and minority ethnic groups, they may also face hostility and racism. The International Day of Older Persons was celebrated on 01 October 2014, and aimed at raising awareness of the impact of an ageing population and the need to ensure that people can grow old with dignity and continue to participate in society as citizens with full rights.

The way in which ageing is experienced is dependent on many factors which include: class, gender, status and biology as well as the perceptions of those around us and how we interact with these phenomena. This experience however may not have universal linearity and Western models often ignore cultural variations of time and age (Holstein and Gubrium, 2000). As Hazan (1994) said:

> **Just as racial stereotypes are not to be mistaken for the real attributes of the people to whom they refer, so the cultural concept of ageing must not be confused with the actual existential experience of being old. (p. 40)**

The chapter will discuss and examine the following issues in relation to older people from black, Asian and minority ethnic groups:

- Patterns of migration
- Health and illness
- Health services

Whist reading this chapter, there are a number of key issues that need to be borne in mind; not just what we know about cultural differences in relation to older people, but a consideration about where our knowledge of 'old age' comes from more generally. Older people have traditionally been treated as a category, a homogeneous group a situation that Latimer (1997) describes as 'absurd but inescapable' (p. 143). Chronological models of ageing can be meaningless and age cut offs should not be regarded as having any particular meaning (Department of Work and Pensions, 2005; Beecham et al., 2008; Royal College of Psychiatrists, 2009); it is more helpful to consider individual differences across the life course (WHO, 2000; Department of Health, 2011).

Most available research is cross-sectional and may misrepresent knowledge of older age as findings may reflect cohort rather than ageing differences (see Riley, 1973). In addition, research often excludes people over the age of 65 or unhelpfully categorises them as one 'group'. Unsurprisingly then, there is relatively little primary evidence we can draw on to inform us of cultural differences in relation to older people. This chapter takes a life course approach to considering the issue of older people, health and cultural differences. Life course theory enables us to shift the focus to individual life trajectory, highlighting experiential variation that occurs within a continually changing social system (Shanahan and Macmillan, 2008; Elder and Giele, 2009). For this reason, it will explore historical patterns of migration to the United Kingdom with a view to developing an understanding of the potential past experiences that older people from black and minority ethnic groups may remember and carry into their seventies and beyond, the meaning and context for their lives in the present. As a popular quote from Madeleine L'Engle says: 'The great thing about getting older is that you don't lose all the other ages you've been through'.

In pre-industrial societies, older people were valued for their experience and knowledge and were frequently used as a resource for the community. In industrial societies, where families migrated for work, older people could be left behind; the association of older age with loss of physical strength resulted in a reduced ability to contribute to the workforce. This has changed the way older people are perceived and problematic discriminatory attitudes have led in the United Kingdom to 'age' becoming a 'protected factor' in legislation (Equality Act, 2010).

Patterns of migration

Most of the people who migrated to the United Kingdom in the 1950s and 1960s as adults (in their twenties and thirties) are now older people who did not necessarily intend to stay. Migration from one culture to another can be a stressful experience that involves major disruptions to an individual's life (Raleigh and Balarajan, 1992). For some people it can be both demoralizing and alienating. On arrival in a new country, the migrant may experience isolation, bewilderment, helplessness and feelings of insecurity. They may have left behind family and friends, familiarity, routine and security. Immigration laws may mean that people experience the additional strain of waiting for their family to join them. Moreover, they may face language problems, which may in turn influence their chances of housing or employment. The host population may have negative attitudes and expectations (The Migration Observatory, 2011).

Reflective exercise

Imagine that you had a change in circumstances (redundancy, for example) and that you needed to find work overseas.

1. Where would you go and why?
2. What preparations would you make? For example, how would you find out about language and cultural traditions?
3. Who would accompany you and why?
4. What would you take with you? Which possessions would you take and why?
5. How do you feel you might cope with a new lifestyle?

Asian migration to the United Kingdom

The majority of migrants in the 1950s and 1960s were single men from rural areas who came to make up the shortfall of unskilled labour in areas of industrial decline. Others were forced to leave their homes because of displacement. For example, a large number of Pakistanis from Mirpur came to Britain in the early 1960s as a result of the construction of the Mangla dam. For some, migration may have represented a chance to strive for better employment and may therefore have been synonymous with increased family status at home.

British society in the post-war years was suffering austerity, and for many migrants their experience was a difficult one. British attitudes at the time were still influenced by ideas and beliefs founded in colonialism. Mistrust and elitist attitudes towards people from overseas still abounded, and many migrants were met with racist attitudes, coldness and reserve from many British people. One man who came from Punjab in 1962 recounted his experience:

> **Although I was educated (I had an MSc in Engineering) my friend had to bribe the seniors with a bottle of whisky to get me a job as a machinist … I had four machines to run and got paid half the amount other machinists used to get who had only two machines to run.**
>
> *(Schweitzer, 1984, p. 42)*

Robinson (1986) described the patterns of settlement for these migrant workers. The first groups began to settle in areas where there was a high demand for labour, in cities such as Birmingham and London and the textile towns of Lancashire and Yorkshire. These men acted as the bridgeheads, helping newly arrived migrants to settle, whether or not they were blood relatives. They often shared lodging houses and helped each other with language and bureaucracy problems. The myths about the British in Southeast Asia still abounded. Britain had an image of being discriminatory and immoral, and therefore a dangerous place for women. However, in the 1960s and 1970s the wives and children and sometimes the parents of male migrants began to join the men. Housing provision was found mainly in run-down inner-city areas where homes were more affordable. By the 1980s and 1990s, family consolidation meant that UK-born Asians were establishing their own families and identities.

African–Caribbean migration

The pattern of African–Caribbean migration gradually developed in the post-war years. Migrants were actively recruited from Barbados and Jamaica by British Rail, London Transport and other

large organizations. In the 1960s, the National Health Service (NHS) began to recruit nurses and midwives. As British citizens they had the unrestricted right to settle and work. In common with other migrants, they often arrived in their late twenties and thirties and were unable to accumulate enough National Insurance contributions for a full pension at retirement age. A report by The Joseph Rowntree Foundation (2004) found that some people who had migrated to the United Kingdom in the 1950s and 1960s and had worked in public services had not been properly advised on pensions and consequently found themselves in poverty in later life. Indeed, it was also found that benefit entitlement was poorly understood as information was not always available in appropriate languages.

They were also less likely to be able to gain promotions and more likely to be made redundant. Britain was perceived as the mother country, and in many cases young single women as well as men were recruited. Like many migrants, African–Caribbean people took the jobs that local people avoided, yet they often faced hostility and prejudice.

Many people were recruited from Mauritius and other Commonwealth countries, and overseas UK colonies like Jamaica, Barbados, Nigeria and others during the 1960s to the 1980s to come and work in the NHS due to local labour shortages specifically in specialties such as mental health and learning disability services. There was a Nurse Recruitment Selection Board in each of these countries to select appropriately qualified young people to travel to the United Kingdom to do their nurse training. As a consequence of this, AC, the brother of Prem, co-author of this chapter, came to the United Kingdom in July 1970 as a direct recruit and worked for the NHS as a psychiatric nurse and manager for 38 years until his premature death, aged 59, from acute peritonitis.

AC experienced chain migration, where migrants helped other newly arrived people find accommodation and employment. Many people believed that their stay would only be temporary and that they would eventually return home. However, few actually did return. On revisiting their home country, they might find the reality to be different from the fantasy, or they might recognize that they have changed and become 'more British'. Prem can relate to some of these tensions:

> **A few years after AC came to the UK from Mauritius in 1973 myself and 2 other brothers came as economic migrants in 1973. The eldest, SC came in this country in 1960 initially as a chauffeur/driver for 2 lawyer brothers who had come here to pursue their QC training. After they finished their courses and went back to Mauritius, SC stayed behind and eventually worked as a stock-taker for a large department store. He married, had a daughter and SC and his wife, J. decided to immigrate back to Mauritius in 1996 as they still had a vision of their motherland, as it was before they left. However, five years later in 2001 they returned back to the UK as they found it difficult to re-adapt as the country had itself gone through lots of social changes. Moreover, they had left behind in the UK their circle of friends and family, daughter, son-in-law and 3 grandsons. Subconsciously, after a period of over 35 years in the UK, they had become 'anglicised' in their outlook, lifestyle and socialisation, and found health care in Mauritius, as well as other bureaucratic civil society, alien to their concept of life in the UK.**

Prem knows of only a handful of colleagues who have successfully returned to Mauritius and resettled there. The reasons for this are that those who avoid going to resettle in their homeland have been in the United Kingdom for so long and have set up firm roots here with new family

bonds, circle of friends and firm adaptation to the UK social, political and cultural systems. Eisenbruch (1988) coined the term 'cultural bereavement' for those groups of people who have suffered a permanent and traumatic loss of their familiar land and culture. This sense of loss and stress is exacerbated if the migrant is a refugee or exile, and if they have had to leave their home country suddenly because of war or persecution:

> **When I left Poland in 1939 it all happened so quickly, there was such a panic, that I hardly brought anything with me, just two suitcases. We were escaping from the Germans and the bombs, one didn't think … I took my little girl to Romania and then to Yugoslavia where my sister was living. My husband was taken as a prisoner and spent the rest of the war in a POW camp. We arrived in Southampton, I still with my two suitcases, and were sent to an army camp near Leominster … If the war had not happened I would of course have preferred to have stayed in my own country, and not be a burden to another country.**
>
> *(Schweitzer, 1984, p. 61)*

The stress and pressures faced by many migrants may lead to higher rates of mental illness (Bhugra and Jones, 2001). The effects of migration may last a lifetime, so these factors should be borne in mind when caring for older people. For example, they may always feel like an 'outsider' in the host community, or the scars and negative experiences of their migration may be borne through life. There are several studies that have found high rates of mental illness among migrants as discussed in Chapter 10.

Researchers in the 1980s began to stress the notion of 'triple jeopardy', which black, Asian and minority ethnic older people often face (Norman, 1985). This refers to groups that are at risk of multiple levels of discrimination such as characteristics of gender, race and class and are at especially high risk for this phenomenon, now referred to as intersectionality (Rosenfield, 2012).

Key points

1. People who migrated to the United Kingdom in the 1950s and 1960s are now forming part of the older population.
2. Migration can be a difficult and alienating experience, and many older people may carry memories and experience from earlier years.
3. Patterns of migration and settlement may reflect social, political and economic pressures.
4. Memories of migration experiences may be carried to old age and continue to affect mental health.

Demography

The young people who migrated to the United Kingdom from India and Pakistan in the 1970s are now starting to retire. The population of black and minority ethnic older people in the UK population compared with the number of white older people is still small but is growing. The 2011 census (Office for National Statistics) shows that, in general, minority ethnic populations have a younger age profile but this is predicted to be reversed by 2051 when ethnic groups with the

highest proportions of people aged 50 and over will be the 'Other white', Chinese, 'Other Asian', white British, Indian, 'Other' and white Irish (The Centre for Policy on Ageing [CPA], 2010). CPA also report that by 2051 in England and Wales:

- There will be a total of 25 million (36%) white and non-white ethnic people in the population
  - 20 million of these will be non-white
    - 3.8 million of these (black and minority ethnic older people) will be aged 65 and over
    - 2.8 million will be aged 70 and over

HEALTH AND ILLNESS

The Parliamentary Office of Science and Technology (2007) states that black and minority ethnic groups are more likely to experience poorer health. They report that:

- Surveys commonly show that Pakistani, Bangladeshi and black-Caribbean people report the poorest health, with Indian, East African Asian and black African people reporting the same health as white British, and Chinese people reporting better health.
- Black and minority ethnic people (BME) tend to have higher rates of cardiovascular disease than white British people, but lower rates of many cancers.
- Ethnic differences in health vary across age groups, so that the greatest variation by ethnicity is seen among the elderly.
- Ethnic differences in health vary between men and women, as well as between geographic areas.
- Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill health are worse among those born in the United Kingdom than in first generation migrants. (p. 1)

There is an established association between ill health and poverty (Townsend and Davidson, 1982), and older minority ethnic individuals may experience particular disadvantages with regard to their health as it is linked to historical and social factors that in turn have affected their economic and social position in society. Epidemiological studies show a number of trends that are worth noting. For example, in 1994 it was reported that osteomalacia was found in excess among older Asian women (Calder et al., 1994). This was surmised to be caused by vitamin D deficiency, also more recently suggested as a cause of widespread pain reported to rheumatologists (Macfarlane et al., 2014). Similarly, rates of hypertension have been reported as high in both the Asian and African–Caribbean populations (Blakemore and Boneham, 1994; Smaje, 1995; Ebrahim, 1996) and older Asian people at higher risk of heart attack compared with the national rate (Smaje, 1995). Such health problems earlier in life have implications for ageing and health and older age (WHO, 2011). More recently, people from Asian and African–Caribbean populations are known to be up to five times more likely to develop diabetes than the general population (Department of Health, 2006; Diabetes UK, 2010).

Ebrahim et al. (1991) found that a group of Gujarati elders in North London was more prone to diabetes, asthma, gastrointestinal bleeding, strokes and heart disease than white groups.

However, in this study there were no significant differences in the problems found in old age (e.g. visual and hearing impairment, falls, urinary incontinence) between the Asian elders and the indigenous population. Around 50% of the people in both groups experienced some type of visual impairment, and indeed more people from the indigenous groups admitted to being incontinent of urine. Ebrahim et al.'s study revealed that the Asian group had a higher rate of use of medication than the indigenous group. Other studies (e.g., Donaldson, 1986) have indicated that the number of consultations in general practice by people from ethnic minorities is high. Indeed, as Ghosh (1998) indicates, most people from minority ethnic groups believed that they are sicker than their white peers. However, breast and lung cancer rates for south Asian migrants are now the same as the general population in England and Wales, and cancer mortality rises with duration of residence. Uptake of screening programmes in this population, however, remains poor (Zaman and Mangtani, 2007).

Older people from BME communities may find it difficult or are reluctant to access health services, social services and housing provision, either because they believe that they do not deserve them or because they perceive those services as being for the white majority population. As Jones (1996) said:

> **Whenever racism appears, and at whatever level, the effects are more accentuated when a person is older. The presence of one deepens the influence of the other; that is, prejudice and disempowerment due to bio-socio-economic deprivation associated with old age is further enhanced when race becomes a factor.**
>
> *(Jones, 1996, p. 109)*

A consultation project with older people from minority ethnic groups carried out by Butt and O'Neill (2004) reported that language barriers in services caused problems. People reported that they often had problems explaining their symptoms of ill health and that as a result conditions could be misdiagnosed or diagnosis was late. Many older people felt that services saw communities as 'problems' rather than respecting different communities. Some people also preferred their own community voluntary groups after losing faith in mainstream services.

Drugs in particular may cause problems for older people from other cultures, and unfamiliarity or language difficulties may be associated with non-concordance. Qureshi (1989) stressed that in Eastern cultures, rectal examination and rectal medication (e.g. suppositories and enemas) may be taboo and even cause deep offence and distress. This is because traditional cultures perceive rectal examination to be a form of punishment and insult.

Key points

1. Older people from black and minority ethnic groups may face multiple challenges in health care owing to adverse factors such as racism and patchy provision of services.
2. Misunderstanding and misinterpretation about older black and minority ethnic people may also jeopardize their access to the provision of care.
3. The health of the older person may be considered to be a family problem and not a problem for the individual.

DEVELOPING SERVICES FOR OLDER BLACK AND MINORITY ETHNIC PATIENTS

Health services do not always meet the needs of older people whose services are often described as marginalized or 'Cinderella' services and this is therefore a particular challenge in meeting the needs of black and minority ethnic populations. Services for older people tend to be perceived as less glamorous than the so-called 'high-tech' services and remain the least popular with which to work (Koh, 2012). These problems may be compounded for older people from black and minority ethnic groups. Butt and O'Neill (2004) identified a lack of empowerment for black and Asian older people, and low levels of expectations. Some older people reported feeling 'invisible' to service providers.

One of the main challenges is in understanding and interpreting how different cultural values come together and potentially clash. In Western health care, great importance is attached to the rights, needs and perceptions of the patient as an individual. In the United Kingdom, for example, we place great emphasis on individual privacy, dignity and respect for confidentiality. Healthcare professionals in the United Kingdom are therefore driven by the desire to be patient-centred. However, in Eastern cultures the person as a patient may be seen in the context of their family and care may be shared as cultures are based on familism rather than individualism (Sanseeha et al., 2009; Wang, 2011). In Eastern cultures, illness may be viewed as a crisis for the whole family, so the outcomes of care will affect all family members. In Western cultures, this approach to health care is sometimes interpreted as interfering or overprotective. For example, people from South Asian cultures may believe that hospital care requires relatives to undertake the nursing care of a member of the family (e.g. washing and feeding). Indeed, to some people the notion of leaving a relative alone in the hospital may seem neglectful or even abusive. However, visits to the ward by large family groups often cause great concern among healthcare staff, not least the nurses.

The cultural differences described above may be misinterpreted and inform a prevalent myth about minority ethnic groups in the United Kingdom, that they 'look after their own'. It is often assumed that older black and Asian people live as part of extended families, and that their needs for care and support in old age are almost always met within the family and community. This notion is refuted by Fennell et al. (1988), who indicate that although many ethnic older people live in multigeneration homes, they may not be receiving adequate or appropriate care. Willis (2008), in her preliminary findings, challenges the idea that minority ethnic groups support each other and found that black Caribbean older people actually gave less support that their white counterparts. Butt and O'Neill (2004) also found that many people refuted the stereotype that black and minority ethnic groups might 'look after their own'. The participants in this study pointed out that family members often lived away or that intergenerational gaps and culture gaps may leave older people living alone and feeling isolated. Collier and McQuarrie (2014) note that assessments of mental health in older people may be culturally biased (Department of Health, 2001; Audit Commission, 2002) with assumptions made regarding, for example, family willingness to act as primary care givers for older relatives (Shah, 2009). Paradoxically, Asian older people have been reported as interpreting offers of help as questioning of the presence and willingness of family support (Department of Health, 2008). Essentially, fatalism and strongly held cultural beliefs should not be seen as resistance to health education (Osman and Curzio, 2012).

Table 9.1 Examples of Behaviour and Alternative Explanations

Examples of behaviour	Possible explanations
'He won't make a decision …'	Perhaps he needs to ask an authority figure in his community
She is off her food – perhaps she always washes her hands before eating	Perhaps it is a fast day
'She has dementia and she is climbing all over the toilet …'	Perhaps she is trying to squat to use the toilet, the way she remembers from her own country
'She is terrified of physical investigations …'	Perhaps she has been tortured
'The family visit in a large group, they never look at the sign saying two visitors at each bed …'	Perhaps it is their custom to support the patient in this way, and the patient would be distressed by their absence

In the conclusion of their literature review, Osman and Curzio (2012) recommend that nurses:

- Do not see culture as a barrier to health education.
- Consider how health information given has been understood and interpreted in a cultural context.
- Identify barriers to self-management, for example, identify each person's perception of their shared culture, their own individual beliefs and how that affects their behaviour.
- Should not make assumptions about cultural beliefs.
- Create individualised care plans according to each patient's cultural needs in the knowledge that culture is subjective and dynamic.

Another common challenge in developing sensitive services is that older people from black and minority ethnic communities may be treated as a homogeneous group with similar cultural beliefs and languages. In one small town in northern England, Blackburn Robinson (1986) reported 17 different dialects in the Asian communities living there. The term 'Asian' may be regarded as similar to the generalization 'European'. If we consider the needs (language, health beliefs, customs, religious beliefs, etc.) of an older person living in a residential home in Glasgow, they would not be considered similar to those of an older woman living in a remote village in Portugal. Although they may have commonalities, they are likely to have had different life experiences, employment patterns, family systems, language, customs and so on. They live in different parts of Europe and may consider themselves to be completely different. One may be a regular attendee of the Church of Scotland, and the other may be a devout Catholic. Thus, although they may be regarded as similar (older, Christian and European), they speak different languages, practise their faith in different ways and may have never visited each other's countries.

Hilton (1996) cites examples of behaviour that may seem strange, and he offers alternative explanations (see Table 9.1).

And, as Blakemore and Boneham (1994) indicate:

> **When we reflect on the experience of a Jamaican widow or a Sikh grandfather going to a GP's surgery, or to a hospital for treatment, we should therefore remember it is not a matter of the older black patient bringing an "awkward" set of expectations or cultural attitudes with him or her. It would be more accurate to see the hospital or medical practitioner culture as**

> **exotic and "awkward", perhaps in the sense that it demands compliance to rules that are in part culturally defined and unlike the everyday rules of social behaviour. The relationship between patients and medical practitioners always involves some negotiation.**
>
> *(Blakemore and Boneham, 1994, p. 105)*

Consider the following case study, which explores some of the issues already outlined.

Case study

Miss K is a 78-year-old Polish woman. Lately she has been getting quite forgetful and has been admitted to the ward with unstable diabetes and a chest infection. The warden (herself of Polish origin) says that she is a very private person who has few friends. According to the district nurses, Miss K's flat is quite chaotic, and there are complaints that she is hoarding things 'again'. Miss K is admitted to the ward today. She speaks little English, she is very tearful, speaking in her own language and is clinging on to her handbag, which contains all her medication.

What actions should the nurse take on the basis of this limited information?
The following nursing actions were taken:

- The nurse who was caring for Miss K interpreted her behaviour as resulting from fear and thought that she was frightened, bewildered and perhaps disorientated. From this point the nurse used her interpersonal skills to help the patient to feel at ease. She approached Miss K in a quiet but firm manner, talking to her slowly and calmly. She used plenty of non-verbal techniques, gentle touch and good eye contact. She made a conscious effort to avoid appearing hostile. She did not attempt to take Miss K's handbag away from her, and instead sat with her at the bedside and allowed her to cry, providing her with tissues and a cup of tea.
- The nurse also made sure that Miss K knew her name and knew how to call her with the call bell. She did this by introducing herself. This ensured that Miss K felt established and accepted. It also meant that she did not feel as lost and isolated in the hospital.
- The nurse then contacted the Polish interpreting service in the hospital. However, the person concerned was on holiday. The nurse then made enquiries and found a nurse who spoke Polish as her mother tongue. The Polish-speaking nurse was enlisted to orientate Miss K to the ward, bathrooms, etc.
- The nurse asked the Polish-speaking nurse's permission to write down some key words that would be useful when communicating with Miss K. Key words (e.g. pain, sugar, urine, bathroom, toilet, hungry, feeling ill, nurse, doctor) were written in Polish and, together with a signboard, were used when she was communicating with Miss K. Once she was able to make herself understood, the nurses began to notice a discernible difference in Miss K's mood.
- The nurse then carried out procedures with Miss K, using a few key words in Polish and the rest in English, quietly and gently. The nurse was aware that even

continued

Case study

though she might not respond in English, she might be able to understand it when being spoken to rather than speaking it herself. The nurse decided that it was better to continue to speak and explain even though Miss K did not understand everything that was being said to her, as this was preferable to caring for her in silence, which could possibly seem quite threatening.

- The nurse then contacted the warden of the flats for some information and assistance. It became apparent that Miss K arrived as a young woman in the United Kingdom in 1946 as a refugee from Poland. Her family had been killed during the war, and she had spent some time in a concentration camp. The hardships and the trauma of this period had made her reclusive and anxious. Throughout her adult life she was inclined to hoard and treasure her possessions. It was felt that this was a direct result of living her life in a concentration camp where she had been stripped of possessions. The warden said that like many people who had experienced life in a concentration camp and as a refugee, she had a fear of destitution and poverty. She still experienced nightmares and had a deep mistrust of hospitals, as she had been physically assaulted by nursing staff while in the concentration camp hospital. Lately she had become even more reclusive and had forgotten to take her medication. She settled in a town in the North of England in a small community of Polish people so that she could be with others from her country. Miss K worked for some time as a cleaner and now lives in a housing association scheme that is warden controlled.
- The nurse asked if the warden could arrange for some of Miss K's personal belongings to be brought in for her. The next day the neighbour brought in her nightwear and a few personal items, including some prayer books, some holy water and a crucifix. She also brought a Polish newspaper. Miss K seemed to be comforted by these items.

Bearing these factors in mind, the nurse planned Miss K's care. As her religion was very important to her, she arranged for the local Polish-speaking priest to visit Miss K (this was done by contacting the chaplain at the hospital).

At handover, the nurse informed all of the other staff about Miss K's individual circumstances and the care and sensitivity that she would need. She also made the other nurses aware of the language resources. The next day the nurse bought a Polish-English dictionary with ward funds. This would be kept on the ward for future reference.

Miss K gradually became less anxious and her diabetes and general health improved. She formed a good relationship with the nursing staff, who were able to understand her in the context of her life experiences. Although communication was difficult at times, Miss K felt accepted and was more confident about trying to make herself understood. Miss K was discharged the following week. The nursing team commented that she seemed to be a different person from the frightened, tense individual who had been admitted to the ward the week before.

CONCLUSION

Many people are extremely resourceful and robust and have sometimes battled against extreme adversity in life. However, they may be vulnerable, and this vulnerability is perhaps heightened when they come into contact with health services. There are many health problems that are similar to those of the indigenous population (e.g. cardiovascular problems, diabetes, etc.) but services may face barriers in planning for the needs of diverse communities due to lack of understanding of those needs. However, the diverse nature of *individuals* from minority ethnic communities (e.g. the so-called 'Asian community') can be recognized and taken into consideration when planning and delivering services. Nurses in particular need to ensure that care assessment and planning take into account the context of the patient's life.

CHAPTER SUMMARY

1. Older people from black and minority ethnic groups need to be considered in the context of their individual life history and social circumstances.
2. There are some common myths and stereotypes about this group of people that may lead to poor service provision and barriers to access.
3. Older black and minority ethnic people may experience health problems in common with all older people, but these issues may be exacerbated by the effects of racism (e.g. poverty, poor housing).
4. Older people are not a homogeneous group, nor are people from ethnic minorities.

FURTHER READING

Blakemore, K. 1997. From minorities to majorities: Perspectives on culture, ethnicity and ageing in British gerontology. In Jamieson, A., Harper, S. and Victor, C. (eds.). *Critical Approaches to Ageing and Later Life*. Milton Keynes: Open University Press, 27–38.
This is a stimulating and interesting chapter that considers the importance of including cultural issues in gerontology. There are some complex issues debated in the chapter, which includes a comprehensive reading list.

Mold, F., Fitzpatrick, J. M. and Roberts, J. 2005. Caring for minority ethnic older people in nursing care homes. *British Journal of Nursing*, 14, 601–606.
This article discusses the issues in relation to caring for older people in nursing homes. It provides a useful framework and some key strategies.

Ndoro, R. and Marimirofa, M. 2004. West African older people in the UK with dementia. *Mental Health Practice*, 7, 30–2.
The mental health of older people from minority ethnic groups is often overlooked. The authors of this article consider the issues of dementia within a West African family and provide some practical insights.

Standing Nursing and Midwifery Advisory Committee (SNMAC) 2001. *Caring for Older People: A Nursing Priority – Integrating Knowledge, Practice and Values*. London: Department of Health.

This is a report on caring for older people inclusive of all cultures. It offers a wide range of recommendations for the future care of older people, including the educational needs of nurses and adopting culturally sensitive practice.

Wambu, O. (ed.) 1998. *Empire Windrush – Fifty Years of Writing About Black Britain*. London: Victor Gollancz.

This anthology of African–Caribbean and Asian writings charts the experiences of the first waves of migrants to the United Kingdom. Within the text there are essays, poetry and fiction which tackle issues such as racism and identity.

WEBSITES

http://www.ageconcern.org.uk/health-wellbeing/relationships-and-family/older-bme-communities/local-bme-services-and-support-available/

Examples of good practice in supporting older people (Age UK) in different parts of the United Kingdom.

http://www.jrf.org.uk/publications/black-and-minority-ethnic-older-peoples-views-research-findings

This website links directly to a report on black and minority ethnic people's views about research findings and their involvement, as well as how it can bring about change in their lives.

http://www.scie.org.uk/publications/guides/guide03/minority/index.asp

Social Care Institute for Excellence (SCIE): this website links directly to a report on assessing the mental health needs of older people in black and minority ethnic communities.

http://www.kingsfund.org.uk/sites/files/kf/field/field_pdf/Library-reading-list-bme-older-people.pdf

This is a reading list produced by The King's Fund Information and Knowledge Services on books and reports related to the care of BME groups. This one was published in 2013. It is an excellent resource for books and articles and also has links to many more websites.

(See the updated November 2014 list here: http://www.kingsfund.org.uk/sites/files/kf/field/field_pdf/Library-reading-list-BME-older-people-Nov2014.pdf.)

http://www.scie.org.uk/socialcaretv/video-player.asp?guid=9d7257a0-42c8-4e74-bf31-014b9ecce735

An SCIE video on the mental health and well-being of elders in black and minority ethnic communities: working together for mental wellbeing; the community in the video are the Chinese elderly people in Barnet.

There are a large number of other short videos showing similar insights into the health and social care needs of elderly people in black and minority ethnic communities on this Social Care Institute for Excellence (SCIE) site. Please access them according to topics raised in this chapter. The following is one of these other examples.

http://www.scie.org.uk/socialcaretv/video-player.asp?guid=9d7257a0-42c8-4e74-bf31-014b9ecce735

The mental health and well-being of elders in black and minority ethnic communities: the impact of poor housing on mental well-being.

CHAPTER

10 Culture and mental health

Shelly Allen and Naomi Sharples

INTRODUCTION

Mental health problems are common and occur in all cultures and societies. Emotions such as distress, anger and grief are universal and most people will experience them at some time in their life. However, the way in which emotional or psychological distress manifests and how it is responded to varies from person to person and from culture to culture.

This chapter will focus on the following issues:

- Concepts of normality and abnormality
- Transcultural psychiatry
- Culture-bound syndromes
- Cultural competency skills for mental health practitioners
- Culture in care and treatment
- Intercultural communication
- Working with interpreters in mental health settings
- Racism and intercultural communication

A case study is included where we will explore the skills that are necessary for caring for a person from another culture who has mental health problems.

CONCEPTS OF NORMALITY AND ABNORMALITY

What people perceive to be normal and abnormal within society is culturally determined. However, like the term 'health', the term 'normal' has different meanings in different contexts. The concept of normality is based on a shared set of beliefs and values that dictate certain codes of behaviour. These principles guide how we speak, communicate, dress, eat, drink, pray and conduct ourselves in day-to-day life. In Western culture, for example, it is traditional for people to wear black clothes at funerals, and indeed the colour black is generally associated with death and mourning. This behaviour conveys to others the message that you are respectful of the dead person you are mourning. People may flout conventions, but generally they are aware of what usually constitutes socially acceptable behaviour and codes of conduct at socially significant events.

Behaviours that appear abnormal at certain times may be regarded as normal at others. For example, it is acceptable for nurses to ask patients questions about their intimate health issues; behaviour not normally accepted between strangers. Normality is therefore a value judgement: it is a relative concept that depends on who is making the judgement and the context in which that judgement is occurring. Our judgments about normality are dependent on many factors.

In the 1970s it was considered abnormal for men to wear make-up in the United Kingdom. However, in the early 1980s it became acceptable and even fashionable for 'New Romantic' pop stars and their followers to wear make-up. In Papua New Guinea, men traditionally paint their faces to celebrate significant events such as independence and weddings. In Australian Aboriginal cultures, men adorn their bodies with paint and/or jewellery for ceremonial occasions. However, despite the similarity on the surface, the face paints and adornments in each of the three cultures above send very different inter- and intra-cultural messages.

Reflective exercise

1. **Think of other events in your life when convention is disregarded and behaviours are changed deliberately (e.g. Guy Fawkes night, Halloween).**
2. **How would you explain them to someone outside your culture?**

Codes of behaviour are constantly changing, and normality seems to depend not only on identity and geography, but also on where we are in history. Normality is a complex term that is difficult to define. Rosenhan (1973, p. 250) states: 'What is viewed as normal in one culture may be seen as quite aberrant in another. Thus notions of normality and abnormality may not be quite as accurate as people believe they are'.

Rosenhan's classic research in 1973 demonstrates the difficulties that are encountered in ascribing normal and abnormal labels to behaviours. In this experiment, eight mentally healthy people gained secret admission to 12 different hospitals. The 'pseudopatients' arrived at the hospital complaining of hearing voices but reported a stable personal life that lacked any other 'symptoms'. On admission to the psychiatric ward the pseudopatients stopped simulating any symptoms of abnormality and maintained ordinary behaviour. It was then left to these patients to try to obtain discharge from the hospital by convincing the staff that they were not mentally ill. This proved to be a difficult task. The pseudopatients were designated as 'in remission' when they were ready for discharge, and the experiment was not detected by staff. Interestingly, it was common for the 'genuine' patients to detect the pseudopatients' sanity, and comments such as 'You're not crazy … you're checking up on the hospital' were made. Behaviour that would not be questioned outside a psychiatric hospital (e.g. note-taking) was pathologized as abnormal behaviour inside the hospital. One nurse wrote in the nursing records 'Patient engages in writing behaviour'. Rosenhan (1973) comments as follows:

> **Once a person is designated as abnormal, all of his other behaviours and characteristics are coloured by that label. Indeed, that label is so powerful that many of the pseudopatients' normal behaviours were overlooked entirely or profoundly misinterpreted.**
>
> *(Rosenhan, 1973, p. 253)*

Reflective exercise

Rosenhan's research was conducted in the early 1970s in the United States.

1. What are the implications of this study for mental health services in the United Kingdom today?
2. Do you think that this experiment could be replicated today? Give reasons for your answer.

Rosenhan's experiment is a sharp reminder that perceptions of normality inside a psychiatric hospital may be skewed and instead we may search for mental illness, often when it does not exist. Both this issue and the problems of interpretation of behaviours will be discussed in more detail later in this chapter.

In 1988, Loring and Powell published the findings of a study examining the diagnostic approaches of 290 American psychiatrists. All were given similar information about clients except for details about gender and race. The study ensured that each group of clinicians evaluated a white female, a white male, a black male and a black female. Using standardized diagnostic criteria (DSM-III: American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 1980 revision), the researchers examined how race affected diagnosis. Generally, black clients were given a diagnosis of schizophrenia more frequently than white clients, and all of the psychiatrists were willing to label the black client as more dangerous than the white client, despite the fact that they were displaying the same behaviour. A similar study undertaken in 1990 by Lewis et al. in the United Kingdom revealed that African–Caribbean clients were judged to be potentially more violent than their white counterparts. It may be argued therefore that judgements about mental health may be influenced not only by who is making the judgement, but also by culturally determined ideas about race and gender.

Alarcón (2009) offers a potential solution to this pattern of misdiagnosis and perception. He suggests that professionals should include cultural elements in the clinical interview. The aim being to include cultural variables, family information, explanatory models and strengths and weaknesses of every individual, thereby taking a more psychosocial approach, which takes into consideration the person's cultural context and how the individual expresses his or her symptoms which may be suggestive of a diagnosable mental health problem.

Key points

1. Normal and abnormal behaviours are culturally determined and shaped.
2. Behaviours that appear normal in some contexts may be deemed abnormal in others.
3. Research evidence has demonstrated that normality is often subjectively determined in mental health.

TRANSCULTURAL PSYCHIATRY

The discipline of psychiatry developed in parallel with European colonialism and the seventeenth and eighteenth century transatlantic slave trade, when myths about race and ethnicity were common throughout European society. These beliefs were dominated by the notion that Europeans, that is, '*white*' people, were naturally superior. In an attempt to emulate contemporary popular biological sciences, psychiatrists began theorising about mental illness. For example, slaves were considered to be vulnerable to mental illness and the term 'drapetomania' was used to describe a condition characterized by the 'irresistible urge amongst slaves to run away from plantations' (Littlewood and Lipsedge, 2001). Indeed, slavery provided a rich source of data for the science of psychiatry, and this was often used as a rationale to retain the practice of slavery.

At the end of the nineteenth century, the myth that the brains of black people were smaller than those of white people was accepted, and the famous psychologist Stanley Hall described Asians, Chinese, Africans and Native Americans as psychologically 'adolescent races' (Fernando, 2002). Black people were perceived as possessing limited capacity for growth and as having abnormal personalities. These theories have since been discredited but the racism they spurred continues to pervade mental health systems.

Of particular concern today is the high rate of diagnosis of schizophrenia among African–Caribbean populations in the United Kingdom, and the high rate of suicide and self-harm among South Asian women and Irish people. People from BME communities are more likely to be prescribed drugs and electro-convulsive therapy (ECT) and less likely to receive 'talking' treatments, such as psychotherapy and counselling (National Institute for Mental Health in England [NIMHE], 2004).

The relationship between mental health and migration is often a source of concern in psychiatry. Bhugra et al. (2011) summarizes this, stating that the diversity of cultures, ethnicity, races and reasons for migration can make a shared understanding of mental illness challenging when the background of the migrant and clinician differs.

Research has demonstrated higher levels of mental illness among migrant populations than in indigenous populations. Research has also identified the relationship between close migrant communities and lower levels of mental ill health compared to dispersed communities (Basqui et al., 2014). The impact of migration is experienced from generation to generation.

There appear to be two broad hypotheses to explain this phenomenon. The first of these is the selection hypothesis. Cox (1977) argues that certain mental disorders motivate their sufferers to migrate. These may be people who are restless or unstable, or who have poor social networks and are thus able to migrate more easily. The alternative theory is the 'stress' hypothesis. It is argued that a high rate of mental illness among migrants is primarily caused by the stress of migration. The new migrant may have to deal with uncertainty, isolation, loss of family and friends, helplessness and in some cases open hostility from the host population (Cox, 1977).

However, Littlewood and Lipsedge (2001) argue that higher levels of mental illness among migrant populations are complex and probably result from an interplay of many factors, including both the stress hypothesis and the selection hypothesis. The detrimental effects of racism and

discrimination may force migrants to experience material and environmental deprivation (e.g. overcrowding, lack of amenities, poor housing conditions), which in themselves may precipitate mental health problems. Language difficulties may also be significant. In a study in Newcastle, Wright (1983) found that 58% of Pakistani women spoke little or no English and were completely illiterate.

However, Helman (2007) indicates that different migrant groups may have specific difficulties. Littlewood and Lipsedge (2001) note that West African students appear to be particularly vulnerable to mental health problems owing to dissatisfaction with food, the climate, discrimination and economic difficulties in the United Kingdom. Those migrants with low rates of mental illness (Chinese, Italians and Indians) seem to have a greater determination to migrate, migrate for economic reasons, intend to return home and have a high level of entrepreneurial activity. Thus, it appears that money protects against the stress of migration (Bhugra and Ayonrinde, 2004).

This point is also highlighted by Bhugra et al. (2011) who state that there is a wealth of evidence to suggest that some migrant groups are more at risk of developing mental disorders. These authors go on to recommend that clinicians, policymakers and service providers need to develop awareness of specific needs that migrants may have and how these may be met in a culturally appropriate way with requisite services being delivered accordingly.

In contrast to those who migrate for economic reasons, refugees and people who are forced to leave their homes against their wishes may be more vulnerable to mental health problems. According to Bhugra et al. (2011) refugees are arguably the most vulnerable of all migrant groups to mental and physical ill health. These authors contend that this is due to a lack of preparation, the attitudes of the new country, poor living conditions, poor or lack of employment and variable social support. (See Chapter 11.)

Without doubt, factors such as dislocation from the native community, transition to new communities and rejection by the host community may also cause stress in individuals who may or may not be psychologically vulnerable. Bhugra et al. (2011) provide further detail of this complex interplay with their description of migration in three stages. The first being premigration where the decision to move is made, the second where the physical relocation of individuals takes place and the third, postmigration, where the person is absorbed within the social and cultural framework of the new society. Drawing on the available evidence base, it is further argued that the initial stage of migration may have comparatively lower rates of mental illness than the latter due to the likelihood of being younger during that stage and a discrepancy between attainment of goals and achievements in the latter stages (Bhugra et al., 2011).

In mental health care, nurses may encounter behaviours that are acceptable in other societies but which could be interpreted as signs of mental illness. An example of this is obeah – a prevalent belief among people from rural and sometimes urban communities of Africa and Asia. Obeah centres on the premise that it is possible to influence the health or well-being of another person by action at a distance. Victims of obeah may believe that illness is caused by a curse being placed on them. Treatment may involve traditional healers who are able to lift the curse (e.g. with counter-magic).

An illustration can be seen in the following brief case study.

Case study

Mrs S, a 39-year-old woman, had emigrated from Trinidad. She was admitted to the hospital after becoming increasingly hostile and angry and refusing to eat or drink. Mrs S reported that she believed an obeah curse had been placed on her. She was diagnosed with severe depression and was detained under the Mental Health Act (1983, amended in 2007) for her own protection and for treatment. She did not respond to the treatment, and a traditional healer was consulted who lifted the curse. Mrs S responded immediately. She began to eat and drink within a day, and she became calmer and less agitated. She was discharged within a week of her admission to hospital.

CULTURE-BOUND SYNDROMES

Culture-bound disorders or syndromes are illnesses found in particular cultures. Each culture-bound disorder has a particular set of symptoms and changes in behaviour that are recognized as abnormal by members of the cultural group that it affects. Often culture-bound syndromes are a way of communicating distress or resolving interpersonal difficulties. An example in Western culture is agoraphobia, in which affected individuals may refuse to leave the home because of acute anxiety or fear.

Alarcón (2009) suggested that a list of culture-bound syndromes was included in the Appendix I of DSM-IV, but it was incomplete and whilst practically every region of the world has a set of culture-bound syndromes, the descriptions are at times too similar and at others too generic to be useful. That said, it is important to have an understanding that such syndromes exist without necessarily knowing the detail. Specific behaviours and beliefs can then be researched as required in order to critically evaluate a person's presentation and to understand the part that culture-bound syndromes may play in it. With that in mind, the following contains examples of culture bound syndromes as an illustration of this point.

Other culture-bound syndromes are listed in Box 10.1.

Box 10.1 Culture-bound syndromes

- *Amok*: A spree of sudden violent attacks on people or animals that affects men in Malaysia. The expression 'running amok' is taken from this syndrome.
- *The evil eye*: A belief in some cultures that illness is caused by the state of a jealous person. It may be found in the Middle East, in Europe and North Africa and in Hispanic cultures.
- *Susto*: Found in Hispanic cultures and is a belief in the loss of the soul after a frightening event, leading to unhappiness and sickness. People may also complain of loss of appetite, sleep disturbance and listlessness. It may be described as 'magical fright'. A curandero or folk healer may coax the soul back to the patient's body using massage and other treatments.

continued

Box 10.1 Culture-bound syndromes (continued)

- *Koro*: Found in males in Asian cultures, particularly South East Asia. There is a belief that the genitals are withdrawing into the abdomen or body and that this may cause death. It may cause individuals to become very distressed.
- *Shinkeishitsu*: A form of anxiety and obsessional neurosis found in young Japanese people.
- *Hsieh Ping*: A trance-like state found in Chinese cultures where a person believes that he or she is possessed by dead relatives and friends that have been offended.
- *Wild man syndrome*: Found in the Gurumba of New Guinea. It occurs in young men during the long betrothal. Men may start running round the village attacking neighbours and stealing objects.
- *Zar*: Reported in North Africa and the Middle East and is a form of spirit possession involving dissociative episodes and socially inappropriate behaviour.

From Helman (2007), Swartz (2000) and Littlewood and Lipsedge (2001).

WESTERN OR EUROPEAN CULTURE-BOUND SYNDROMES

The term 'culture-bound syndrome' can be criticized on the grounds that it is ethnocentric in that it implies that other cultures may exhibit strange behaviours that are not apparent in 'Western society'. However, some behaviours that are exhibited in Western cultures may themselves appear bizarre or odd in other cultures. Examples of culture-bound symptoms as defined by MacLachlan (1997) are listed in Box 10.2.

Box 10.2 Western culture-bound syndromes

- *Anorexia nervosa*: A syndrome characterized by refusing food until one becomes extremely emaciated, sometimes to the point of death.
- *Agoraphobia*: The fear of leaving a restricted area, characterized by mood disturbance and panic.
- *Kleptomania*: A condition in which people steal goods from shops when they are capable of paying for them. It may be associated with anxiety or depression.

These expressions of emotional distress may appear bizarre or strange to members of other cultures but are recognized in Western cultures as mental health problems. MacLachlan (1997) has discussed the issues related to eating disorders, which are classically perceived as 'Western' disorders. However, there are indications that anorexia nervosa is increasing in incidence among young Asian women in different countries (Miller and Pumariega, 2001; Soh et al., 2006). MacLachlan (1997) argued that an Asian girl who develops an 'English disorder' could be demonstrating her identity with England and thus rejecting her Asian heritage and cultural traditions.

CULTURAL COMPETENCY FOR MENTAL HEALTH PRACTITIONERS

Cultural competency is firstly the ability to understand your own culture, the cultures of others and the impact these different cultures may have on each other. Secondly, cultural competency is the ability to know, work with and care for people from a variety of cultures in ways that value and respect the individuals and communities concerned (Dayer-Berensn, 2011). A report published in 2014 by the Joint Commissioning Panel for Mental Health also recommends that there is a need to develop cultural competency in the mental health workforce. This is a panel with members from all the mental health organisations in United Kingdom working together to consider mental health services for black and minority ethnic communities. (See this direct link to the report: http://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pdf.)

Understanding how we can culturally impact on other people requires us to have a curiosity about historical, spiritual, linguistic and societal aspects of other cultures and traditions. Whilst we cannot have an in-depth understanding of all the global communities and cultures, it is reasonable to expect nurses to find out and understand the cultural norms, values and behaviours of the clients they nurse and the families they support (Tseng and Streltzer, 2010).

Culturally competent practitioners understand and manage the power dynamics between practitioner and client and work towards an equitable and ecological relationship wherever possible. (See Chapter 2 for additional information on cultural competency.)

ISSUES IN CARE AND TREATMENT

A systematic review cited in Bhugra et al. (2011) states that migrants are at a threefold risk of schizophrenia. In this meta-analysis, 'migrant' referred to someone with a foreign birthplace (first-generation migrant) or with one or both parents born abroad (second-generation migrant) (Cantor-Graae and Selton, 2005). In order to generate a hypotheses that could be tested, these authors introduced further groups on the basis of skin colour and the level of economic development of the country of birth. which led to the conclusion above regarding migration and risk for developing schizophrenia (Cantor-Graae and Selton, 2005).

In mental health care, most attention has focused on the elevated rates of schizophrenia diagnosed in Caribbean populations. Initially, high rates were attributed to factors relating to migration, but studies have shown that the rates are actually higher among UK-born people of Caribbean origin (McGovern and Cope, 1987; Bhugra et al., 2011; see the website list at end of the chapter for NHS Evidence – Ethnicity and Health, 2009).

There are several possible explanations for such high rates of schizophrenia (London, 1986; Harrison et al., 1988; Lloyd, 1993; Littlewood and Lipsedge, 2001; Bhugra et al., 2011):

- *Biological/genetic*: Black people are more 'prone' to schizophrenia because of their physical make-up; however, due to the high rate among second generation African–Caribbean people, Bhugra et al. (2011) suggest that genetic factors may not play a role and that social and environmental factors may be more important.
- *Economic deprivation*: For example, the effects of living in inner-city areas with poor housing and high levels of unemployment.

- *Psychological*: For example, having to cope with racism, discrimination and harassment on a day-to-day basis.
- *Service-related*: Accuracy in diagnosing, labelling and stereotyping behaviours, types of services offered and the relevance and suitability of those services.

Once in contact with psychiatric services, it appears that their problems are compounded. For example, it has been shown that people from black and minority ethnic communities are

- Less likely to have contact with the GP prior to admission to hospital (Cope, 1989; W Koffman et al., 1997; Bhui and Bhugra, 2002; Healthcare Commission, 2008);
- More likely to be detained by the police to a 'place of safety' under the Mental Health Act (MHA) (Moodley and Thornicroft, 1988; Bhui and Bhugra, 2002). This is a particular issue for African–Caribbean and Irish people and may be because they do not receive adequate care in primary health services and thus detention by the police is the first point of contact as 'help';
- Up to three times more likely to be admitted or detained compulsorily under the MHA (Littlewood, 1986; Coid et al., 2000; National Institute for Mental Health in England, 2004; Healthcare Commission, 2008);
- More likely to be diagnosed as violent and to be detained in locked wards, secure units and special hospitals (McGovern and Cope, 1987; Coid et al., 2000);
- More likely to be placed in 'seclusion' or isolation (Healthcare Commission, 2008);
- More likely to receive 'physical treatments' (e.g. medication and ECT [Littlewood and Lipsedge, 2001]) and less likely to be offered talking treatments (e.g. psychotherapy and counselling [Moodley and Perkins, 1991]);
- Likely to spend longer periods in hospital than their Caucasian counterparts and less likely to have their social care and psychological needs addressed in their treatment (National Institute for Mental Health in England, 2004; Healthcare Commission, 2008).

Commentators on these figures point out that data from hospital admissions are notoriously problematic, and that they may reflect the policies and attitudes of the health professionals instead of the prevalence of disease. Sashidharan and Francis (1993) argue that most studies have been undertaken in large, inner-city hospitals. They indicate that there is an ethnic drift to inner-city areas of mentally ill people, so the figures are naturally artificially high. Finally, many studies fail to take into account the fact that schizophrenia itself is linked to social and economic deprivation, to which black and minority ethnic groups are more vulnerable owing to the effects of racism and discrimination.

A report published by the Schizophrenia Commission in 2012 was given the title: *The Abandoned Illness* and includes a specific chapter on the plight of those from black and minority ethnic groups who suffer from this illness. It refers to similar issues as those highlighted above.

This data indicates concerning trends in mental health care for the African–Caribbean population. Pilgrim and Rogers (1993) offered a number of possible explanations for these trends. They argued that young black people spend a greater part of their social lives in public places, so

they are more visible and hence more vulnerable to police attention. They may also be stereotyped by the police as more violent and dangerous than their white counterparts. When a mental illness is indicated, they may therefore be considered 'doubly dangerous'.

This issue is further exacerbated by African–Caribbean people's mistrust of the psychiatric services because of fear of racism and mistreatment, which may prevent them from accessing services at an early stage of the illness. Pilgrim and Rogers (1993) argue that mainstream psychiatric services may be perceived as part of larger social control networks, such as the police, which serve to repress black people.

The plight of young black men in psychiatric services was highlighted by the case of David Bennett. David 'Rocky' Bennett was a 38-year-old African–Caribbean man who died in a medium secure unit after being restrained by staff. The inquiry into his death highlighted that greater numbers of black and minority ethnic (BME) people were diagnosed with schizophrenia and were given higher doses of medication than Caucasians with similar health problems. The report recommended, among other findings, that all staff in mental health care should receive cultural awareness training and that the Care Programme Approach (CPA) care plan should include details of each patient's ethnic origin (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003).

The survey 'Breaking the Circles of Fear' (Sainsbury Centre for Mental Health, 2002) of over 200 black service users, carers and professionals and police found that stereotypical views of black people, racism and cultural ignorance were prevalent in mental health services. These factors are responsible for stopping BME groups engaging with treatment and accessing support. Services were generally seen as inhumane and unhelpful and sometimes inappropriate. Primary care was seen as lacking and acute care as unhelpful in enabling people to recover from mental health problems. Many people spoke of their fear of being admitted to hospitals, which were viewed as being similar to prisons (Sainsbury Centre for Mental Health, 2002).

In response to findings like these, seven years later the Department of Health made a point of identifying the need to improve access to psychological therapies (IAPT) for people who belong to BME communities and who experience anxiety and depression with the Positive Practice Guide (Department of Health, 2009).

In a similar vein, the report 'Inside Outside' (National Institute for Mental Health in England, 2004) focused on making services non-discriminatory to ensure that organizations work towards racial equality and cultural and ethnic diversity. The report stressed the need to develop a mental health workforce capable of delivering effective mental health services to a multicultural population. It also stressed the need for building capacity within communities and the voluntary sector for dealing with mental disorders.

'Delivering Race Equality in Mental Health Care' (Department of Health, 2005), was a 5-year action plan designed to tackle race inequalities in mental health care in England and Wales that builds on the 'Inside Outside' report. It is based on the themes of improved services between community engagement and better information. The plan aims to improve the quality of care and indicates the need for a reduction in the use of seclusion and compulsory detention. The plan also describes an improvement in the provision of effective therapies and a more active role for BME communities. A key outcome measure for the programme is route of admission to the hospital.

Since 2005 a yearly census of inpatient units – the 'Count Me In' – has monitored the statistics on the inpatient populations by gathering information on the ethnicity of patient populations (Healthcare Commission, 2008).

However, according to work by Kline (2014), institutional racism within large NHS Trusts remains a concerning and intractable problem for healthcare providers. Kline found a huge discrepancy between the numbers of BME NHS workers and the numbers of BME people on boards and in leadership positions. The same issues face large organizations in other Western countries. It is argued that where there is scant representation from diverse populations within higher levels of professions and leadership positions, then patients have less opportunity to experience culturally meaningful services, treatments and diagnoses.

Higher rates of schizophrenia among African–Caribbean populations are of great concern. However, of equal concern are the high levels of suicide and self-harm among black and minority ethnic groups. Raleigh and Balarajan's (1992) research indicated that with the exception of African–Caribbean-born people and men born on the Indian subcontinent, suicide rates are higher than for the general population. Of particular concern are the high rates of suicide, para-suicide and self-injury among young South Asian women and Irish people (Raleigh and Balarajan, 1992; Leavey, 1999; Department of Health, 2001; National Institute for Mental Health in England, 2004). Raleigh and Balarajan (1992) indicate that the suicide rate in women in the 20–49 years age-group born in the Indian subcontinent is 21% higher than that in the general population. In the 24 years age-group, it is almost three times higher.

A group often overlooked in mental health care is Irish people. Irish people may be excluded from discussions about inequality and discrimination in health care perhaps because they are predominantly and ostensibly a 'white' community. In the 2001 census approximately 691,000 people in England identified themselves as 'white Irish' – this represents 1% of the population.

Erens et al. (2001) note that some groups of Irish people (older people, particularly homeless men, people with alcohol problems and the Irish Travelling community) do not access primary care because of stereotyping, perceived hostility and lack of confidence.

Migration to the United Kingdom was a feature of Irish life in post-war Britain. Many Irish migrants were young, single and female and were typically employed in nursing or domestic service. In post-war society, prejudice and discrimination was rife, with signs advertising accommodation saying 'No Blacks, No dogs, No Irish' common. In the 1970s and 1980s, political conflict in Northern Ireland (often referred to as the 'Troubles') led to negative stereotypes of Irish people and often they were subject to hostility, mistrust and abuse (Kelleher and Cahill, 2004). Stereotypes of Irish people led to some people changing their accents to disguise their identity. Irish populations in the United Kingdom tend to be older and single, and poor housing facilities and homelessness are particular issues. Irish communities also have higher rates of physical health problems and disabilities, which in turn may lead to mental health problems.

There are higher rates of mental health problems in Irish populations, above the rates of other migrant groups (Sproston and Nazroo, 2002). Suicide rates are higher particularly among Irish Travelling communities and in particular among men (Commission for Racial Equality, 2004). Like other minority ethnic groups, mental health issues may be related to discrimination, unemployment, poor housing and homelessness. There is also evidence to suggest that Irish

people have difficulty in accessing help in primary care (Tilki, 2000). It is suggested that problems with accents may hamper care, that Irish culture may not be understood or that Irish people may be stereotyped as alcoholics. There may be higher rates of alcohol abuse but sometimes there may be self-medication of alcohol to cope with depression or other problems. There is some suggestion that GPs may fail to deal with mental health issues underlying alcohol problems, such as depression and anxiety, and that the Irish people are disproportionately labelled as having problems with alcohol abuse because of their cultural identity (Erens et al., 2001).

In a study by Parry et al. (2004) examining health issues in Gypsy and Travelling communities, mental health issues were recognized and discussed at length. Many people reported that they had experienced depression or had a relative with depression. The report also noted that many people tried to keep this hidden: 'I said I felt great and happy and all that, you know, gave them a bluff'.

The specific problems encountered by young South Asian women are largely labelled as 'culture conflict'. D'Alessio (1993) claimed that young women in Asian families are often in conflict with their parents and families, and thus generational clashes occur. Young Asian women who are born and raised in the United Kingdom may be exposed to an ethos at school that espouses the value of individual advancement and self-fulfilment by means of education and a career. However, this may be in direct conflict with the values they encounter at home, which stress the importance of the home, collective family life and marriage. The family may value submissiveness and loyalty to family above all else. When young Asian women go to school and mix with young white women of their own age, they will be subject to all the usual peer pressures of adolescence. Young women may, for example, wish to reject the tradition of arranged marriage and may demand greater freedom, such as the right to pursue a career and choose a partner themselves.

However, it is important not to stereotype and label their distress as simply 'rebellion'. The danger here is that mental health nurses may view rebellion and the rejection of traditional ways of life as 'good' or healthy. Individualism may be perceived as the norm in Western cultures but it may be viewed as selfish in other cultures, inevitably leading to direct confrontation. Rejection of one's family values may be regarded as a part of growing up to others, but may lead the young Asian woman in particular to feel even more isolated, thus exacerbating her emotional distress (Yazdani, 1998).

Webb-Johnson (1992) argues that conflict between generations exists in all societies and nearly all cultures, not least in the indigenous UK population. Moreover, many South Asian women find the idea of arranged marriage acceptable. Certainly the issues are more complex than mere oppression and culture clashes. For example, to what extent do racism and isolation play a part in poor mental health? There are other cultures and religions where young teenage women are subject to a high degree of parental control (e.g. in Orthodox Jewish communities), yet the incidence of suicide and self-harm is apparently not as high. Another common stereotype that pervades mental health issues is that Asian people and others from non-Western cultures somatize psychological distress. Somatization is defined by Lipowski (1988) as:

> **… a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them.**
>
> *(Lipowski, 1988, p. 1359)*

This leads to the assumption that people from the Indian subcontinent in particular communicate emotional distress in physical terms. Another prevalent stereotype is that South Asian people are not 'psychologically minded' and are therefore unsuitable candidates for certain therapeutic interventions, such as the psychotherapies. However, a study by Belliappa (1991) refutes this notion. This study, which was conducted in Haringey in North London, consisted of in-depth interviews into the lives of South Asian people. It revealed that they expressed major concerns and distress about their lives. The men, for example, identified distress caused by feeling the effects of powerlessness and racism, while the women were most affected by feelings of isolation. In this study, 82% of individuals could identify concerns and 23% reported experiencing emotional distress. A high percentage of people talked openly and readily about their concerns, which contradicts the stereotype of Asian people being 'psychologically tough' or unable to recognize or believe in mental distress.

The study also highlighted the fact that only 3% of individuals perceived the health services to be a possible source of support. Other sources of support were also lacking. Only 13% of people regarded the family as a source of support, and then only for concerns relating to childcare. None of the people with marital problems felt that the family was an appropriate source of help for their difficulties. This suggests that there is a large gap in the support available to South Asian people who are experiencing severe distress. Following the recent death of her husband, another woman described her health in the following way:

> **Since my husband's death, I have been feeling very poorly with dizziness, aches and pains. I feel this has been caused by sorrow and loneliness.**
>
> *(Belliappa, 1991, p. 41)*

The term somatization is therefore misleading, and may be used either to minimize or to discredit a person's distress. Moreover, it might be suggested that somatization is not restricted to other cultures but is actually present in our own. Western biomedical models of health do not recognize the relationship between mind and body. However, Eastern medicines do not isolate the mind and body, but regard them as interdependent. Thus, it may appear quite logical for people to express their distress in different ways and for them to refer to parts of the body as being affected.

In a study in 1996, Fenton and Sadiq-Sanster interviewed a group of South Asian women to elicit their beliefs and views about mental health and emotional distress. In this study, the women did not use conventional terms such as 'depression', but used other expressions instead. Many of the women referred to the heart when describing emotional distress:

> **My heart kept falling and falling … I felt as if my head was about to burst. The life would go out of my heart. My heart has taken many shocks. I'd get up in the morning and feel as if something heavy was resting on my heart.**
>
> *(Fenton and Sadiq-Sanster, 1996, p. 75)*

Another phrase that was commonly used in the study was 'thinking too much' as the key description of illness. Fenton and Sadiq-Sanster (1996) argue that the women in the study were describing a syndrome of mental distress in which a number of symptoms correspond to those of depression.

The notion of expressing emotional distress in physical terms is not uncommon in UK culture and throughout the English language. For example, we use expressions such as 'a heavy heart' or 'feeling gutted' or 'feeling empty inside' to denote extreme distress. We commonly have physical reactions to emotional distress or anxiety (e.g. feeling nauseous before an important event or needing to urinate when anxious).

Reflective exercise

1. **Consider the issues with regard to culture and mental health problems and undertake a search for different reports on some of the issues raised in this section. To help you begin your search there are some reports and websites can be found at the end of this chapter.**
2. **In particular, consider some of the recommendations in these reports as it relates to information related to men, women, young adults and children.**

INTERCULTURAL COMMUNICATION

All world languages are made up of arbitrary sounds (or handshapes in sign language) produced in certain set patterns that when heard or seen by other people who share the same language are understood and accepted. All languages have a set number of sounds they can use or a set number of handshapes, for example, British Sign Language has 47 different handshapes, spoken English has about 44 phonemes or sounds that are used in combination to make all the 1 million words plus available to English speakers.

All these words and their meanings are culturally accepted; they arise from and are defined by the society that uses them. This is the case for all the world languages. No one language is better than another as no one culture is better than another – they are as complex and extraordinary as each other; this position/belief is a useful starting point for nurses who want to understand and be resourceful for people from other cultures and communities.

Here is a list of the nine world language families and their origins:

Afro-Asiatic: Semitic – Arabic
Altaic: Turkic – Turkish
Austro-Asiatic: Mon-Khmer – Khmer
Austronesian: Malayo-Polynesian – Tagalog
Dravidian: Tamil – Kannada
Indo-European: Germanic – English
Niger-Congo: Volta-Congo – Dogon
Sino-Tibetan: Chinese – Mandarin
Uralic: Finno-Ugric – Hungarian

We must be able to communicate in some way with people and therefore if we are not able to do this, then nursing patients of any culture become very difficult or impossible. We cannot nurse people without communicating and of course there will be barriers to effective care and treatment

that arise when we do not fully share the other person's language or culture. Such barriers can lead to misunderstanding, misdiagnoses and mistreatment. For some patients this means extended time in the hospital, which impacts their lives and the lives of their families (Sharples, 2013).

Intercultural communication must be undertaken with the understanding that the rules that govern languages change between languages. There are some, as above, that tend to remain static; however, other aspects of language such as tone, intonation, loudness, emphasis, speed, pauses, plurals, gender negation, affirmation and word order will differ slightly. For example, in Japan subordinates will speak loudly to their bosses as a show of respect, but in the United Kingdom this could appear disrespectful.

In the United Kingdom, people like eye contact when speaking as a sign of trust and to show you are listening. In parts of Africa and South Asia, such eye contact is more likely to show disrespect. Southern European people will use more direct eye contact than people from the United States who in turn use more than people from the United Kingdom. So the words and how they are transmitted, the distance between the speakers, how we show we are listening, the changes due to gender and status all require consideration and attention when engaging with people from different language cultures (Giger, 2013).

Effective communication skills are essential when caring for people with mental health problems (Smith, 2014), and especially when helping someone from another culture or minority ethnic group. When considering the issues related to intercultural communication, perhaps the greatest challenge of all is that of language barriers. However, communication requires knowledge about the person's culture as well as his or her language.

For example, Schott and Henley (1996) argue that:

> **Every language is part of a culture and has its own cultural feature. It is often assumed that it is easy to communicate with clients whose first language is not English but who speak English well. In fact, people who retain features of their mother tongue that clash with those of English often unintentionally cause offence or give the wrong impression. Such misunderstandings can be difficult to overcome because they are often subtle and unrecognised.**
>
> *(Schott and Henley, 1996, p. 69)*

As children we develop our language within our own community. We develop accents (how we pronounce a word), dialects (words used within the wider community but not nationally), idioms and metaphors (local 'sayings'). So, for someone from Lancashire, England '*gi' o'er moitherin' me*' is easily understood as '*stop annoying me*' but someone from Southampton would probably have difficulty understanding this deep accent and dialect.

Emphasis in utterances conveys different meanings. In British English, we tend to emphasize the point we want to make. In other languages (cultures), the point of the sentence may be made more quietly to draw attention to it and its significance (Burnard and Gill, 2008; Sharples, 2013).

Inevitably, such subtle linguistic differences may be misinterpreted in mental health. For example, people who speak quickly and/or loudly may have their behaviour interpreted as a symptom of hypomania or grandiosity. Alternatively, people who speak slowly or quietly may be labelled as depressed, shy or anxious.

The amount of eye contact that is made may also differ in other cultures. In Western culture, looking people directly in the eye may denote honesty and straightforwardness, but in other

cultures it may be interpreted as challenging and rude. In Arabic cultures, people like to share a great deal of eye contact, and not to do so may be interpreted as disrespectful. However, in South Asian cultures and in Australian Aboriginal cultures direct eye contact is generally regarded as aggressive or even confrontational.

Linguistic conventions are often very complex and subtle, and again require a great deal of understanding and consideration. The convention in English of saying 'please' and 'thank you' presents problems for some languages. For example, in Urdu there is no equivalent for these terms, and instead they are built into the verb. This may be interpreted as hostility or rudeness. However, sometimes it is not just a linguistic difference, but also a cultural one. In North America, for example, it is considered vulgar to use the word 'toilet', and people prefer to use the word 'bathroom' instead. By contrast, North Americans use the term 'fanny' to refer to one's backside, whereas in British English it is a slang word used to denote the female genitalia.

Schott and Henley (1996) stress that when people cannot be understood they may begin to feel nervous and anxious, and will inevitably become sensitive to the non-verbal signals of others. They may remain quite passive and silent, avoid eye contact and avoid initiating conversations or prolonging them. They may also give simple yet inaccurate answers (e.g. 'yes' to everything) simply because they cannot explain themselves. Finally, they may avoid situations that they find difficult to cope with. For someone who is already distressed, these difficulties may compound their feelings of inadequacy and low self-esteem. Furthermore, behaviours such as passivity may be misinterpreted as depression, social avoidance or anxiety.

In 1992 Perry highlighted the need for greater sensitivity and self-awareness when caring for someone from a black or minority ethnic population. Of particular importance is the need for white staff to recognize and confront the overt and covert messages about black people from their own culture. These may often result in the internalization of negative feelings.

Perry (1992) makes the following points:

> **When a white mental health worker becomes involved therapeutically with a black client, he or she carries a legacy, which affects the context and outcome of that relationship. How can workers begin to discuss how powerlessness and racism affect mental health unless they have already acknowledged and begun to deal with their own prejudices? Without such preparation there is danger that the power imbalance experienced by black people in society will be reproduced in the 'therapeutic relationship' and the client's mental health will suffer. The client may become angry and demoralised and feel the therapist does not listen and is incapable of empathising with his or her problem. The therapist may be unaware of the dynamics behind the apparent 'failure' and so will conclude that black clients are not receptive to counselling.**
>
> *(Perry, 1992, p. 63)*

Therefore, unless attention is paid to language and communication needs, clients from a different background are at risk of receiving inadequate or inappropriate care, and health service staff may make decisions based on inadequate information.

Corsellis and Crichton (1994) argue that service provision needs two elements: first, reliable channels of communication, and second, the delivery through these of a service that is appropriate to the background and needs of the individual. More specifically, they advocate

more mental health professionals that have a second language and/or interpreters that hold a qualification in mental health.

WORKING WITH INTERPRETERS IN MENTAL HEALTH SETTINGS

Given the barriers that can present themselves in the communication environment, the provision of interpreters can be central to clients receiving good-quality care (see Chapter 1). Interpreters are qualified individuals who are able to translate complex and sensitive information between the client and the practitioner. All hospitals and services have a duty to provide interpreters for people whose first language is not English and who would struggle understanding the assessment and treatment process. The National Register of Public Service Interpreters is an organization that finds interpreters, monitors their conduct and maintains a register of qualified people (see: http://www.nrpsi.org.uk/).

Qualified and registered interpreters follow a code of conduct that should ensure the patient's confidentiality. Using a reputable interpreting agency can also safeguard from unprofessional behaviour more common when using an unregistered individual.

Nurses and healthcare practitioners must avoid using partners, other relatives, friends and even children to interpret for them (see Chapter 1). In most cases, complex, delicate and sensitive information needs to be discussed, and this could cause embarrassment and compound the client's distress. This may result in people withholding vital information or negatively impact on family relationships. One nurse recounted the following experience:

> **It was a Saturday night when Mrs A was admitted to the ward. Try as I could there were no interpreters available. Mrs A was very upset, crying and threatening to harm herself, and we were worried about her safety. As a last resort, it was decided to ask Mrs A's teenage daughter to interpret for us. It turned out that Mr A had been having an affair and that the family business had been in some trouble for some time. Mrs A's daughter didn't know about this situation, and you can imagine her shock and disbelief. It taught me a big lesson. Children, whatever their age and the situation, shouldn't be used in this way – they have a right to be protected just as people have a right to have their feelings kept confidential. In that situation we ended up with the daughter in a terrible state as well as the mother. From then on we made sure that there was always someone on call to interpret for us, but it's a shame that a teenager had to undergo so much trauma because of our inadequate services.**

Reflective exercise

1. Consider this narrative and determine what it tells us about the culture that this woman could be from.
2. Have you had an experience like this as either a student or a qualified nurse?
3. What was the outcome and what did you learn from it?
4. Consider after reading this chapter and others in this book what you might know now to manage the situation such as the one above. Identify the knowledge you would require to manage this situation.

Over the past 30 years, much effort has gone towards increasing the numbers and skills of community interpreters, particularly those who work in health and education settings. Whilst government bodies expect service providers to use qualified, proficient and effective interpreters, as yet there are no governmental guidelines, bodies of scrutiny or accreditation frameworks to support the development of high quality provision (Cambridge et al., 2012). However there is now a National Register of Public Service Interpreters (see: http://www.nrpsi.org.uk/about-us.html) that actually keeps a register of qualified interpreters and even has its own Code of Conduct (see: http://www.nrpsi.org.uk/for-clients-of-interpreters/code-of-professional-conduct.html).

Working with interpreters in mental health services requires sensitivity and commitment on the part of the practitioner, the client and the interpreter. It is an aspect of mental health care that may not take priority when funding is limited. However, if people are to receive care that is individualized and comprehensive, then interpreting services must become a central communication strategy for the nurse whose communication skills and ability to form a therapeutic alliance may be compromised by language barriers.

RACISM AND INTERCULTURAL COMMUNICATION

People from black and minority ethnic groups/communities may already face racism and hostility because of perceived differences, and this may be compounded by the stigma of having a mental health problem. Mental illness, particularly schizophrenia, is synonymous with the notion of danger, and the association between black people and violence perpetuates this stereotype. This double discrimination may actually prove to be of greater disadvantage for women, that is, being black, having a mental illness and being female (i.e. more likely to be diagnosed with a mental illness).

However, central to these issues are the effects of racism on mental health. The extent to which racism contributes to mental health is an important question, but one that may get overlooked. For example, racism is a contributing factor to the maintenance of social and economic deprivation, which is itself a contributing factor in poor mental health. Moreover, as Fernando (1986) has argued, racism itself causes depression by knocking self-esteem, which may evoke a sense of helplessness and powerlessness in the individual.

Thomas (1992) argues that being black affects people's psychological development in the same way as being male or female. The ways in which people behave and respond towards us shape us as individuals and influence our sense of self.

A black colleague related the following incident:

> **I can be in a good mood, going to work in the morning full of the joys of spring, minding my own business, when something can upset me. It's usually a chance remark or something stupid that people say or do. Like the other day. I went into a shop to buy a paper; the woman served everyone else in the queue and deliberately left me till last. She didn't speak to me or give me any eye contact, I could tell that she resented me; she was so cold and stand-offish. By the time I got to work I felt like the pits. It's not the direct in-your-face abuse that gets you down, I can cope with that. It's the subtle things that aren't always obvious to everyone else – they're the worst.**

If you are reading this narrative above and English is not your first language, you may find some of the words being used are not understood. This is important for us as authors of this chapter to relay the conversation as it was expressed by our colleague in his own words. His reflection on the event clearly had implications for how he felt as an individual person as well as someone who clearly believed himself to have been racially abused. The fact that this was not unusual was a concern, of course, and the scenario expressed clearly offers us an insight into different kinds of communication between people in that shop.

The detrimental effects of overt and covert racism and the undermining effect that this may have on a day-to-day level may cause people immeasurable distress. In the past there was a trend to promote services that were 'colour-blind' in their approach. Colour-blind care and treatment assumes that everyone is equal and therefore that everyone should be treated in the same way, irrespective of culture, race or ethnicity. At the heart of this notion is equality, but in reality it may, paradoxically, result in everyone being treated as 'white', leading to inequality.

Now all services must provide staff with equality and diversity training that reflects the Equalities Act (2010). This law of the United Kingdom addresses discrimination against people with nine '*protected characteristics*' including race, religion or belief and disability all of which may support the needs of people with mental health problems in accessing a fair service. Using a transcultural approach to providing mental health care would therefore seem to be an ideal way forward to support the patient and help the nurse and the organization stay on the right side of the law, as well as offering the patient and the nurse an enhanced approach to the delivery of a better quality of care.

Transcultural therapy, for example, addresses the limitations of Western models of therapy, which may separate the mind and body and may not address or recognize the power of racism and the different contexts of people's lives. It also addresses the issues of racism that may occur within a therapeutic relationship. (See Chapters 4 and 5 regarding health and illness beliefs.)

Within a therapeutic relationship it could be argued that there is a possible unequal relationship between, for example, a white therapist and a black client. This imbalance of power needs to be addressed through the process of race awareness training, through clinical supervision and by self-awareness and self-knowledge.

In contrast, where the client and the nurse/therapist have similar backgrounds and cultures, sociocultural factors may be taken for granted. Counselling may be an example of this. In Western cultures the individual is placed at the centre of the therapeutic process, and choice and empowerment may be given a high priority. However, in Eastern cultures people may view themselves and their whole identity in terms of the family. The pursuit of individual goals may conflict directly with the wishes and/or needs of the family, and this may in turn cause tension, antagonism and further distress, and possibly even deterioration in the person's mental state.

However, a report by the Joseph Rowntree Foundation (Netto et al., 2001) demonstrated that although the uptake of counselling was still low for South Asian people, those that had used it found it to be beneficial. They seemed to derive increased self-esteem and a feeling of comfort from counselling. Factors that were important included the opportunity to communicate in one's own language, the opportunity to speak with someone of their own gender (particularly for women) and someone from the same community/ethnic background.

In many Eastern cultures, great importance may be attached to a person's relationships with others. Kuo and Kavanagh (1994) discussed Chinese beliefs about and perspectives on mental health. For example, interpersonal relationships may be held together by a hierarchy of social roles that tend to restrict personal choice and individual action while promoting a group response over individual action. For example, Confucian philosophy demands that people behave in certain ways according to their own social status, valuing compliance and self-control in order to avoid conflict. In Chinese traditional medicine, the concept of balance and the dual forces of yin and yang are central to good mental health. Kuo and Kavanagh suggest:

> **In conventional thinking, harmonious personal relationships are the basis of psychosocial equilibrium. The keys to survival, peace and happiness are harmony, interdependence and loyalty.**
>
> *(Kuo and Kavanagh, 1994, p. 555)*

They go on to stress that these values are in sharp contrast to American culture, which is frequently characterized by competitiveness, independence and change. It is argued that interventions may need to focus on interpersonal relationships, adjustment to others' expectations, and negotiation skills. An interesting study undertaken by the University of Nottingham in 2011 investigated 'the mental health support needs of international students with particular reference to Chinese and Malaysian students'.

EXERCISE

1. Read the Executive Summary in its entirety and then consider these findings in relation to what we have already been discussing.

See Box 10.3 for key findings and conclusions as well as recommendations.

Box 10.3 Key findings, conclusions and recommendations (University of Nottingham, 2011, p. 5, Executive Report)

Key findings and conclusions

- International students have greater support needs and need more targeted information in comparison to UK students.
- Students from mainland China have significant additional barriers to accessing mental health support compared with Malaysian and home students.
- The project identified a complex range of cultural differences.
- In addition to the common challenges faced by all international students, Chinese and Malaysian students face particular barriers to seeking help. When seeking help, differences of culture and language are their major concerns.

continued

Box 10.3 Key findings, conclusions and recommendations (University of Nottingham, 2011, p. 5, Executive Report) (continued)

- Stigma relating to mental health is a major barrier for many international students and is particularly acute within the Chinese and Malaysian populations.
- The tutor and academic staff support system is perceived as the most important source of help and students made the most use of these services in comparison with other support services on campus.
- The university website and Welcome Week induction are vital information sources for Chinese and Malaysian international students to learn about support services before, and after, arrival.
- Good awareness of cultural differences for staff working with international students was identified as a particular need.
- Training in cultural beliefs and awareness, particularly for those involved in delivering health care to international students, needs to be given high priority and organisational support.

Recommendations

- Increase students' awareness of services, knowledge of Western health care approaches and understanding of mental health by providing clear and culturally tailored information and/or workshops to Chinese and Malaysian students.
- Increase cultural awareness and understanding of students' mental health needs among professionals and university staff through professional training courses and online information, particularly for tutors involved in personal support.
- Provide specialist awareness training for those professionals working within the mental health arena. Understanding the impact of cultural and language difference, as well as making good use of culturally appropriate community, and other, services is central to overcoming existing barriers to the access of services.
- Increase the use of interpreters (bilingual workers are likely to be a great asset but likely to be limited in supply).
- Rationalise the collection of data, particularly the recording of ethnicity, nationality and first language, to facilitate the analysis and development of services.

Communication skills of mental health nurses and other health care workers in the field of mental health generally are possibly the most important means of enabling people to gain a sense of self and to communicate and express their distress. In working with those from other cultures, who may speak a different language or who may have different ways of communicating, nurses may be faced with unique challenges. However, this challenge may present opportunities to improve nurses' skills in communication and self-awareness.

Consider the following case study.

Case study

Yusuf is a 19-year-old man in the first year of a course in chemistry at the local university. He lives with his mother and father, who describe him as a quiet but polite young man. He is the second eldest of four children, two of whom live at home. Yusuf has been spending long periods at home in his bedroom, locked away from the family. His father, who is a devout Muslim, says that Yusuf is becoming obsessed with religion and he feels that his son is becoming very distant and difficult to talk to. Yusuf has grown a beard and started to wear traditional Islamic dress, whereas previously he had been wearing Western clothes. He prays every 4 hours, getting up in the night. The only time he leaves the house is to attend the Mosque. He rarely spends time with his younger brothers and sister (something he used to do), and this morning he hit his 14-year-old sister, Jasmine, saying that she was 'Satan's daughter'. His mother and father are extremely distressed, saying that they are in despair. His mother speaks a little English and is crying quietly.

How would you ensure effective and therapeutic communication?
Use the following points to help you to make informed decisions.

- Find a quiet place to meet. It would be preferable to assess Yusuf at home and to meet him in his own environment (e.g. to assess how he lives and how he gets along with his family).
- It would be useful to speak to both parents, so it may be necessary to get a link worker with a good knowledge of mental health to speak with Yusuf's mother as well as his father.
- A broad mental health assessment will be needed, taking into account Yusuf's religious and spiritual needs. This may include information gleaned from his parents.
- Assess his physical state (e.g. sleep, appetite and signs of recent weight loss).
- Assess his social interactions. Does he still have friends? Does he still mix with his peer group? How has he been coping at university? How does he spend the day?
- Assess his psychological state. What is his explanation of recent events and circumstances? Why did he hit his sister? Why does he believe that she is 'Satan's daughter'? Does he have thoughts of harming himself or anyone else? Does he hear voices? Does he feel that he has special powers? Does he feel that he is being controlled by anything or anyone?
- It is vital to elicit from the family whether they feel that Yusuf's behaviour is appropriate for a young man of his age, and how they feel about his behaviour in terms of his religious beliefs and practices. Has anyone else in the community commented on his behaviour? Has anyone spoken to the elders in the Mosque? What are their views?
- It may be useful to ask his father if he had similar problems or patterns of behaviour in his youth. Is it usual in his peer group?

continued

Case study

- Is there any mental illness in the family? What are the family's views on mental illness?
- Ask Yusuf what importance religion plays in his life. Has anything significant changed in his life recently? Has he felt stressed in any way? Has he suffered any threats or persecutions recently in his life? Is anyone intimidating him?

If Yusuf is admitted to the hospital, the following points may assist his stay there.

- He needs appropriate care to accommodate his religious beliefs. For example, he will need somewhere quiet and private to pray. It may be relevant to ask the family to bring in appropriate articles such as a prayer mat, a compass, a copy of the Qur'an and clothing for him to wear in accordance with his religious needs.
- He will also need an appropriate diet and should be offered a choice of halal food.
- He will need to be offered appropriate facilities for personal hygiene (i.e. running water to wash with, a jug for washing after using the toilet, and the opportunity to wash before praying).
- He may feel uncomfortable mixing closely with women and may find it easier to relate to a male key worker. Be aware that he is likely to find the hospital a strange and disorientating environment. He may also be vulnerable to exploitation and may need some degree of protection. His key worker needs to engage the family in order to inform them and discuss Yusuf's progress and care.
- Yusuf may wish to receive spiritual guidance while he is in hospital. With his permission, it may be useful to contact leaders at the Mosque who will be able to maintain contact with him. The key worker and other staff may need to give Yusuf the opportunity to discuss his spiritual needs and beliefs.
- Key workers need to be aware that Yusuf's parents may be consulting traditional healers and/or alternative medicines from home (i.e. Pakistan or within the community).
- Yusuf's parents and family need to be kept fully informed of his progress and must be given opportunities to express their concerns and fears for their son.
- The key worker needs to ensure that Yusuf has time and space to consider his spiritual needs.

CONCLUSION

The relationship between culture, race and ethnicity and mental health is both controversial and fraught with difficulties. Central to these difficulties are the issues related to racism and discrimination, and some argue that the starting point for the provision of transcultural care in mental health is to challenge oppressive and discriminatory practice in Western psychiatry (Fernando, 1991).

Mental health nurses are in an ideal position to promote the needs of patients from other cultures. They are often in close proximity to patients, and their capacity to form close,

long-standing relationships with patients and their families can play a central role in helping to provide holistic and sensitive care. However, at the heart of this undertaking is the need for nurses to understand and confront overt and covert racism in mental health, psychiatry and the organisations that deliver and procure care.

Central to this is the need for self-reflection and an honest approach to one's own prejudices and preconceived ideas. In mental health nursing, this premise is perhaps underpinned by the promotion of such support mechanisms as clinical supervision, the concept of self-awareness and the practice of reflection. When considering transcultural mental health issues, there needs to be sensitivity and it is sometimes necessary to suspend and challenge our ideas about 'normality'. Thus, if we are to provide quality services that are appropriate and responsive to people's needs, we must listen and involve people in those services, in addition to being willing to learn, understand and respond to the world from someone else's perspective.

CHAPTER SUMMARY

1. Mental health problems occur in all cultures, but are manifested differently and are culturally determined.
2. Good communication skills are essential for caring for people with mental health problems, and thus interpreting and translating services are needed as a priority.
3. Nurses need to be sensitive to issues relating to prejudice and stereotyping of people from black and minority ethnic groups with mental health problems.

FURTHER READING

Basqui, T. J., Hoy, K. and Shannon, C. 2014. A systematic review and meta-analysis of ethnic density affect in psychotic disorders. *Social Psychiatry and Psychiatric Epidemiology*, 49(4), 519–529.
An interesting article looking at the relationship between community cohesion and psychosis in mentally ill individuals.

Bhui, K. and Bhugra, D. 1999. Pharmacotherapy across ethnic and cultural boundaries. *Mental Health Practice*, 2, 10–14.
An extremely useful and interesting article that examines psychotropic medication and minority ethnic groups.

Kline, R. 2014. The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England. https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf (accessed 10 April 2017)
This article gives an interesting perspective of the power positions of white and BME NHS workers in twenty-first century London.

Endrawes, G., O'Brien, L. and Wilkes, L. 2007. Mental illness and Egyptian families. *International Journal of Mental Health Nursing*, 16, 178–187.

This article discusses Egyptians' beliefs about mental illness and looks at how families cope with a mental illness in the family. It also describes the Zar cult and the belief in the evil eye, magic and evil possession.

Littlewood, R. 1998. *The Butterfly and the Serpent. Essays in Psychiatry, Race and Religion.* London: Free Association Books.
This is an extremely interesting and in-depth analysis of transcultural psychiatry from an anthropological perspective.

WEBSITES

http://www.mmha.org.au/
Multicultural Mental Health Australia. This is a very interesting and informative website that aims to build greater awareness of the issues in relation to mental health for people from culturally and linguistically diverse backgrounds. It discusses a new framework for care that has been developed for their multicultural community. This also has an excellent group of personal stories told in different ways from people with a range of mental health issues. (See: http://www.mhima.org.au/finding-our-way.)

http://www.mentalhealthcare.org.uk
This website provides a range of different information sources on mental health problems experienced by adults as well as young people. This site also has a wide range of short videos and linked information for both professionals and service users. These would also be an excellent addition to teaching and learning in practice.

http://www.nrpsi.org.uk/about-us/professional-standards.html
This website gives information about public service interpreters, keeps a register of the interpreters and is developing robust quality assurance in interpreting services.

https://www.kingsfund.org.uk/audio-video/alternative-guide-mental-health-care-england (accessed 10 April 2017)
This is a short video produced by the Kings's Fund. It has a very different approach to illustrating the issues related to developing a mental health problem but the messages about examples of what can be classed as mental illness are very well illustrated through three short case studies.

https://www.evidence.nhs.uk/search?q=barriers+to+communication+with+different+cultures (accessed 10 April 2017)
This site is the National Institute for Health and Care Excellence (NICE) Evidence Search for Barriers to Communication with Different Cultures. It offers a wide range of reports and other documents related to inter-cultural communication.

http://collections.europarchive.org/tna/20100509080731/library.nhs.uk/ethnicity/

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CHAPTER 11

Caring for the health needs of migrants, refugees and asylum seekers

Moira McLoughlin, Angela Darvill and Karen Holland

INTRODUCTION

Migrants, refugees and asylum seekers are not a new or recent phenomenon. In the twenty-first century, war, persecution, political unrest, hunger, conflict, adverse economic conditions and social upheaval have led to significant demographic changes and the migration of populations around the world. However, some healthcare professionals may feel ill-equipped to deal with the complex medical and social needs of asylum seekers and refugees. Refugees and asylum seekers are often considered a single homogeneous population but the two groups have different needs and risk factors. There is also much diversity within these groups as people originate from different parts of the world and have differing experiences and backgrounds.

This chapter will focus on the following issues:

- Migration and health
- The universal legal definitions of refugee and asylum seeker status
- The healthcare needs of refugees and asylums seekers, focusing on mental health, children and young people's health, the effects of torture and women's health

MIGRATION AND HEALTH

Migration can be defined as the movement of people from one place to another, with further subdivision into internal migration, when people migrate within the same country or region, for example, moving from Manchester to Plymouth, or international migration, when people migrate from one country to another, for example, Mexico to the United States.

Some key migration terms:

Emigration – When someone leaves the country of origin
Immigration – When someone enters a different country
Economic migration – Moving to find work or follow a particular career path

Social migration – Moving somewhere for a better quality of life or to be closer to family and friends
Political migration – Moving to escape political persecution or war
Environmental migration – Moving to avoid natural disasters such as flooding

The United Kingdom has a long history of receiving migrants, refugees and asylum seekers, indeed the number of people migrating to the United Kingdom has been greater than the number emigrating since 1994 (Hawkins, 2016). For example, in post-war Britain, the United Kingdom drew from the Indian subcontinent and the Caribbean in order to help rebuild the economy including the National Health Service (NHS).

Winklemann-Gleed (2006) reported on a number of issues from her study into migrant nurses in Britain. In particular was the shortage of nurses in the NHS and this has always been linked to a 'staffing crisis' leading to potential deterioration of care. Although there appears to have been a reduction 'in the 1970s as a result of changes in immigration law and by the mid-1980s it was negligible' (p. 25) the issue of employing nurses from other countries has not really disappeared and there have been many additional time periods when the issue of bringing in nurses from other countries has caused the media to report it. (See the website list for examples.)

More recently, in nursing and health care, Buchan and Seccombe (2012) found that NHS nurse staffing numbers fell in 2011 for the first time in a decade, and at the same time the overall numbers of newly qualified nurses entering labour markets also fell because of a reduction in the number of commissioned places for undergraduate nursing. So, many hospital Trusts have been recruiting from abroad to try to fill the vacancies and raise staffing levels.

This recruitment of nurses from other countries however has brought about a change in the requirements of the UK Nursing and Midwifery Council (NMC). There is now a 'two part process to gain registration' which tests competence through:

- Part one – Computer-based multiple-choice examination which is accessible around the world for applicants to access in their home countries.
- Part two – Practical observed structured clinical examination (OSCE) which will always be held in the United Kingdom (http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/immigration-rules-and-the-points-based-system/overseas-nurses-and-midwives).

EXERCISE

1. Access this site and read the Rules for Employers and overseas nurse applicants.
2. If you are a student, consider how your route to registration in the United Kingdom differs from others.

How do we therefore define 'a migrant' or in simple terms, someone who migrates (*moves from one place to another*)?

In the House of Commons Briefing paper (Hawkins, 2016) on Migration Statistics it asks the question: Who is a migrant? These are the definitions used:

> **A migrant can be broadly defined as a person who changes their country of usual residence. Conventionally, there are three different ways of making this definition more precise.**
>
> **A migrant can be:**
>
> - **Someone whose country of birth is different to their country of residence.**
> - **Someone whose nationality is different to their country of residence.**
> - **Someone who changes their country of usual residence for a period of at least a year, so that the country of destination effectively becomes the country of usual residence. (p. 4)**

He states however that:

> **Each definition has its strengths and weaknesses**
>
> **The first definition is consistent and objective, but it classifies as migrants people who were born abroad but who are nevertheless nationals of the country in which they live (e.g. children born to armed forces personnel stationed in foreign countries).**
>
> **The second definition excludes nationals born abroad, but it also excludes people who have recently changed their country of residence and acquired the nationality of their new home country. There is also the possibility that when a person is asked their nationality, their self-reported answer may express a sense of cultural affiliation rather than their actual legal status; a problem that does not arise when asking someone their country of birth.**
>
> **The third definition is objective but it poses problems of measurement. People's intentions regarding their length of stay in a country are subject to change: those people who intend to stay longer than a year may leave more quickly, while those who initially intend a short stay may become permanent residents. This definition is also somewhat arbitrary; as the number of people meeting it would change were the minimum period of residence longer or shorter than a year.**
>
> **In practice, each of these definitions is used in certain circumstances, depending on the data in question.**
>
> *(Hawkins, 2016, p. 4)*

Migration is often described as being caused by two factors: the 'push' factor (conditions that force people to leave their country such as oppression, violence or civil war) or 'pull' factor (the promise of better prospects, for example, employment opportunities). In recent years, the 'pull' factors in Western Europe – demand for labour, good economic conditions and opportunities – has attracted migrants from other parts of Europe, in particular former Eastern bloc countries. Citizens of the United Kingdom are also migrating to countries such as Australia, New Zealand and North America, 'pulled' by favourable economic conditions and the promise of better pay and conditions.

However, even when the 'pull' factors are high and seemingly beneficial, migration can be a stressful experience and migrants can still experience a period of adjustment. This period of adjustment occurs when a migrant needs to find out about the new culture they are entering (Polay, 2012). This means possibly learning a new language, new customs and social norms, and encountering new foods and new laws. This is known as 'acculturation' and is a process of adaptation, which, depending on the individual, may take time (Helman, 2007).

Ngo (2008) undertook a critical examination of acculturation theories and informs us that:

> **The concept of acculturation, conceived in the fields of anthropology and sociology in the 20th century, has been used to explain the dynamics involved when people from diverse cultures and backgrounds come into continuous contact with each other.**
>
> *(Online, Volume 9, Issue 1)*

Some migrants prefer to fully embrace the cultural norms and values of the host country. This process is known as assimilation (Faulkner, 2011). According to Faulkner (2011), migrants may either assimilate, semi-assimilate, or do not assimilate at all. Assimilation may also depend on factors such as the ability to speak the new language, adapt to the new environment, attain social and economic well-being and an individual's gender. So, for example, older women may have considerably more difficulties than younger men in gaining employment. Some migrants prefer to remain apart, retaining the practices and values of their culture but many people find a middle way. The process and experiences of living and adjusting to a new culture are individual. However, migration is a stressful and challenging time as people adjust to new lifestyles and new communities. Migrants often leave behind family and friends and their grief and sense of detachment may surprise them, as may the feeling of being an 'outsider'. Some may experience bouts of acute homesickness and isolation and expectations of the better life they expected might not be met (Johns, 2014, p. 1).

Reflective exercise

Think of a time when you were in a strange place. You may have been on holiday or working in an unfamiliar town or country.

1. What was it like? Describe your feelings.
2. How did your behaviour change as a result of being a stranger?

To put this in perspective and a real case scenario consider what is happening across Europe at present (2015–2016) where the migration of people from Syria, for example, is currently having a major impact on their lives and those in countries and communities where they have migrated to. This is mass migration of people from one country to anywhere except that country and is a result of the impact of warring factions on their daily lives, with many families having family members who have been killed. The media reports that many children can be found amongst the large groups of migrants, and that a large number of them are without any family at all.

This BBC News item offers an explanation of the migrant crisis facing Europe and uses seven charts to explain why this has become a major issue facing governments and aid organisations worldwide. (See: http://www.bbc.co.uk/news/world-europe-34131911.)

The use of the term economic migrants is an interesting addition and the definition of one kind of migrant status. This leads us to consider the difference in status of refugees and asylum seekers.

Refugees and asylum seekers

There is a difference between refugees, migrants and asylum seekers. A review by Aspinall and Watters (2010) concerning refugees and asylum seekers 'from an equality and human rights perspective' used the following definition to understand their data collection and findings:

> **The term 'asylum seeker' is usually reserved for those who have applied for asylum and are awaiting a decision on their applications and those whose applications have been refused.**
>
> - **The term 'refugee' is usually adopted for those who, having applied for asylum, have been given recognised refugee status. In addition, it also usually encompasses those who have received 'exceptional leave to remain' or 'indefinite leave to remain' (now included in the term 'humanitarian protection').**

(Aspinall and Watters, 2010, p. 2)

These terms are considered helpful in this chapter. There are other similar ones of course. Some of these can be seen in the following organisation websites:

- UNHCR – The UN Refugee Agency: http://www.unhcr.org/pages/49c3646c137.html
- The Refuge Council: http://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/the_facts_about_asylum
- Migration Watch: http://www.migrationwatchuk.org/briefing-paper/70
- UNHCR: The Facts: Asylum in the UK: http://www.unhcr.org.uk/about-us/the-uk-and-asylum.html

Reflective Exercise

1. Access all these sites and read the meaning of these terms and also put them in perspective by reading many different reports concerning refugees and asylum seekers.
2. Consider some of these issues – some of which can be distressing to some readers – and discuss with a colleague or your mentor how these issues can be impacting on the care given to many of these people by the health and social care services.

Here is an example of one person looking for refuge and safety:

> **I had no husband left, no children, no friends, no roof over my head, no past, in short. I never imagined that when I left Rwanda, I would feel abruptly and profoundly torn apart. Especially as the bodies of my husband and children lay in common graves, in this country which never wanted us. As far I was concerned, I had nothing left to do on that soil, which swallowed up my family in an ocean of torture, humiliation, suffering unmatched – perpetrated by our brothers the Rwandans. I thought myself disgusted with my own country.**

('The Road to Refuge', BBC, 2001: http://news.bbc.co.uk/hi/english/static/in_depth/world/2001/road_to_refuge/default.stm)

Since 1945, civil war, unrest and violations of human rights in some countries have led to large numbers of people seeking refuge in other countries or people being internally displaced in their own country. Refugees may flee war, political oppression, violence or sexual or physical abuse.

The 1951 Refugee Convention was established after the World War II to ensure that atrocities such as the Holocaust were never allowed to happen again. The United Kingdom is one of 142 countries that signed up to it. The UNHCR uses the words of Euripides (431 BC) to describe the plight of being a refugee: 'There is no greater sorrow on earth than the loss of one's native land'.

Asylum is a human right and is recognized by the 1951 United Nations Convention. Under the convention, countries are obliged to consider the application of anyone who claims refugee status and grant that person refuge on the basis of evidence.

Under the 1951 United Nations Convention, a refugee is a person who:

> **… owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear is unwilling to avail himself of the protection of that country.**
>
> *(Convention Relating to the Status of Refugees, United Nations, 1951)*

A refugee therefore is a person whose asylum application has been successful. An asylum seeker is someone who has submitted an application for protection under the Geneva Convention and is awaiting a decision from the UK Home Office.

The number of refugees in the worldwide population is difficult to measure but reports on World Refugee Day in June 2014 suggested that the number of refugees, asylum seekers and internally displaced people worldwide has, for the first time in the post-World War II era, exceeded 50 million people (United Nations High Commission for Refugees [UNHCR] and for the United Kingdom: http://www.unhcr.org.uk/).

In the United Kingdom, the number of applications for asylum in 2013 was 23,507, a rise of 1.164 (+8%) compared with 2012. This figure remains low relative to the peak number of applications in 2002 (84,130) and similar to levels seen since 2006 (23,608). In 2013, the largest numbers of applications for asylum to the United Kingdom were from nationals of Pakistan (3342), followed by Iran (2417), Sri Lanka (1808) and Syria (1669). As can be seen here, world events have an effect on asylum seeking, for example, the increase in the number of applications from Syria since the outbreak of the civil war in early 2011. In 2013, there were also 1174 asylum applications from unaccompanied asylum seeking children, although the Home Office disputes some of the asylum applicants who claim to be children.

Contrary to widespread beliefs and misconceptions, the United Kingdom received a lower number of applications than other European Union (EU) states. The Migration Observatory (http://migrationobservatory.ox.ac.uk/briefings/migration-uk-asylum) in their summary of asylum in the United Kingdom offer the following numbers for 2014:

Key points

- Asylum applications (excluding dependents) rose from 4,256 in 1987 to a peak of 84,133 in 2002. They stood at 32,414 in 2015.
- Asylum applicants and their dependents comprised an estimated 7% of net migration in 2014, down from 44% in 2002.

- In 2015, 64% of asylum applications were initially refused. A majority of refused applicants lodge appeals.
- In 2015, 35% of appeals were allowed.
- Men made up nearly 3 out of 4 (73%) main applicants for asylum in 2014.
- The UK received 3% of asylum claims made in EU countries (plus Norway and Switzerland) in 2015, making it the tenth highest recipient of asylum claims.
- In 2015, 1,194 Syrians were resettled through the Vulnerable Persons Resettlement Programme.

Having considered the issues impacting on asylum seekers and refugees, we need to consider how communities and individuals view these group of people and their lives.

The image of asylum seekers and refugees

It is good to have clear definitions of the terms *asylum seeker* and *refugee* as they are often used in association with negative perceptions and with derogatory terms such as 'bogus', for example 'bogus asylum seekers' and 'scrounger'.

Indeed Kofi Annan, Secretary-General of the United Nations, was reported to have said:

> **let us remember that a bogus asylum-seeker is not equivalent to a criminal; and that an unsuccessful asylum application is not equivalent to a bogus one.**

This statement was used in the UNHCR paper on The Facts: Asylum in the UK:

> **What is a bogus asylum seeker?**
>
> **There is no such thing as a bogus asylum seeker or an illegal asylum seeker.**
>
> **Everybody has a right to seek asylum in another country. People who don't qualify for protection as refugees will not receive refugee status and may be deported, but just because someone doesn't receive refugee status doesn't mean they are a bogus asylum seeker.**
>
> *(UNHCR, 2013, p. 2)*

Smart et al. (2007) noted that reporting in the media is often factually incorrect and unbalanced and then again in 2012 the Refugee Council submitted evidence (on how the UK newspapers wrongly portrayed asylum seekers and refugees) to the Levenson Inquiry on the UK Press (Newspapers). Headlines such as 'Record Number of Asylum Claims' can be misleading, given that at the end of 2013 the population of refugees and asylum cases and stateless persons in the United Kingdom made up just 0.23% of the population. That is 126,055 refugees, 233,070 pending asylum cases and 205 stateless persons. The United Kingdom might be seen as a desirable destination for refugees and asylum seekers as people may have friends or family here, and English is widely spoken throughout the world, but by comparison, Pakistan has 2.4 million Afghan refugees who fled the Taliban regime.

Statistics from a UNHCR Report in 2011 showed that 80% of the world's refugees are living in developing countries, often in refugee camps (http://www.unhcr.org). Asylum seekers may sometimes be described as 'over-running' a country and are likely to be viewed with suspicion or as 'cheating the system'. Conversely, the term refugee tends to evoke sympathy. Therefore, use of language is important.

In the United Kingdom, refugees and asylum seekers have often been viewed with suspicion, and indeed with many misconceptions about them as a group of people given this title and subsequently individuals that find themselves as a result living in many local communities (see Box 11.1).

Misconceptions are highlighted in a story told by a colleague working in local authority housing:

> **I was contacted one day by a senior healthcare professional who said that he had had a number of people in his practice complaining that some Muslim asylum seekers resident in a house in the area were deliberately stirring up feelings by their display of a picture of Osama Bin Laden in their front window. It was felt by many passersby that this was upsetting and was creating racial tensions in the area. On investigation the housing worker found that the house was inhabited by a group of Portuguese migrant workers employed in the local canning factory and that the picture was actually Jesus Christ. They had put this in the window, as they couldn't afford curtains at the time.**

Box 11.1 Facts about asylum seekers and refugees

Facts and information concerning asylum seekers and refugees can be found on the following websites. Please read the briefing papers, policy documents and reports found on these sites in order to be able to understand the social and political context in which many of these men, women and children of all ages have experienced prior to arriving in the United Kingdom and other countries worldwide.

1. https://www.refugeecouncil.org.uk/assets/0003/4969/Ref_C_TILII_June_2015.pdf
   Example: http://www.refugeecouncil.org.uk/assets/0003/7935/England_s_Forgotten_Refugees_final.pdf
   Report: Refugee Council
   England's forgotten refugees:
   Out of the fire and into the frying pan
   Josephine Basedow and Lisa Doyle
   May 2016
2. http://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/facts_about_asylum_-_page_1
   Example: http://www.refugeecouncil.org.uk/glossary:
   Terms and definitions
   Glossary of terminology relating to asylum seekers and refugees in the United Kingdom.
   This glossary is intended as a basic explanation of terms used across the refugee sector.
   The definitions are not legal definitions
3. http://www.scottishrefugeecouncil.org.uk/assets/0000/6115/SRC_The_Facts_Booklet.pdf
4. http://www.scottishrefugeecouncil.org.uk/assets/0001/1369/Anti-stigma_ briefing_FINAL.pdf

A briefing paper by the Scottish Refugee Council, Mental Health Foundation and SeeMe (Scotland's national campaign to end the stigma of mental health. Title: Refugees, mental health and stigma in Scotland).

Key points

1. To claim asylum is a human right.
2. The number of people seeking asylum in the United Kingdom has fallen in recent years.
3. The average age of the refugee and asylum seeker population is generally lower than that of the indigenous population.

HEALTH CARE FOR REFUGEES AND ASYLUM SEEKERS

The healthcare status of migrants is generally lower than the indigenous populations but for refugees this may be compounded because of previous experiences. Refugees by definition are people who have been forced or 'pushed' out of their home country. They may have experienced political oppression, torture, violence, social injustices and economic hardships prior to seeking refuge elsewhere. They may have experienced or witnessed intimidation, violence or rape and may well be scarred both emotionally and physically by their experiences.

For asylum seekers, the decision to leave their own country may have been sudden and secretive so they may not have had time to sort their affairs or say farewells. They may have also been living in refugee camps, which can be hostile and frightening places. The process of flight itself may have been lengthy, dangerous and traumatic (Reynolds and Muggeridge, 2008; Johns, 2014). On arrival in the host country asylum seekers may feel a sense of immediate relief that they are in a safe haven while at the same time they are faced with difficult bureaucratic processes, language problems and the uncertainty of the application and decision-making process. They are likely to be short of money, and living in an unfamiliar country where the climate is often colder than their home country.

Reflective exercise

Consider this scenario: You are woken up in the middle of the night to be told that you and your family must escape now as your life is in danger. You have 10 minutes to pack your bags.

1. What would you take with you?
2. What has led to you making that decision?
3. How do you think you would feel?

Although refugees and asylum seekers are not a homogeneous group, studies demonstrate that, in general, their health is poorer as a result of the process of migration (Carbello, 2006). They suffer poorer health in their country of settlement mainly as a result of adverse effects of poverty and poor housing. These patterns are similar to the general health and well-being of minority ethnic groups. There is evidence that many migrants, upon arrival in the United Kingdom, are

relatively healthy but that good health can deteriorate over time. There is an excellent briefing paper by Jayaweera from the The Migration Observatory at the University of Oxford on the health of migrants in 2014. It offers an overview of the key issues impacting on both the physical and mental health of migrants as well as access to and use of health care. They recognize however that this is just a briefing, an overview of their situation, and have added an impressive reading list for those wishing to know more (access this at: http://www.migrationobservatory.ox.ac.uk/resources/).

However, many people accessing care may be a bewildering and confusing process, not of course just for asylum seekers and migrants.

Crawley's (2010) research indicated that many asylum seekers arriving in the United Kingdom have very limited knowledge of the UK healthcare and welfare systems.

A young woman from a refugee community notes:

> **Like here it is small and slow and if you don't have an appointment … the doctor is always busy and there are so many people all the time … you can't find somewhere to sit … In the surgery … a lot of people just sitting and a long time to wait … That's if you don't have an appointment …**
>
> *(Williamson et al., 2009, p. 37)*

Consider the following case study to explore some of the health issues faced by refugees and asylum seekers.

Case study

Marika and Bernard have been married for 15 years. They arrived in the United Kingdom with their children a year ago, coming from a refugee camp in Malawi. The couple has three children aged 13 years, 7 years and 14 months old. They are finding it difficult to adjust to life in Britain. They live in local authority housing and receive income support and child benefit. Marika finds it difficult to cope in winter – the children struggle to wake up in the morning and they can't afford new clothes for winter. Bernard can't speak English so finds it difficult to communicate and is unable to help the children with their homework. One of the children is showing aggressive behaviour at school and there have been reports from school that he is bullying other children. Marika is tired much of the time; she complains of terrible headaches and seems hostile and angry to people trying to help her.

In Malawi, the family experienced various kinds of trauma, as they had been separated while fleeing the war. They had been united in the camp but Marika and Bernard found out that their son, aged 7, had been recruited into the army as a child soldier.

The family avoids discussing issues from the past and say that they are happy to be in the United Kingdom. However, the health visitor notices that Marika is neglecting herself and that Bernard seems to be away from the home. She advises Marika to see the GP but she refuses saying that she will be 'OK'.

The following information may help the reader to gain more understanding of the complex issues that impact this family's health and well-being.

Refugees come from a variety of backgrounds and often show great resilience in their capacity to survive. Their experiences are likely to be diverse and their health status may be dependent on varying factors such as their prior experiences or the healthcare provision in their home country. For example, for some refugees and asylum seekers, their home country may not have had good immunisation programmes and this might make them susceptible to communicable diseases in the United Kingdom. Common communicable diseases are tuberculosis (TB), hepatitis A, B and C, HIV/AIDS and parasitic infections (see WHO: Europe website for the most up to date information on all issues related to migration and health: http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health).

Some refugees might not understand the role of the GP or may have differing experiences of healthcare provision, so, for example, they might expect a hospital referral or may be accustomed only to dealing with medical staff and may not be used to receiving help or advice from other healthcare professionals, such as nurses.

Some refugees may suffer from the adverse consequences of living in camps for extended periods. For example, TB can spread rapidly through cramped and squalid living conditions in refugee camps. Women in particular may have been subject to sexual violence and abuse in refugee camps (Kelly and Stevenson, 2006; Girma et al., 2014).

Burnett and Peel (2001) and subsequently Robjant et al.'s (2009) systematic review exploring the implications of detaining asylum seekers identify an association between the experience of immigration, detention practices and poor mental health of asylum seekers and refugees. They may be placed in low quality temporary accommodation or inadequate or poor housing conditions and are likely to suffer adverse health consequences such as respiratory problems, dermatology problems and infections. Poverty has a negative effect on physical and mental health and thus good living conditions may be central to maintaining good health.

In its guidance on mental health and health care for migrants, the World Psychiatric Association (2011, p. 3) notes:

> **refugees are perhaps the most vulnerable of all migrant groups to mental and physical health. Lack of preparation, attitudes of the new country, poor living conditions, poor or lack of employment and variable social support all add to this vulnerability**

Torture

It was estimated that between 5 and 30% of asylum seekers had been tortured (British Medical Association, 2002). Torture is defined as 'the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under control of the accused' (Article 7.2(e) excerpt of the Rome Statute of the International Criminal Court; cited in Burnett, 2002). Methods of torture commonly experienced are beating, slapping, kicking, burning or electric shocks. Women and some men may have been subjected to rape or other forms of sexual violence. The perpetrators of torture may be the military, police, government agencies or even health workers. The physical effects of war and torture may include:

- Fractures and crushed bones;
- Wounds and burns which may become infected;
- Keloid scars;

- Head injuries, which may result in epilepsy, poor memory and concentration;
- Ear damage – slapping round the ears is common during interrogation, resulting in otitis media;
- Eye damage from detention in dark rooms;
- Land mine injuries;
- Partial loss of vision;
- Dental problems caused by torture (Burnett, 2002; McColl et al., 2012).

Henley and Schott (2001) note that in some countries doctors are involved in carrying out torture and thus medical instruments that are normally considered benign (e.g. syringes and oxygen masks) may be associated with methods of torture and may reawaken terrors. People who have been tortured may not want to disclose or discuss their experiences, fearing shame or believing that they should and could be allowed to forget their experiences. However, during physical examinations they may become extremely anxious; they may feel frightened about being touched and may not cooperate with some medical and nursing procedures. They may be distrustful of healthcare workers and avoid seeking help as a result. A study by the International Rehabilitation Council for Torture Victims and reported by Towers (2013) looked at the issue of 'recognising victims of torture in national asylum procedures' (see the website for the full report) and offers this explanation about the importance of the documenting of torture by asylum seekers – and for this study, the countries of Europe, North America and the Pacific:

> **The Istanbul Protocol,14 adopted by the United Nations in 1999, sets out international standards for states and health and legal professionals, on the investigation and documentation of allegations of torture and other ill-treatment. Although the principles in the Istanbul Protocol are not legally binding, its adoption by the United Nations gives it global authority as an instrument that should be used to guide standards for the documentation and investigation of torture. By detailing the process of documenting medico-legal evidence, the Istanbul Protocol's key objective is to contribute to achieving justice and to the fight against impunity in cases of alleged torture and other ill-treatment. However, given the principle of non-refoulement of asylum-seekers, the proper investigation and documentation of allegations of torture and other forms of ill-treatment is often a key element of an asylum claim. Therefore, in asylum-seekers' cases, the systematic documentation of allegations of torture according to the Istanbul Protocol can also provide a foundation for both the asylum claim itself and for the rehabilitation of the victim. (p. 10)**

Men seeking asylum may well have experienced torture and with it physical and possibly sexual violence. In searching the literature there is very little information across many of the aid agencies and research articles. There is allusion to this, especially male rape, but it is very much an un-talked about subject, probably in part due to the lack of disclosure by men seeking asylum who may have experienced this during torture or outcome of war. Peel (2004), in his chapter on men as perpetrators and victims (of rape), offers the following insight into why this act is often undisclosed, and may be one of the reasons why there is specific lack of focus on this in the literature, unlike the amount of evidence available on women and rape:

> **Male rape is rarely disclosed. Neither victims nor perpetrators want to talk about it. In the South African Truth and Reconciliation Commission, male victims of rape never used the term. They sometimes said that they had been 'sodomised', but more commonly described the experience as having a metal rod pushed through their anus.1 In the one press account of male rape in the Croatian press during the war there, the victims were Muslim, described in a way that diminished their masculinity and sexuality, and the perpetrators were Serb, portrayed as aggressive perverts. No society wants to admit to being party to male rape, but this quiescence leaves victims isolated and rape seen as a sexual act rather than one of the exercise of power and the infliction of humiliation. (p. 61)**

He believes that men 'find it very difficult to disclose rape' and that they will hide this even during therapy for torture, until they have complete trust in their therapist.

Patel (2009) states that therapeutic approaches to torture should:

> **… not aim narrowly to 'fix' symptoms but serve a significant function in bearing witness to atrocity, in offering humanity, compassion and honest communication … Experiences of powerlessness, hopelessness and worthlessness need to be acknowledged and explored.**
>
> *(Patel, 2009, p. 131)*

Since writing the second edition of this book the availability of information, policies, research, and even what local authorities in the United Kingdom are putting in place to care for any asylum seeker, refugee or migrant that seeks help from their community, has become more available on the web. This is not always of benefit to readers of this book who wish to learn more in order to care for patients, and we advise caution when accessing some of these resources. The ones at the end of this chapter have been checked for content.

Key points

1. Refugees and asylum seekers are likely to have been through adverse experiences that may negatively affect their health and well-being.
2. They are entitled to receive NHS treatment and care in the United Kingdom.
3. They may be vulnerable to health problems related to poverty and poor housing.
4. Many will have experienced torture and require therapeutic understanding as well as the services of various health and social healthcare organisations.

MENTAL HEALTH ISSUES

As we have seen in the above section on torture, many asylum seekers and refugees suffer from health and well-being problems and Bhugra and Jones (2001) and Fazel et al. (2005) argue that, as a group, migrants are also more vulnerable to mental health problems. Thompson (2001) noted that the incidence of mental health problems in refugees was five times higher than the general population. Refugees and asylum seekers commonly experience mental health problems that

often are related to their past experiences. Some might show signs of anxiety, depression, guilt or shame as a result of their previous traumas such as rape, torture or oppression. (See evidence offered at the various websites at the end of this chapter.)

There is no doubt that refugees and asylum seekers are vulnerable to emotional health problems either owing to their past experiences or to their current experiences (e.g. living in poor housing, attempting to adapt to new circumstances or being the victims of racism). Carey Wood et al.'s (1995) research study for the Home Office on the settlement of refugees in Britain noted that two-thirds of respondents said they had experienced some form of anxiety or depression. Burnett and Peel (2001) also noted that refugees and asylum seekers in primary care often show signs of panic attacks, agoraphobia, disturbed sleep patterns, poor memory or concentration. In 2009 the mental health charity MIND produced a report on how to improve mental health support for refugee communities – through using 'an advocacy approach'. This report offers an insight into many people's experiences of mental health, such as isolation, disturbed family relationships and other problems and how health services are trying to help.

McColl et al. (2008, p. 452) argue that 'the psychological health of asylum seekers in the UK is affected by the "seven Ds"':

1. *Discrimination*: Being stigmatized by the host countries. This could be through the media or political processes.
2. *Detention*: There is evidence that the health of people held in detention centres worsens as access to health care may be impaired (Fazel and Silvoe, 2006).
3. *Dispersal*: Asylum seekers generally have no choice in where they are sent and they may be moved many times. They may be cut off from social networks.
4. *Destitution*: Asylum seekers receive benefits that amount to 70% of the lowest level of income support.
5. *Denial of health care*: Asylum seekers and refugees are entitled to free access to primary health services in the United Kingdom, although failed asylum seekers are no longer eligible for free secondary health care except in cases that are deemed life threatening.
6. *Delayed decision*: There is evidence that the length of the asylum process adversely affects health (Steel et al., 2006).
7. *Denial of the right to work*: Asylum seekers are prevented from undertaking work. Lack of work can inhibit social integration and increase poverty.

The majority of asylum seekers and refugees has no mental illness and are able to use their own coping strategies and resources to survive adverse circumstances. However, there is evidence that refugees and asylum seekers are more likely to suffer depression, anxiety and post-traumatic stress disorder (PTSD) than the general population (Burnett and Peel, 2001; Fazel et al., 2005).

More recently, Bogic et al.'s (2012) results are consistent with other studies suggesting that war and migration experiences can be associated with mental disorders in long-term settled war refugees.

The traumatic experiences that some refugees and asylum seekers may have experienced might lead to people behaving in ways that may be described in Western frameworks as PTSD. The symptoms of PTSD include:

- Anxiety
- Irritability
- Reliving the experiences in flashbacks or nightmares
- Avoidance of reminders of events/increased nervous system arousal (e.g. hyper vigilance, jumpiness, excessive anger, sleep problems)
- Low mood
- Frequent crying
- Headaches, palpations and sweating

The use of the term PTSD is perhaps controversial. It is a 'Western' concept and healthcare workers should exercise caution before labelling people. However, the effects of trauma may be hidden as this health visitor describes:

> **I had one refugee family from [country]. The children were on the register for child abuse … she (the mother) always appeared very depressed. And we could never get to the bottom of this. And she would just say she was fine, she was fine. Things were happening at school and they were really concerned and I would see them at home again … Eventually it all came out that her father was murdered in front of her when the country was in upheaval and there was a coup and the country was in anarchy. She was very traumatized. Her husband then left her with all the children. She has no other relatives or children around … She is actually suffering from post traumatic stress, you know, and it has been quite some time before we actually found out that her father had been executed in front of her.**
>
> *(Drennan and Joseph, 2005, p. 160)*

It is important therefore to be cautious about labelling people with a psychiatric disorder as this may compound the sense of shame, fear and isolation they may be experiencing. Furthermore, being diagnosed with a mental health problem may carry taboo or stigma and this may further alienate people. However, if the person continues to express or show signs of psychological difficulties, help from mental health services may be required.

Burnett (2002) noted that symptoms that may require specialist help include:

- Consistent failure to perform basic tasks;
- Frequently expressed suicidal ideas or plans;
- Social withdrawal and self-neglect;
- Behaviour or talk that is abnormal within the person's culture;
- Aggression.

McColl et al. (2008) argue that by focusing on PTSD as a disorder, health workers might neglect current adversities causing distress. There is some indication that post-migration stresses may

affect an individual's emotional well-being (Iverson and Morken, 2004). The National Institute for Health and Care Excellence (NICE) published a new NICE Pathway in 2015 which included the care of refugees and asylum seekers:

1. The National Institute for Health and Care Excellence (NICE) published a new Pathway in 2016 for the management of Post Traumatic Stress Disorder, which included the care of refugees and asylum seekers.
2. (See this website for the source of this Pathway plus many other resources to support your care of patients from these communities which you may have contact with in your practice: https://www.nice.org.uk/guidance/cg26). Working with people in emotional distress.

   Understanding and helping people who have mental health problems is challenging and, to date, there is little concrete evidence to facilitate the process. However, there are some general principles that can be applied in practice.

   Understanding the challenges and experiences of being an asylum seeker and refugee may help the health worker to empathize with the person's present difficulties. This might include gaining an understanding of the geopolitical context of the person's country of origin. It may also be useful to consider the language, cultural norm and expectations of healthcare provision and the medico-legal issues involved in the person's background. Information about health care is accessible from the World Health Organization (WHO), and the BBC website provides up-to-date, essential information on the geopolitical context of nations. (See http://www.bbc.co.uk/news/world/africa as an example from one country.)

   Other agencies such as Asylum Aid, Health for Asylum Seekers and Refugees Portal (HARP) and the Refugee Council provide up-to-date information, support and guidance (see the Website list at the end of this chapter).

   It should also be remembered that asylum seekers and refugees are not a homogeneous group so there is no one method or approach to working with them. Health workers need to approach people with the principles of cultural sensitivity and cultural competence (Papadopoulos, 2006). This embraces the notion of clients as partners in care and the creation of an environment in which ideas, information and issues are shared, understood and exchanged between the client and the professional.
3. *Working with people who may be experiencing mental health problems*: There are some general guidelines when working with people from refugee and asylum seeker groups who may be experiencing mental health problems.

Prior to the assessment process, the health worker should find out what language the person prefers to speak in and arrange interpreters accordingly. Care and sensitivity should be taken when arranging interviews as past adverse experiences may impede the process of assessment. For example, if a woman has suffered sexual violence she may feel more comfortable being interviewed by female staff and using a female interpreter. It is also important to remember that some people may express their distress through physical symptoms and that they may describe their problems as physical and not psychological. In some cultures, mental health problems may be taboo or stigmatizing and thus people may prefer to express their distress through physical symptoms such as headaches, weakness or pain.

Some people may find that the process of being listened to is therapeutic in itself. Allowing a story to be told may be helpful and supportive. Burnett (2002) advised listening but not expecting too much in one session, with Burnett and Fassil (2003) citing a Glasgow GP who stated:

> **The catharsis of being listened to for long enough and patiently enough can be all that is needed to restore health to nearly a normal level.**
>
> *(Burnett and Fassil, 2003, p. 36)*

However, it must not be assumed that people should be expected to talk in order to recover and, indeed, talking through a problem may not be considered appropriate or helpful. Other individuals may be extremely suspicious or fearful of disclosing personal information believing it may lead to denial of refugee status. Tribe (2002) notes that the idea of talking to a psychiatrist who is a stranger may be alien, particularly as he or she may be associated with 'madness'.
Discussing distressing events may be indicated but this should be undertaken at a pace and at a time when people feel comfortable. Rather than directly questioning about experiences of torture and violence Burnett and Fassil (2003) suggest the following as a gentle indirect opener:

> **I know some people in your situation have experienced torture and violence. This is something I might be able to help you with. Has this ever happened to you?**
>
> *(Burnett and Fassil, 2003, p. 38)*

Weaver and Burns (2001) suggested that discussion of distressing events should be done in a safe environment without probing or pushing a refugee or asylum seeker to disclose information about trauma. They advise the health worker to take cues from the client about whether talking about the trauma is therapeutic or retraumatizing. The worker should be prepared to stop the discussion if it seems to be harmful.

Counselling may also be an unfamiliar concept for some people who might not be accustomed to talking about themselves or discussing intimate issues outside the close family. Refugees from Mozambique describe 'forgetting' as their usual way of coping with difficulties and Ethiopians call this 'active forgetting' (Summerfield, 1996).

Burnett and Fassil (2003) recommend building on people's strengths and giving them control. For example, assisting people in meetings to make decisions may help them to feel less powerless. They quote the stance of a psychologist in London who described the importance of 'being a witness' and of 'politicizing and not pathologizing anger'.

Mental health needs and emotional distress may not be addressed by talking therapies but instead some people may respond to activities or help that reduces their social isolation. Gorst-Unsworth and Goldberg's (1998) study of 84 Iraqi refugees found that depression was more closely linked to poor social support than with a history of torture. In this specific group depression was found to be more common (44%) than PTSD. Depression was linked to poor social support, separation from children, lack of political organizations in exile, few confidants and social activities. Mental well-being may benefit from improved housing, acceptance in communities and access to links and friendships with people from the host country and their own cultural groups. Practical help in finding employment or education may be as helpful in allowing people to gain improved self-esteem.

Working with asylum seekers and refugees and hearing stories of trauma and oppression may be painful and difficult for health workers, and support and supervision should be sought on a regular basis.

EXERCISE

1. Please watch the following YouTube video: My journey – An Asylum Seeker's Experience and answer the questions it poses at the end. This video tells a story through drawings, song and music. A couple of the comments attached to the video are negative but in fact it helps understanding of the difficulties facing asylum seekers and refugees. (https://www.youtube.com/watch?v=cW4Zuktuq_I: accessed 18 May 2017.)

Key points

1. When working with people who have experienced trauma, care must be taken as being diagnosed with a mental illness may be stigmatizing and may compound people's distress.
2. Mental well-being may be enhanced through helping people to feel more in control of their social and environmental situation.
3. Working with people who have experienced trauma may be overwhelming and distressing for the health professional and guidance and support is advisable.

WOMEN'S HEALTH

The complex experiences of women refugees in their countries of origin and in refugee settings can have a major impact on their health. As a group, women refugees are highly vulnerable and are more likely to suffer deteriorating health. They are less likely to have English language skills or to be literate. Women with children may neglect their own health but may bring their children for health consultations (Burnett, 2002). The women may also be experiencing health problems as a result of sexual incidents such as HIV and AIDS, rape and sexual violence and also they may be pregnant when they arrive in their new country.

Some asylum seekers and refugees come from countries where exposure to HIV/AIDS is greater. Women may have been placed at risk of HIV/AIDS in countries where sexual crime is perpetrated by the military who may have a higher incidence of HIV. Other women may have been forced into paid, unprotected sex in order to survive and may again be at risk of HIV. HIV/AIDS continues to carry a stigma and many people may fear that disclosure of their experiences may bring shame. Alternatively, these experiences may evoke strong negative emotions in people who may wish to forget the incidents rather than repeat them. Other people may fear that a positive HIV test will lead to deportation from the United Kingdom. This is a recent excerpt from a report on the NAM-Aidsmap website, a UK organization that began as the National Aids Manual (NAM) which grew and now has a very different work in relation to 'sharing information about HIV and AIDS':

Pregnant women and families

In the case of HIV-positive women who are pregnant, the Home Office policy notes that additional care is required and instructs that the case be referred to the Asylum Support Medical Advisor. If accommodation is available, dispersal should be to an area where they can reasonably be expected to access their current medical facilities. In the event a baby is born to an HIV positive mother and is due to be dispersed out of the area she can access treatment at her current medical facility so that continuity of care is ensured. There are already special guidelines for the dispersal of pregnant women from initial accommodation, but it is a requirement that doctors confirm a woman's HIV status in writing if specialist treatment is required so that other arrangements can be made.

(See further details at: http://www.aidsmap.com/Dispersal-of-people-living-with-HIV/page/1507639/)

Many women will have experienced serious sexual crimes on their person during war time but also in their own families by their husbands. Rape has been used through history as a weapon of warfare to degrade and humiliate a nation (UNICEF, 2017; IRC, 2014). Women are more likely to be the subject of sexual or physical violence and many have stories that go untold. In most countries, sexual violence is a shameful and taboo subject, leaving many women feeling guilty. Some women may prefer to suffer in silence or in isolation, fearing rejection or hoping that the memories of atrocities may, in time, fade. Women may be shunned by their communities and families. They might also find intimate examinations and investigations such as cervical screening to be difficult. Women may express their distress through physical symptoms. For example, they may complain of frequent headaches, panic attacks or forgetfulness.

For other women, unwanted pregnancy may occur from sexual violence and rape and although termination of pregnancy may be stigmatizing and unacceptable, it may be a choice for some women. Women in this situation may need to have female workers and access to as much relevant information as possible. Should they also become pregnant because of these situations they may be vulnerable to health problems during pregnancy and childbirth. Access to antenatal care might have been poor in their home country and they may have suffered poor nutrition at home, in refugee camps, in fleeing and in their current circumstances as poverty and poor housing conditions compromise their health status.

EXERCISE

1. Keefe and Hage (2009) following their Vulnerable Women's Project produced a Good Practice Guide: Assisting Refugee and Asylum Seeking Women Affected by Rape or Sexual Violence (http://www.refugeecouncil.org.uk/assets/0001/7083/RC_Vulnerable_Women_GPG—v2b.pdf). This includes real-life stories of many women's experiences. Read the guide for an understanding of their situation in the United Kingdom and prior to being supported by this project.
2. If you are a midwife, there are other reports and information to help you understand the situation of women asylum seekers and refugees who are expectant mothers. Read this paper on dispersal of women (https://www.refugeecouncil.org.uk/assets/0002/6338/

ma_dispersal_summary_final.pdf) and MCarthy and Haith Cooper (2013) Evaluating the impact of befriending for pregnant asylum-seeking and refugee women, *British Journal of Midwifery*, Volume 21, no 6, 404–409.

CHILDREN AND YOUNG PEOPLE'S HEALTH

Children and young people claiming asylum are a particularly vulnerable group. Consider the following example:

> **One family we had in here, an [ethnic group] but living in [country].The child at that time when I met him was about 8 months old. The child was continually being brought to the clinic and to the GP's surgery, mainly for problems around eating … This family had problems. They've been the victims of torture in [country] and also the father of the family had been beaten up over here in a racist incident as well … I managed to work with the psychologist with that family around the eating problem … and the child is no longer being presented and he is a different child now.**
>
> *(Drennan and Joseph, 2005, p. 161)*

Refugee children are at risk of ill health. They may suffer from physical problems associated with their physical and social deprivation prior to entering the United Kingdom, for example, if they have been living in a country where healthcare resources are scarce. They may have endured difficult and traumatic experiences while in flight. For some children and young people, the flight experience may have been bewildering or frightening.

Central to the health development and well-being of any child is the ability of parents, carers or guardians to meet the needs of the child. In some cases, asylum-seeking and refugee parents may themselves struggle to cope and may have endured severe adverse experiences that might compromise their ability to care for their children. When caring for the health needs of any child, it is necessary to see them in the context of their family life, structure and context, but this is even more important in refugees and asylum-seeking families (see Box 11.2).

Box 11.2 Some questions that may be asked or considered when caring for the health needs of a child

Who is in this family?
How is the family made up?
Who is missing from the family?
What recent experiences have affected this family?
What was the status of the family in their home country?
What are the relationships between family members like? (Parents to children, children to grandparents, siblings)
Is there extended family nearby or is the family alone?
What relationships/connections exist outside the home?
How does the family see itself (e.g. complete, normal, incomplete, fractured)?

continued

Box 11.2 Some questions that may be asked or considered when caring for the health needs of a child (continued)

What are the strengths of the family?
How have they coped in adversity?
What are the positions in the family? (e.g. who is seen as head, if any, of the household?)

Health for children may be compromised *in utero* if the mother has left a country where there is poor antenatal care or poor nutrition. Pregnant women may also have low expectations of antenatal healthcare provision, or may be fearful or mistrustful of health services. Some children are born in countries where prolonged war, conflict or famine has led to poor child health facilities, which may lead to poor screening facilities and poor immunization programmes. Thus, routine screening for health conditions such as phenylketonuria or congenital dislocation of the hip may not have been offered. (Detailed information about immunization programmes is available from the World Health Organization [WHO] – see the list of Websites at the end of this chapter.)

Children from refugee families are more likely to be living in substandard or crowded housing or detention facilities and therefore are more prone to having accidents in the home, such as burns and falls. They are also more likely to have road traffic accidents, particularly if they have been brought up in rural areas (Levenson and Sharma, 1999; Peden et al., 2008). Refugee children and young people may also suffer from under-nutrition, particularly if they have been living in adverse circumstances such as refugee camps.

Other issues to take into consideration when working with families/children and young people are whether the child/family understands the importance health services attache to confidentiality. This may be vital when people are coming from countries where health service workers are involved in the perpetration of oppression, torture or violence. Families may also need help to understand the function of health visitors, school nurses and other health service personnel who may be involved in their care as these roles may be unfamiliar.

Other specific health issues that may be noted with children and young people are female genital mutilation (FGM) (see Chapter 6), tropical diseases and recurrent conditions such as malaria. Mulongo et al. (2014) discuss the evidence relating to the mental health needs of women exposed to FGM and importantly the mental health nurses' role in the future. It is also worth noting on assessment if the child or young person has any physical injuries resulting from war or torture. Some children and young people may even have been child soldiers.

School and school life may play an important role in the health and well-being of refugee children. It may represent an opportunity to belong and to become part of a community, to make friends and to learn. School may also represent a haven – a place of safety, security and stability for children and young people. School nurses can play an important role in helping children to access health care. However, school may also be a place where refugee children and young people are subjected to bullying and racial abuse. They may also find that they are behind in their schooling because their life has been disrupted by flight from war and conflict. Refugee children may also inevitably need to learn a new language and adapt to different ways of learning in school. Generally, it takes 2 years to acquire the expression of language to the level of the indigenous population. Their parents may also struggle to support their children in homework if, for example,

their English is poor. However, it is important to note that they are often very resilient and like many migrants are often determined and motivated to do well and succeed. Integration and inclusion in schooling is a lynchpin to the well-being of refugee and asylum-seeking children.

EXERCISE

1. Please access this YouTube video called Refugee Kids – The International Refugee Trust: https://www.youtube.com/watch?v=2N3ndNyuU2k (hosted by Teachers TV and produced by Big Heart Media). It offers an insight into a number of children's arrival in the United Kingdom and going to school.
2. Please consider the main issue they had in coming to the United Kingdom and being with other children in school and in the community.

Children and young people may be living in families where domestic violence occurs. This may be occurring between parents, and a partner's violent behaviour may be tolerated because of the violence he or she may have experienced. Children and young people may be witnesses to such violence and this may cause emotional distress.

There are also children escaping this kind of life and worse in their own country and they try to seek refuge and asylum in other countries such as the United Kingdom.

Lewis (2007) offers this insight into the experiences of children:

> **Afghan children Ramazan and Abdul-Khaliq admit they are haunted by their journeys, especially in their nightmares. Ramazan lost his family as they crossed a border on foot; rushing through a rough mountain terrain in the dead of night with hundreds of other refugees, they became separated in the chaos. 'I was shouting, calling their names', he said. Whenever I asked the smuggler [to help] he said be quiet, I will take you to your parents. I was crying. Some of them [fellow travellers or agents] were laughing. Others said: 'Don't worry, we will take you to your parents'.**
>
> *(Lewis, 2007, p. 1)*

Unaccompanied children are defined as those young people under the age of 18 years without adult family members or guardians. They are a particularly vulnerable group. Under the age of 15 years they will usually be 'looked after' by the local authority in the United Kingdom. They are usually defined as 'in need' and services are provided under Section 20 of the Children Act (Department of Health, 1989). They will be provided with foster care or residential home placement, an allocated social worker, a care plan, financial cash support and full leaving-care services. Those aged 17 and 18 years usually receive services under Section 17 of the Children Act (Department of Health, 1989) and may be living in bed and breakfast accommodation or hostels.

Nandy's report (2007) on children in the asylum process stated, '3,000 children come to the UK every year and claim asylum and that many more arrived with their families'.

This process and experience of asylum-seeking and becoming a refugee may lead children and young people to experience a range of emotions and feelings. Many are likely to have experienced terror, shame, grief, fear, helplessness and enormous anger. Children, for example, may have experienced imprisonment, beatings, rape, mines, bombs or gunshots. They may have been tortured

or have witnessed torture. They may have been forced into becoming child soldiers and may have inflicted violence on others. Some are likely to have experienced oppression in the form of persecution because of their family's religious or political beliefs, for example. It is likely that they have experienced loss of friends, family or siblings. They may also have witnessed or experienced violence.

Case study

A 12-year-old boy was referred by the local secondary school because of repeated aggressive outbursts that led to his permanent exclusion. He came from Angola where at the age of 8 he had seen his parents killed because one of his brothers had defected from the army. He and another brother were able to flee via Congo and came to London where they lived together. On interview it was found that he was having flashbacks and nightmares of his parents' killing.

(From Hodes, 2000, p. 64)

Children respond to such experiences in different ways, and they may feel under pressure to keep information secret. Children who have been separated from their families may face particular problems. Some feel that their parents have failed to protect them and may feel disconnected from their carers. Their emotional health may be compromised, which can result in problems arising in other areas, for example, they may refuse to go to school, or they may be disruptive in school and face exclusion. Other behaviours they may display are listed in Box 11.3.

Box 11.3 Behaviours exhibited by children (Burnett and Fassil, 2003)

- Withdrawal, lack of energy and lethargy
- Aggression and poor temper control
- Irritability
- Poor concentration
- Repetitive thoughts about traumatic events
- Poor appetite, overeating, breathing difficulties, pains and dizziness
- Regression (e.g. bed-wetting)
- Failure to thrive
- Nightmares and disturbed sleep
- Nervousness and anxiety
- Difficulty in making relationships with other children and adults
- Lack of trust in adults
- Clinging, school refusal
- Hyperactivity and hyper alertness
- Impulsive behaviour
- Self-harm
- Unexplained headaches, stomach aches or other body pains
- Memory impairment

Children and young people may also take on responsibilities at home caring for parents whose health and well-being may be compromised, or assuming other roles such as interpreting, if their language skills are better than their parents'. Children and young people may also be affected by their own parents' psychological state; adults may be preoccupied with the implications of their refugee status and the traumas they have suffered. Hence, parents may not be able to take care of their children's emotional well-being.

Children and young people may face the negative effects of the attitudes of the host country such as bullying at school or racism and hostility in the community. This may be especially difficult when their expectations of a country as a haven and a place of safety are dashed. Other factors such as poverty, unemployment, poor housing and loss of status may also undermine their sense of well-being.

Very few children need psychiatric care but they may instead need strategies to help them develop a range of coping skills and to improve their resilience (see Box 11.4). Care should be taken in labelling children and young people with a mental health problem as this may be stigmatizing.

Box 11.4 Strategies to help children develop a range of coping skills

- The negative effects of emotional distress may be ameliorated by having a key adult (ideally a parent) to have a close relationship with. This may help them to maintain and preserve a sense of belonging.
- Children and young people may need time and space to talk about their experiences. This may be facilitated by creative therapies such as art, music, drama and storytelling. However, they may not be able to articulate their stories as they might not have the language skills or vocabulary to describe their feelings. Also, they may live in families where it is not felt appropriate to express feelings, or parents and siblings may have experienced traumatic or difficult experiences. It may be beneficial to talk with a health worker in an environment where time is afforded and privacy is maintained.
- It is worth remembering that some children and young people may have experienced trauma or unpleasant events at the hands of adults.
- Children and young people may benefit from keeping links with their refugee community in order to develop and integrate their cultural identity. This might help them to feel connected and supported. It may help them come together in a group to discuss their situation among other peers who understand their stresses and issues. They may also benefit from being part of a local community, for example, a youth group, football team, etc.

Some families may avoid formal therapy with health professionals if the interviews remind them of traumatic adverse past experiences, such as torture and interrogation; parents might not be able to listen to their children's stories as they may be too painful. Hodes (2000) noted that some research demonstrates that many refugees, having escaped and survived terrible circumstances, may want to look forward and not back. For parents this might be expressed as their high aspirations for their children, preferring them to go to school rather than clinic or

therapy sessions. Support is important in helping to raise their self esteem and provide a sense of belonging. Helping them to acquire a 'normal life' and a sense of security and safety may be fundamental to this. Healthcare professionals can advocate for children and young people but a holistic approach is necessary where professionals work together to assess needs (e.g. health education and community links at the end of this chapter).

CONCLUSION

Refugees and asylum seekers have experienced great difficulties but it should be remembered that despite adversities they may often show great resilience and courage. They are not a homogeneous group; they come from diverse countries and backgrounds and their individual experiences are unique. They may have specific health needs as well as communication difficulties. It is important for health workers to take into account their past experiences and the 'road' they have travelled. Evidence shows that for many people there is a need to feel accepted and part of the community, and to be given the opportunity to get on with their lives.

CHAPTER SUMMARY

1. Women and children from refugee and asylum-seeker communities are particularly vulnerable.
2. Women may suffer multiple and complex health issues if they have been subjected to sexual violence.
3. Children's emotional and social well-being may be tied into family health issues but schooling is often central to children and young people's well-being.
4. Men may also have experienced physical and sexual violence in their own country and may need much help in trying to both disclose and move forward from this experience.

FURTHER READING

Anonymous. 2007. *From Here to There: Sixteen True Tales of Immigration to Britain*. London: Penguin Books.

This book is a collection of personal accounts of migration to Britain. The stories are moving and provide an insight into the trauma and difficulties of migration and 'finding a place called home'.

Girma, M., Radice, S., Tasnagarides, N. and Walter, N. 2014. *Detained Women Asylum Seekers Locked up in the UK*. London: Women for Refugee Women (https://www.barrowcadbury.org.uk/wp-content/uploads/2014/01/Women_for_Refugee_Women_Report_Detained_29_Jan_20141.pdf).

Hosseini, K. 2003. *The Kite Runner*. London: Bloomsbury Publications.

This novel traces the story of Amir, a young Afghan boy, his life growing up in Kabul and his forced exile as a refugee to Pakistan.

Moorehead, C. (2006). *Human Cargo—A Journey Among Refugees*. London: Vintage Publications.
This book is a collection of essays in which the researcher has carefully documented the predicament of refugees and asylum seekers across the world. It is an interesting read with some alarming and harrowing stories of the plight and human cost of migration across the world.

Reacroft, J. 2008. *Like Any Other Child? Children and Families in the Asylum Process Believe in Children*. Barnardo's.
This report is about one of the United Kingdom's most marginalised groups – asylum-seeking and refugee children and families. Since 2002, we estimate more than 40,000 children have arrived or been born in the United Kingdom in asylum-seeking families

Tremain, R. (2008). *The Road Home*. London: Chatto & Windus.
This novel traces the story of an East European migrant, Lev, to Britain and his struggle to find work and accommodation. It is an interesting account of an 'outsider's' view of the United Kingdom.

WEBSITES

http://www.amnesty.org/
Amnesty International provides information and campaigns to protect human rights on an international level.

http://www.asylumaid.org.uk
Asylum Aid is an independent, national charity. They work to secure protection for people seeking refuge in the United Kingdom from persecution and human rights abuses abroad.

http://news.bbc.co.uk/hi/english/static/in_depth/world/2001/road_to_refuge/default.stm

http://www.better-health.org.uk/resources/research/race-health-driving-forward-race-equality-nhs
HARP (Health for Asylum Seekers and Refugees Portal) Harpweb consists of three websites, each developed in collaboration with health professionals working with asylum seekers and refugees in the United Kingdom. There is access to a range of information, practical tools and articles.

http://www.ons.gov.uk/ons/rel/migration1/long-term-international-migration/index.html
The largest independent producer of official statistics and recognised as the national statistical institute for the United Kingdom.

http://www.refugeecouncil.org.uk/
The Refugee Council. The aim of Refugee Council is to provide support and help to refugees and asylum seekers and to make information and advice available to them directly. The website provides some important information.

https://www.freedomfromtorture.org/

Medical Foundation for the Care of Victims of Torture (MFCVT). The Foundation has branches in London, Glasgow, Manchester, Newcastle and Birmingham. It provides services for survivors of torture, offering counselling, advice and various forms of therapy.

http://www.unhcr.org/

The United Nations High Commissioner for Refugees (UNHCR) is a humanitarian organization mandated by the United Nations to lead and coordinate international action for the worldwide protection of refugees. The website provides a huge amount of valuable information about the plight of refugees across the world.

http://www.who.int/en/

The WHO website contains a range of information about immunization programmes and other issues.

http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/immigration-rules-and-the-points-based-system/overseas-nurses-and-midwives (accessed 3 March 2016)

This is the NHS Employers site and page on recruitment of overseas nurses and midwives which outlines the NMC rules and regulations with regard to employment and expectations of standards of registration for nurses seeking employment from overseas.

http://www.unhcr.org/pages/49c3646c4b8.html

This site offers a wide range of publications from a whole world perspective, including legal publications, operational publications and if you insert the phrase health care into the advanced search place you will be able to access many publications related to health care of women, children, young people and men. Here is one on the rise of tuberculosis (TB): http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4b4c986d9&query=health%20care.

http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues

This site is the WHO site for migration and health issues across Europe.

https://www.youtube.com/user/unhcr: (accessed via Google on 13 March 2016)

This is the United Nations High Commissioner for Refugees (UNHCR) website and has numerous resources, information and videos concerning refugees.

http://www.irct.org/files/Filer/publications/MLRweb.pdf (accessed via Google 13 March 2016)

https://www.youtube.com/watch?v=PGjDNUtTX1w (accessed via Google 13 March 2016)

This is the story of a Dominican woman coping over time with mental illness when she arrived in Boston, MA. It is called: An Emptiness in My Heart: Coping with Mental Illness in a Foreign Land. It offers not just her journey but also commentary from her children (8 minutes long).

http://www.scottishrefugeecouncil.org.uk/how_we_can_help/other_useful_websites/sanctuary

On this site is a short film about asylum seekers in Glasgow that have willingly shared their experiences so that others can understand how they arrived there and why, along with the traumas they have had and also still experience. The asylum process is discussed and the impact of being asked questions. There are some stories from men and women that are very powerful and occasionally distressing (for the person). The short film is part of a bigger film which advises people to read this pack prior to watching the film. It is advisable to do this as well before this short film (http://www.scottishrefugeecouncil.org.uk/how_we_can_help/other_useful_websites/sanctuary). Check this same site also to read stories of many other asylum seekers.

http://www.scottishrefugeecouncil.org.uk/what_we_do/refugee_storieseport

On child injury prevention.

CHAPTER 12

Death and bereavement: A cross-cultural perspective

Karen Holland

INTRODUCTION

Death, dying and grief are personal life experiences that become very public when they occur in a hospital setting. The beliefs, rituals and customs associated with death in different cultures are extremely varied. This includes the nurse's own professional culture where, for a student nurse, meeting death for the first time is part of their initiation into the profession. As our society becomes more multicultural, both nurses and healthcare professionals are exposed to a wider range of spiritual and religious beliefs, which in turn influence the need for care practices to become culturally orientated. This chapter explores the meaning of death and bereavement in different cultures; it also examines various practices that nurses should adopt when caring for those who are dying, their family and friends.

This chapter will focus on the following issues:

- The meaning of death
- The meaning of bereavement
- Nursing practice and caring for the dying and bereaved, with particular emphasis on Jewish, Sikh and Muslim cultures

The examples used in this chapter illustrate the main issues for nurses in practice with regard to dealing with death and bereavement experiences, and they are in no way intended to convey a 'recipe' approach to care of the dying. Recommendations for good practice are included.

THE MEANING OF DEATH

Given its simplest meaning, death is the stage when a person ceases to exist in their previous 'physical form' (i.e. biological death). Two other definitions of death have been identified by Sudnow (1967), namely 'clinical death' and 'social death', the former being 'the appearance of death signs upon examination' and the latter 'when the individual is treated essentially as a corpse although still clinically and biologically alive' (Bond and Bond, 1986).

An example of social death can be seen in hospitals where patients are moved from the main ward area into side rooms if there is any possibility of them dying, or alternatively pulling the curtains round the bed. Death can occur at any time and for many reasons (e.g. surgical procedures for life threatening conditions, suicide, sudden illness, cancer, an accident or simply death without any specific cause, such as often happens in old age).

Determination of the precise point in time at which death occurs has become an important issue in today's technologically advanced society, especially when someone else can benefit through, for example, organ donation. An article written by the Muslim Law (Shariah) Council (1996) stated their view and ruling on organ transplantation, to the effect that they accepted 'brainstem death as constituting the end of life for the purpose of organ transplant', which they supported as a 'means of alleviating pain or saving life on the basis of the rules of Shariah'. This process can also be viewed as a form of 'social death' (e.g. when relatives are asked if the dying person is a donor and if not would they, as next of kin, consent to organ donation taking place). This ruling means that 'Muslims in the UK may carry donor cards, and live donation is seen as an act of merit' (Oliver et al., 2010).

Randhawa (2012) stresses the importance of clinical staff being able to explain in basic terms understood by non-medical persons what is meant by a definition of death in relation to organ donation, but at the same time being aware of what this could mean for different families and their beliefs and religion.

However, some cultures and religions will not believe in or accept this 'biomedical' interpretation of death. It is important to remember this when an actual diagnosis of the point of death is made because this is of major significance for any associated rituals. Many cultures (e.g. Chinese) regard death as a transition for the person who dies, and such an event is a time for rituals to take place (Pattison, 2008). These are known as 'rites of passage', and they occur when a person moves from one social status to another (e.g. birth, marriage or death). These rituals ensure that those who are dying or bereaved know what is expected of them. The way in which individuals experience death will therefore have a major impact on how nurses and healthcare professionals support the patient's families and relatives, and also how they cope with their own feelings when someone they have been caring for dies.

The issue of euthanasia, or assisted death, is also important to consider given the way this is often highlighted in the media. Sheikh and Gatrad (2000, p. 98) make it clear that 'Islam views life as sacred and a "trust" from Allah' and therefore both suicide and euthanasia are prohibited. However, they point out that 'undue suffering has no place in Islam and if death is hastened in the process of giving adequate analgesia then this is allowed … what is important is that the primary intent is not to hasten death'.

Purnell and Selekman (2008) point out the views of Jewish culture and religion, whereby active euthanasia is forbidden and is considered murder. However, they explain that 'passive euthanasia may be allowed, depending on its interpretation'. Anything that prevents someone dying 'naturally' or 'prolongs the dying process' is not acceptable and they point out that 'therefore, anything that artificially prevents death (e.g. cardiopulmonary resuscitation) may be possibly withheld, depending on the wishes of the patient and his or her religious views'.

Hollins (2009, p. 93) also points out:

> **Orthodox Jews may not accept brain death as a definition of death. The traditional understanding is that the body has to be without breath or heartbeat for a short period of time, which would then make resuscitation impossible. Some Jews may wish to use a**

traditional method in which a feather is placed over the nose and mouth of the deceased person as a means of detecting any breath.

According to Skultans (1980), death itself creates change 'in terms of individual loss and social disruption for the wider group' and because of this any rituals associated with death are extremely elaborate. However, this practice of death rituals is kept to a minimum in most communities in the United Kingdom today. For example, in many English homes there is no longer a ritual public display of mourning after death, such as the wearing of black clothes and armbands, although in Ireland the custom of the wake, at which family and friends gather to pay their respects to someone who has recently died, still remains.

EXERCISE

1. Find at least two private rituals that are carried out after the death of a person from different religions and cultures.
2. Consider how knowing about these will help you with caring for a dying patient and his or her family.
3. Some answers to Point 1 can be found in this chapter and others throughout the book and in the Appendices.

THE MEANING OF BEREAVEMENT

Bereavement is a term that is associated with dying and the events that follow death. Its meaning implies that those who experience this life event have suffered a loss and that something or someone has been taken away from them. Andrews (2008) points out that 'it is a sociologic term indicating the status and role of the survivors of a death' (i.e. they are the 'bereaved').

According to Cook and Phillips (1988), bereavement can involve four phases, as described in Box 12.1.

Box 12.1 Phases of bereavement (Adapted from Cook and Phillips, 1988)

- Shock, numbness and grieving (Phase 1)
- Manifestations of fear, guilt, anger and resentment (Phase 2)
- Disengagement, apathy and aimlessness (Phase 3)
- Gradual hope and a move in new directions (Phase 4)

A similar staged pattern was also identified by Kubler-Ross (1970) and consists of denial, anger, bargaining, depression and acceptance.

This model is very much a Western view of how people manage the grieving process or respond to a loss (Andrews, 2008), but these types of models have also been applied to other situations where loss is experienced. Examples are loss of cultural identity and social structure experienced as a result of migration or loss of homeland as with refugees (Bhugra and Becker, 2005). (See Chapter 11 for further discussion about the life experiences of refugees.)

The way in which individuals cope with or manage bereavement varies according to the culture to which they belong, and even within cultures there are individual differences. For example, when a Hindu person dies, the older women may continue to mourn in the traditional manner by wailing loudly to show their grief and the whole family 'may wear white as a sign of mourning, usually for the first 10 days after the death' (Henley, 1983b). Colour is significant in many cultures during the bereavement period following a death. In the United Kingdom, for example, black is still seen as symbolic of death and many people retain the practice of only wearing black as a mark of respect at a funeral. Black armbands are also symbolic of the period of mourning after death as is a period of silence, as experienced at a number of public events such as a football match when someone who is well known in the sport has died.

EXERCISE

1. Find out different colours, other than black and white, that are associated with both death and after-death periods in different cultures.
2. Make a note of all those that are relevant to patients and their relatives in your area of work.

'Grief' is an emotion that may follow bereavement and individuals experience and show their grief in different ways according to the culture to which they belong (Andrews, 2008; Pattison, 2008). However, the concepts of 'dying' and 'grief' are Western cultural concepts and this needs to be remembered when coping with the death of someone whose cultural beliefs differ from our own.

Grief is also experienced in different ways both individually as well as culturally. This can either be a physical response such as fainting or insomnia to aggressive behaviour (Pattison, 2008). A sudden or unexpected death may trigger complete denial that the person has died. How the patient died is also important and being denied access to their loved ones, as in the case of a serious infectious illness, for example, can cause long-term concerns on the part of close family members. This would be particularly important for individuals from cultures where there are specific death rituals to be undertaken or where they believe the person should not die alone (Galanti, 2008).

In Muslim culture and religion, relatives and friends visit the recently bereaved family in their own home. The dead are expected to meet God and, hopefully, find eternal peace. However, any prolonged grieving is discouraged and considered wrong, although according to Rees (1990) any traditional patterns of mourning are expected to be followed. Mourning, according to Andrews (2008), 'is the culturally patterned behavioural response to death' and each culture will have its own way of responding.

Bhugra and Becker (2005) offer a definition by Eisenbruch (1991) for the concept of cultural bereavement:

> **The experience of the uprooted person – or group – continues to live in the past, is visited by supernatural forces from the past whilst asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds**

> **constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life.**
>
> *(Bhugra and Becker, 2005, p. 19)*

Eisenbruch (1991) developed a diagnostic interview for Southeast Asian refugees to help him understand their 'grief reaction, and start the process of healing' (Bhugra and Becker, 2005). Since the last issue of this book the world has seen many situations, as a result of physical, environmental and human cause, where the outcome has been many refugees trying to find a new home country for themselves and their families. These people have not only lost family members but are also displaced from everything they have culturally known in their own country. We have seen the images of what can only be described as 'outpourings' of grief displayed in the media from these families. This imagery does not need words; however, we cannot interpret these reactions as the same in every cultural group that has been affected.

To attempt to classify people at the same time into different 'stages' of grief could also be viewed as a very ethnocentric approach, rather than supporting a culturally sensitive way of dealing with the bereavement process. Understanding the nature of bereavement, grief and associated mourning in various cultures is an essential part of nursing and healthcare practice. We will consider some of the issues facing nurses and others in this chapter but also in other chapters such as Chapter 11 – Caring for the Health Needs of Migrants, Refugees and Asylum Seekers.

EXERCISE

1. Find out from your workplace (hospital or community) how bereaved families and individuals are supported and whether there are colleagues dedicated to supporting them.
2. Find out how the needs of different cultures and religions are met if there has been a death.

NURSING PRACTICE AND CARING FOR THE DYING AND BEREAVED

The beliefs, rituals and customs associated with death in different cultures are extremely varied, and this includes the nurse's own professional culture. De Santis (1994) found that the nurse–patient encounter can be viewed as an interaction of a minimum of three cultures:

- The culture which is founded on the nurse's professional knowledge;
- The culture which is based on the patient's own individual belief systems;
- The culture of the organization or situation in which the patient and nurse actually meet (e.g. the hospital or home; see Chapter 1).

We can use these three encounters to explore some of the issues related to caring for the dying and bereaved.

Nursing culture

If we examine the professional culture of nurses in relation to death and dying, it becomes apparent that there are many rituals and customs associated with their own nursing practice. As mentioned above, for a student nurse, 'meeting death' for the first time is part of her 'initiation' into the world of nursing, and for the majority of them this encounter will take place in a hospital. Student nurses worry a great deal about this, and Kiger (1994) found that the main causes of concern are the expected additional difficulties of caring for dying patients. These include the pain of seeing them suffer, the shock of seeing a dead body and the difficulty of dealing with bereaved relatives. However, after students have encountered death-related experiences their perceptions begin to change, and they speak of caring for and communicating with dying patients, coping with cardiac arrest situations, laying out a dead body, coping with the family of the dead person and handling their own responses to death (Sewell, 2002).

Smith (1992) believes that 'death and dying in hospital can be considered the ultimate emotional labour' for nurses and although her findings mirror those of Kiger's (1994) study of students, she also found that there were 'clearly defined technical skills required in dealing with death situations, e.g. resuscitation during cardiac arrest and laying out the body when the patient was pronounced dead'. These essential skills are very much part of the student's training experience, and are taught by mentors who usually have more experience of death (Pattison, 2008). Death and dying are thought by some to represent the ultimate emotional labour, but all nurses find their own ways to cope with this experience.

Superstitions about death and the dead person still exist within nursing (e.g. unlucky rooms, or death comes in threes), and according to Wolf (1988, 2014) post-mortem care or 'laying out of the dead' can be regarded as a nursing ritual. Wolf (2014) calls this final stage 'the last nursing care' (p. 60) and states:

> **The dying and the deaths of patients as sacred events. Many nurses recognize this. They also acknowledge the spiritual, religious, cultural and interpersonal concerns of patients before death and relatives and friends after death (p. 80)**

and cites Pulchaski's (2006, p. 128) view that

> **to walk with people upon such a journey is to tread on sacred ground.**

Many will be familiar with the rituals identified by Chapman (1983) in relation to death in a hospital ward, and she recalls what happened when a patient died in the hospital where she was undertaking research observation:

> **First the dead patient was screened from sight. No mention of the death was made to the inhabitants or visitors to the ward. The laying out procedure began. Although the corpse should lie for an hour before 'last offices' are performed, this time was diminished by the nurses who were perhaps anxious to dispatch the body. The laying out procedure involved washing the corpse. This was done even though the now deceased patient had recently had a bath. The body was clothed in a white gown and labelled. It was then wrapped in a white sheet or shroud. The nurses wore gowns to do this even though this was not necessary as a prevention against infection … Next all the curtains in the ward were drawn up to and slightly**

> **beyond the deceased person's bed. In this way no other patients were allowed to view the corpse or the mortuary trolley on which it was wheeled away. The trolley was disguised by a sheet. The corpse was not seen at all as there was a sunken container within the trolley to conceal it. The corpse was wheeled away, the curtains drawn back and normal ward life continued. The dead person when mentioned at all was spoken about in hushed whispers.**
>
> *(Chapman, 1983, p. 17)*

How can we explain the events in this scenario? It could be that because of the stressful nature of their work nurses find this a reassuring 'ritual' – a way to help them cope with the death of patients.

However, Lawler (1991) believes that 'death and the dead body are a problem for nurses' from a Western culture because death is seen as a very private experience and not a topic for general conversation. It has become a taboo subject. This could make it difficult for nurses who are not only expected to cope with the dying person and their family, but are also expected to undertake care which requires handling a dead body. This practice is known amongst nurses as 'last offices'. However, Lawler (1991) believes that this difficulty in coping is also very much dependent on how nurses themselves 'see death and what they believe takes place at death'. A study by Goopy (2006) of the way in which Italian nurses managed the death of a person in a modern Intensive Care Unit was reflective of Chapman's observations 20 years earlier. She stated:

> **Italian nurses make the 'sign of the cross'; they visibly recite prayers over the body of the deceased; they openly cry over the body, and they open the windows of the room in which the patient has died to 'allow the soul to pass to heaven'.**
>
> *(Goopy, 2006, p. 113)*

A similar example to Chapman's observation can be seen in Box 12.2.

Box 12.2 Observation from Goopy's study (2006, p. 114)

The deceased now shrouded looks like an oversized baby who has been wrapped in swaddling – the shroud neatly and firmly folded around the body, with only his face visible. (The face is left uncovered by the shroud as the body is now to be transferred to the lower ground 'viewing room'.)

The nurses lift the body onto the trolley and cover the shrouded body, including the face, with another sheet. (In this case the sheet that had been covering the patient earlier, as it has been inspected and deemed clean enough for this purpose.)

The body is wheeled outside the unit and the lift is called. On its arrival the trolley with the deceased is pushed inside and the nurse reaches in and presses the button for the lower floor. As the lift doors close and the body disappears, the nurse scurries down the internal staircase which is located beside the lift. The body is pulled from the lift – the nurse will not enter the lift even now – at the lower floor and wheeled into the viewing room.

Both the nurses and nursing assistants later tell me that they will not under any circumstances get in a lift with a dead body … 'we do not have to stay in the lift with the body. Shall we say we are afraid of him (the body)'.

Bryan (2007) asks the question 'Should ward nurses hide death from other patients?' and discusses how as in Chapman's observation, the 'body' is 'mysteriously concealed behind ward curtains or wheeled, disguised under sheets, along a hospital corridor'.

She offers a case scenario of how the dying patient is hidden away from others and how nurses' managed it (Box 12.3).

Case study

The Hidden Dying Patient: Case Scenario (Bryan, 2007, p. 79)

Mrs Roberts, aged 83 years, was admitted from a nursing home to a general medical ward. On admission she was frail and breathless but conscious. She was diagnosed with pneumonia and treated with intravenous antibiotics. Her chest infection did not improve. Over the next 24 hours her condition deteriorated and she slipped into unconsciousness. Her family (a daughter in New Zealand and a grandson in Belfast) was informed and all active treatment withdrawn. The following evening, as the patients were settling down for the night, the nurse in charge pulled the curtains around Mrs Roberts's bed, believing her to be dying. Mrs Roberts died at 2.30 a.m. At 5 a.m. the curtains were drawn around the beds of the other sleeping patients and Mrs Roberts's body was removed. When the patients were woken at 6 a.m. for the drug round, Mrs Roberts's bed had been stripped and it was empty. At morning handover, the nurse in charge reported that she had not spoken to any of the patients about Mrs Roberts's death because they had not asked.

Reflective exercise

When you next experience caring for a dying patient and you are required to undertake 'last offices', think about the care that you gave prior to death.

1. How will the care that you are about to undertake be any different now that you have read how people may grieve or what they might believe about death?
2. Chapman's experience of death and associated practices in hospital occurred in 1983. From your own experiences, are these rituals still taking place? Goopy's (2006) example appears to imply this as does Bryan's (2007).
3. Consider the cultural and religious beliefs of patients in your care and find out what information is available in the organization you are learning or working in to help them with the end-of-life period as well as their relatives' subsequent bereavement. In addition, find information about how nurses and other healthcare workers will know how to manage this.

Patient culture

The cultural beliefs of an individual are those related to religion and spirituality, which many people view incorrectly as one and the same. However, individuals who have no religious

affiliations may have spiritual beliefs that contribute to their health. Naryanasamy (1991) claims that the 'provision of spiritual care is less than ideal in practice', and that holistic care (meaning care of body, mind and spirit) is therefore not an achievable goal without this. For example, a patient may tell you, when asked for details of his or her religion, that he or she is not religious and does not go to church. However, later the patient tells you that he or she goes to the park every day and sits there thinking about his or ehr day and 'feeling very much in tune with the world'. This could imply a 'spiritual well-being' which can give the person an inner strength to cope with life events such as death without the need to believe in and pray to God.

Naryanasamy and Owens (2001) carried out a study to explore 'how nurses respond to the spiritual needs of their patients' as well as their interventions. They found that there were many variations in how nurses offered spiritual care to patients and their families, ranging from the 'cultural interactionist approach' of accommodating religious needs, such as enabling a patient to pray to Mecca in the ward, to an evangelical approach where the nurse's own religious beliefs were shared by the patient and in some instances even imposing their own personal ideals to 'fulfil their own religious beliefs'.

Ross et al. (2013) undertook a large multinational research study, involving '618 student nurses and midwives from 6 Universities in 4 European countries in 2010' focused on perceptions of and competence of delivering, spiritual care. Their findings discovered that on the whole 'students held a broad view of spirituality/spiritual care and considered themselves to be marginally more competent than not in spiritual care'. They reported that the students were 'predominantly Christian and reported high levels of spiritual wellbeing and spiritual attitude and involvement' (p. 697).

EXERCISE

1. Obtain access to this article and consider the definitions included of: Spirituality, spritual care, spiritual care competency and spiritual care education

   Ross et al. (2013) Student nurses perceptions of spirituality and competence in delivering spiritual care: A European pilot study, *Nurse Education Today,* 34(5), 697–702.
2. Read Cooper et al.'s (2013) review article on the impact of spiritual care education upon preparing undergraduate nursing students to provide spiritual care. *Nurse Education Today*, 33(9), 1057–1061.
3. Consider the above topics in this paper and if there are any major differences in the findings.
4. How many sessions in your curriculum can you identify as being about spirituality and providing care for patients?

Religious beliefs also have a major influence on caring for dying patients and their families, especially their attitudes to and beliefs about death itself. By looking at a variety of religions, we can explore the care that should be given to a dying patient.

Case study

An elderly man named Jacob Levy is admitted to your ward from the Accident and Emergency department unconscious after being knocked down by a car. His relatives have yet to arrive and he is alone. His condition suddenly deteriorates, and although resuscitation measures are undertaken, he dies before his relatives arrive.

Points to consider

1. What knowledge of Jewish religion and culture would help you to prioritize the care of Mr Levy?
2. What physical care can be given once his death has been diagnosed?
3. What help will his family require once they arrive?

The information below will help you to make informed decisions.

The Jewish community considers itself both as a religion and an ethnic group. There are two main groups within their community, namely Orthodox Jews and Progressive Jews. Orthodox Jews pursue a traditional religious lifestyle, whereas Progressive Jews seek to make their religious beliefs and practices fit more into a modern way of life. When caring for a dying Jewish patient in hospital, the nurse needs to determine which group he or she belongs to because this will affect the care given to the patient and his or her body after death. The normal practices carried out when a Jewish person dies may not be practical in a hospital or hospice (e.g. placing the body covered with a sheet on the floor, with the feet towards the door and then placing a lighted candle by the head). Therefore, Rabbi Julia Neuberger (1994) recommends that the guidelines issued by the Sexton's Office of the United Synagogue Burial Society in 1960 can be followed instead:

> **Where it is not possible to obtain the services of a Jewish chaplain, it is permissible for hospital staff to carry out the following: close the eyes, tie up the jaw, keep arms and hands straight and by the side of the body. Any tubes or instruments in the body should be removed and the incision plugged. The corpse should then be wrapped in a plain sheet without religious emblems and placed in a mortuary or other special room for Jewish bodies.**
>
> *(Neuberger, 1994, p. 14)*

In deference to 'not touching the body', it may be advisable for a non-Jewish nurse to use disposable gloves. The burial and funeral normally take place within 24 hours of death, so the time for which the body of a Jewish person is left alone will be short. After the hospital staff have finished administering the initial care, a member of the Jewish community may watch over the body day and night. Neuberger (1994) states that this practice (known as shemira) is part of the belief that 'the body is the receptacle of the soul and the body is to be honoured, respected and guarded'. The family will normally make the funeral arrangements, but in exceptional cases if there is no family the solicitor or the hospital social worker may have to make the arrangements (Neuberger, 1994).The family will probably want to know that their relative did not die on his or her own and that he or she was not left on his or her own after death. If the patient dies on the Sabbath (from sundown on Friday to sundown on Saturday) the body must not be moved from

the hospital because this is a day of rest. After burial and the funeral, the immediate family of the deceased may mourn for a period of seven days (called Shivah) and a candle is lit to mark the beginning of this period (see Box 12.3 for a definition and meaning of Shivah).

Box 12.3 What is shivah

In Judaism, the first period of structured mourning is shivah. The word 'shivah' has different meanings across different cultures and in Hebrew it means 'seven'. Shivah, as it relates to Jewish mourning, is the 7-day mourning period for the immediate family of the deceased which consists of spouse, child, parent or sibling.

Access this website: http://www.shiva.com/learning-center/understanding/shiva/

Read what the purpose of the shivah tradition is and how it can help the grieving process.

Then access this site: http://www.shiva.com/learning-center/understanding/how-shiva-observed/ for information on how shivah is observed by mourners and families.

Nurses need to be aware that Orthodox Jews do not allow post-mortem examinations and organ donations unless the post-mortem is for medical reasons. Progressive Jews may believe otherwise, so if a post-mortem is necessary the nurse needs to approach the subject with the family in a sensitive way. Being aware of the cultural and religious needs of Mr Levy and his family will ensure that the nurses can offer support and help which will be appreciated.

An expected death may be dealt with in a different way as indicated in the following case study.

Case study

Amarjit Singh is a 48-year-old man in the terminal stages of cancer and aware of his condition. He has been admitted to the hospital from the care of his family so that his pain management can be reassessed. He is only able to undertake a minimal amount of personal care.

Points to consider

1. What knowledge of Sikh culture would help you undertake an assessment of Mr Singh's needs?
2. How will you involve the family in his care during his stay in hospital?
3. If you were to care for him in the community, how would you ensure that Mr Singh's family were given support from healthcare professionals?

The information below will help you to make informed decisions.

The Sikh religion has its roots in Hinduism, and as such Sikhs believe in only one God and pray in a Sikh temple (Gurdwara), which usually contains a prayer room in which the Sikh Holy Book (Gura Granth Sahib) is kept. There are no appointed priests in the Sikh community, but 'holy

men' are identified. As a Sikh, Mr Singh may wish to pray, and he may have brought a prayer book (gutka) with him. Nurses need to be aware that this must be treated with respect, and if they find that they have to move it for some reason, it should only be touched with a clean hand. Mr Singh's family will probably wish to stay with him in the hospital at all times, and this needs to be allowed for as part of his care.

Friends and other members of the community will also wish to visit him, and if they have travelled some way to do so, the nurses caring for him need to balance the need to ensure that no offence is caused to him or his family with the needs of other patients in the ward (e.g. by allowing more visitors than is usual). This change from the norm could be incorporated into a Patient Information Booklet which acknowledges the spiritual and cultural needs of all patients and ensures that patients from different cultures are conversant with each other's beliefs and customs.

If Mr Singh is a formally baptized Sikh man (Amridharis), he will probably wear the five signs of Sikhisim. These are known as the 'five Ks' – Kesh (uncut hair), Kangha (a comb), Kara (a steel bangle), Kirpan (a symbolic dagger) and Kaccha (symbolic undershorts). Although many Sikhs no longer wear kirpan and kangha, most men and women have retained the kara and kaccha. It is important that nurses understand the significance of these for the patient and do not remove them unless the patient or his family gives permission to do so. As Mr Singh is unable to take care of himself, the nurses need to ensure that they do not cause unnecessary embarrassment or distress when undertaking his personal care. If Mr Singh requires patient-controlled analgesia as part of his pain management, it will be important to ensure that the nurse or doctor use the right hand to insert the intravenous needle (the left hand is traditionally used for washing the body after using the lavatory, and the right hand for eating, drinking and shaking hands).

After his pain management is seen to be effective, Mr Singh will be discharged home to the care of his family, who will still require the support of a community healthcare team. Caring for Mr Singh during his stay in hospital will have been enhanced by an understanding of his individual and cultural needs, and will enable the nurses to ensure that information required by the community team following his discharge home will reflect this.

Telling someone that they are going to die requires special skills and although the doctor will inform individuals and families, it is very often the nurse who has to explain the actual meaning and implications of the situation for them. In some cultures, however, telling someone they are going to die, even though they have the right to know, may not be acceptable. Galanti (2008, p. 167) points out that 'in many Asian countries, including China and Japan, it is customary for the physician to reveal a cancer diagnosis only to the patient's family, and leave it up to the family whether or not to tell the patient'.

O'Kelly et al. (2011) considered the difference in cultures about truth telling and diagnosis, whereby they state, 'Truth telling is a cardinal rule in Western medicine' but that this approach was 'not a globally shared moral stance'. In 'many cultures it is found that truth concealment is common practice'. Like Galanti (2008) they also state, 'In collectivist Asian and Muslim cultures, illness is a family affair' (O'Kelly et al., 2011, p. 3838).

Tse et al. (2003) offer an important explanation of possible family involvement in decision making about 'breaking bad news' to a family member:

1. **The family takes part in decision making with the patient. This approach adequately addresses the relational concept between self and the family. Both the patient and the family understand the bad news, and decisions about further medical treatment or personal affairs are decided together.**
2. **The patient asks the family to decide. The patient does not want the bad news, and the right for information and decision making is delegated to the family. However, though the patient is not told the bad news, it is the result of the patient's own choice. This is also considered as exercising the patient's autonomy.**
3. **The family decides alone despite the patient's wish to participate. The patient wants to know the diagnosis, but the doctor colludes with family in not letting the patient know, hoping to protect the patient from potential harm. (p. 340)**

Dr Tse's article then discusses the moral and ethical issues around decision making for terminally ill Chinese patients, and concludes that there is need for more research in Chinese communities to determine 'the influence of Western culture' on how involved in decision making the patient wants to be.

EXERCISE

1. Obtain a copy of this article written by Tse, C. Y., Chong, A. and Fok, S. Y. et al. 2003. Breaking bad news: A Chinese perspective. *Palliative Medicine*, 17, 339–343. It can be accessed online at: http://pmj.sagepub.com/content/17/4/339.
2. Obtain a copy of O'Kelly et al. 2011. The impact of culture and religion on truth telling at the end of life. *Nephrology Dialysis Transplantation*, 26(12), 3838–3842. It can be accessed online at: https://ndt.oxfordjournals.org/content/26/12/3838.full.
3. Read both of these papers looking at the ethical and moral aspects of truth telling in different cultures.
4. Decide whether you agree with their conclusions on their evidence.

In the following case study, the family may want more information about the future care of their mother and how they could ensure that her needs will be met.

Case study

Mrs Nasreen Akhtar is a 68-year-old Muslim woman who has undergone major surgery for cancer of the colon. During the operation, metastases are discovered and only palliative surgery is undertaken. Mrs Akhtar's family were informed by the surgeon about the decision and she has yet to be told, as she was very ill following surgery, and had to be admitted to the intensive-care unit (ICU) for 24 hours. Her condition is critical.

continued

Case study

Points to consider

1. What knowledge of Mrs Akhtar's culture would help you to communicate effectively with the relatives once they have been told of her critical status?
2. How will the nurses working in the ICU arrange for both the patient's and relatives' needs to be met in the first 24 hours after her surgery?
3. What specific cultural care needs will nurses have to accommodate following surgery?

The information below will help you to make informed decisions.

The ICU can be regarded as a subculture of its own where, because of its critical nature, the nurse's assessment of the patient may not immediately focus on the patient's cultural needs. However, it is essential that there is an awareness of Mrs Akhtar's cultural background so that she and her family can be cared for effectively. Many ICU settings have a small number of critically ill patients and, given that the space around each bed is limited, the opportunity for family involvement in care may be restricted.

The grief and anticipatory loss for the family have to be allowed for, but because of the clinical condition of the other patients in the ICU, the nurses will need to ensure that they adopt a sensitive and culturally aware approach to meeting their needs while ensuring that the needs of the other patients and their families are also met. For example, it may not be possible for more than one or two members of the family to be present at any one time within the ICU setting because of the intense activity that is normally taking place, and this could be even more problematic if Mrs Akhtar requires acute interventions and resuscitation.

Muslims are followers of the Islamic faith, and they believe in 'living their lives according to the will of Allah (God)' (Karmi, 1996). Their guiding rules are to be found in the Qur'an, which is their holy book. Karmi (1996) also states that there is great emphasis on 'modesty, social responsibility, health, cleanliness and the importance of family ties and children'. If one considers that modesty is important and that 'nakedness is considered shameful' (Karmi, 1996), then the type of care that Mrs Akhtar will receive in the ICU will be crucial to her general well-being and the experience of her family. She has undergone major surgery and will be receiving life-sustaining treatment which is potentially invasive. It will be important to both her and her family that her body is not exposed unnecessarily, and for the healthcare staff to acknowledge that being touched and examined by male nurses and doctors may be frightening and totally abhorrent to her.

Prayer is very important to Muslim families, and although women do not go to the Mosque for public prayer, they do undertake this at home. Mrs Akhtar will be unable to do this because of her illness, so it is important to her care that prayers are read to her by relatives, and that the Islamic call to prayer is whispered into her ear.

Good communication and continuous assessment are essential in all such situations, and nurses can enhance their care by talking to the family and the patient so as to provide individualized care.

Organization culture: Hospital and community

All care that is given to the patient and their relatives will depend very much on the effectiveness of the hospital or community responding to the needs of a multicultural–multiracial community. If it is acknowledged that patients should all receive individualized care, then this will be apparent in different policies and procedures throughout the hospital or community service. Hospitals that acknowledge the cultural needs of patients are likely to have not only a chapel but also a mosque and a temple (or their equivalent) for prayer. It is also recommended that 'symbols of Christianity should be removed from chapels of rest when these are being used by non-Christians' (Black, 1991).

Care plans and other documentation, both in the hospital and in the community, should reflect an awareness of cultural differences. Many NHS trusts have produced guidelines on the spiritual and bereavement needs of different cultures, which have been developed through collaborative multiprofessional and multicultural groups.

Reflective exercise

1. Think about your own working environment and use the recommendations below to assess your experience of providing care that is culturally aware. You may wish to discuss this with colleagues, which may not only lead to learning about other cultures and their needs, but may also enable you to understand why nurses' own beliefs about death and dying are so important to delivering culturally sensitive and competent care.
2. Using a nursing assessment tool that is familiar to you, consider how you would initially assess a person's needs with regard to the issue of death and dying. You may then wish to consider the following questions identified in Holland et al. (2008, p. 495) with regard to the 'Activity of Living: Dying'.

Factors and possible questions to consider during the assessment stage of care planning for the dying:

- Physical
  - Are there any confirmed diagnostic factors threatening the person's life?
  - What are the physical effects upon the person, family and friends?
  - Is the person aware of the diagnosis, stage and progress of the life-threatening disorder?
  - Is the possibility actual or potential?
- Psychological
  - Is the person expressing a 'desire to know', anxiety or fear of dying?
  - Does the person desire that significant others 'know'?
  - What is the person's behaviour, mood, personality?
  - What is the person's understanding of his or her own dying/death?
- Sociocultural
  - What are the person's attitudes, beliefs and life experiences about death?
  - Does the person have specific cultural, religious, social or personal requests?

continued

Reflective exercises

- Who needs to be contacted on behalf of the person: Family, partners, friends?
- Environmental
  - Choice of environment to facilitate a peaceful death (i.e. hospice, home or hospital)?
  - What resources will be required to meet the needs of the person, family and carers?
- Politico-economic
  - Are there any economic, legal, ethical, resource, social or domestic factors inhibiting a peaceful death?
  - What is the effect of the death and reduced life expectancy of the person on others?
  - Are there sufficient and appropriate support services within the hospital and the home for the dying and bereaved?
  - Does the person wish to donate any organs and does the family know?

Demonstrating evidence of good practice is becoming an essential part of a nurse's role, and one way to do this is by encouraging cultural awareness and effective communication between all healthcare workers and the wider cultural community. The following statements (recommendations) are examples of how this good practice could be developed.

1. There should be access to specific information on death and dying practices, including the contact numbers of local religious and spiritual leaders.
2. Leaflets and booklets that outline hospital or community protocols for the bereaved should be available for healthcare workers and patients and their families.
3. Booklets should be made available that explain the terminology used by nurses and others when caring for individuals from different cultures.
4. Integration of cultural issues into care assessments and care plan documentation should be mandatory.
5. Visiting times based on cultural practice should be encouraged and information made available about special occasions (e.g. festivals or fasting times).
6. A learning environment that encourages cultural and racial awareness across the healthcare professions should be a priority for all those involved in developing educational programmes.

CONCLUSION

It is very important that patients receive culturally sensitive care at all times during their stay in the hospital, and it is essential to ensure that there is no prejudice shown through any stated rules of the organization or institution in which the dying patient may be cared for. As societies become more

multicultural, nurses and healthcare professionals will be exposed to a wider range of spiritual and religious beliefs, which will influence the need to adopt care practices that are culturally orientated.

The meeting of three cultural realities (the nurse, the patient and the organization) requires that all those involved acknowledge the differences in the needs of the nurses, the patients and the organization (which arise from individual belief systems about death and dying in both Western and non-Western societies). However, nurses are in the very privileged position of being able to care for those who are dying and those who may be bereaved, and they can directly influence the type of care that is given.

CHAPTER SUMMARY

1. Caring for the person who is dying or bereaved requires knowledge of specific cultural and religious rituals.
2. Dying in the hospital can be a very isolating experience for the patient. Nurses need to know who to contact from the patient's own culture or religion in order to ensure that traditional practices are followed.
3. Nurses have their own cultural beliefs as individuals and as members of a nursing culture. Both could influence the way in which they manage and cope with death experiences.

FURTHER READING

Galanti, G.-A. 2008. *Caring for Patients from Different Cultures*, 4th edition. Philadelphia: University of Pennsylvania Press.

Hollins, S. 2009. *Religions, Culutre and Healthcare, a Practical Handbook for Use in Healthcare Environments*, 2nd edition. Oxford: Radcliffe.
This book offers an introduction to many different religions and cultures.

Kirkwood, N. A. 2005. *A Hospital Handbook on Multiculturalism and Religion: Practice Guidelines for Health Care Workers*, 2nd edition. London: Morehouse.

Parkes, C. M., Laungani, P. and Young, B. 2015. *Death and Bereavement across Cultures*, 2nd edition. Hove: Routledge.
This is the new edition of this excellent book for all healthcare professions and hospital chaplains. It has general chapters as well as specific ones focusing on death and bereavement in other cultures and religions.

Valentine, C. 2008. *Bereavement Narratives: Continuing Bonds in the Twenty-First Century*. London: Routledge.
This book explores the experience of bereavement in British society, based on the narratives of bereaved people and how people make sense of their experience of bereavement.

Bennet, H. 2012. *A Guide to End of Life Care: Care of Children and Young People before Death, at the Time of Death and after Death*, 1st edition. © Together for Short Lives, August 2012.

This is a guide for end of life care for children and young people, and includes issues of spirituality, faith and cultural care. http://www.togetherforshortlives.org.uk/assets/0000/1855/TfSL_A_Guide_to_End_of_Life_Care_5_FINAL_VERSION.pdf (accessed 24 February 2016).

Wolf, Z. R. 2014. *Exploring Nursing Rituals – Joining Art and Science*. New York: Springer Publishing Company.

This book is as the author states 'a reexamination of nursing rituals in the context of professional nursing practice' which she built on her doctorate work and also published her first book in 1988 on the topic of nursing rituals. It is an excellent and worthy text focusing on different nursing rituals and the most up to date literature in that field.

WEBSITES

http://www.jewfaq.org/death.htm

This site explains some of the beliefs and customs in life, death and mourning of Judaism.

http://www.mwrc.org.uk

This is the website of the Amina – Muslim Women's Centre in Glasgow, Scotland. There are a number of resources including two called: Grief and Grieving and Helping Bereaved Muslims.

http://www.kingsfund.org.uk/sites/files/kf/field/field_pdf/Library-reading-list-BME-older-people-Nov2014.pdf

This is a report on palliative and end of life care for black and minority ethnic groups in the United Kingdom – it offers a 'demographic profile and the current state of palliative and end of life care provision' – and is authored by N. Calanzani, Dr J. Koffman and I. J. Higginson.

CHAPTER

13 Cultural diversity and professional practice

Karen Holland

INTRODUCTION

The need for care delivery based on cultural understanding and lack of prejudice has been highlighted in the previous chapters. We consider that healthcare professionals working in both hospital and community settings require additional skills and knowledge in order to be able to ensure both quality and equality of healthcare provision in a culturally diverse society. This means there is a need for understanding about the broad issues of cultural diversity and how to work in multicultural teams to deliver quality care. Effective communication across cultures is therefore a key to this goal as is understanding about societies' and individuals' prejudices which can impact on the delivery of health and, indeed, social care (Kline, 2014).

Since we wrote both the first and second editions of this chapter there has been a fundamental change in the structure of many organisations such as the National Health and Social Care Services in the United Kingdom, following the findings of major inquiries into a wide range of organizational failure and duty of care issues. In addition, on a global scale, there have been major environmental disasters and the displacement of people due to the result of wars. Both of these have resulted in changes to the lives of people, and in Europe, for example, we have seen the result of this change in the vast number of refugees and asylum seekers fleeing untenable conditions in their own country.

Due to the impact of these issues on most world countries, nursing and healthcare colleagues are making every attempt to manage and deliver culturally appropriate care in a constantly changing society. To attempt to consider this in all countries is not possible so this chapter will use the United Kingdom nursing profession and healthcare services as the main focus for understanding some of the issues impacting on different cultures. Examples from the global community, however, will be offered to illustrate similarities and differences.

This chapter will focus on the following issues:

- Cultural diversity
- Working in multicultural healthcare teams
- Education of nurses to care for patients in a culturally diverse society
- Intercultural communication

CULTURAL DIVERSITY

Cultural diversity implies that there are many different cultures in a society which, in the context of health and social care, will have a direct impact on the way in which care is delivered. Other areas of society and communities that are related to the term diversity are gender, religion/faith, sexual orientation, socioeconomic background, political convictions/philosophy and physical disabilities/mental disorders (illness – my term) (Cultural Diversity Network: http://www.culturaldiversitynetwork.co.uk/).

It is important to consider that these other areas of diversity in society will also cross over all cultures, thereby making it even more important that nurses and other healthcare workers understand all forms of diversity and how those impact on the day-to-day cultural life of a person.

Douglas et al. (2014, p. 109) present these issues in a clear and focused way:

> **The global migration of populations presents nurses with the challenge of delivering care to unprecedented numbers of patients with healthcare beliefs and practices that may differ from their own. The global migration of nurses to meet world-wide shortages places migrating nurses in the similar situation of caring for patients with different cultural backgrounds. There is growing evidence of increasing inequalities in access to healthcare and health outcomes among populations in local, national and global contexts. There is a need to advocate for vulnerable populations to lessen the impact of social inequalities on their health. These challenges heighten the need to identify guidelines for the delivery of culturally competent care for increasingly diverse populations and minimize health inequities regardless of geographic location.**
>
> *(Rosenkotter and Nardi, 2007; Miller et al., 2008)*

EXERCISE

1. Obtain a copy of the article: Douglas, M. K. et al. 2014. Guidelines for implementing culturally competent nursing care. *Journal of Transcultural Nursing*, 25(2), 109–121. (It is available for download at this site if you have legal access to the journal: http://tcn.sagepub.com/content/25/2/109.)
2. Consider whether you have enough knowledge to begin to care for people from a variety of cultures and if not identify sections of this book that could help you in your specific workplace.
3. Make a note of the issues you may have faced yourself as a qualified or student nurse, with regard to inequalities in cultural care.

Douglas et al. (2014) undertook a major study of documents 'from nursing organisations around the world' as well as other types of documentation to develop a set of guidelines to help nurses deliver 'culturally competent nursing care'. They believe that 'no single set of guidelines for culturally competent care can apply to all cultures' (p. 110).

In many ways their view and subsequent identification of key points in their developed guidelines are similar to our own, in that it is about being aware of the broader and specific

Table 13.1 Ten Guideline Topics for Delivery of Culturally Competent Care in Any Cultural Context and Setting

G1: Knowledge of cultures
G2: Education and training in culturally competent care
G3: Critical reflection (by nurses –my addition)
G4: Cross-cultural communication
G5: Culturally competent practice
G6: Cultural competence in healthcare systems and organsiations
G7: Patient advocacy and empowerment
G8: Multicultural workforce
G9: Cross-cultural leadership
G10: Evidence-based practice and research
Final guidelines endorsed by the International Council of Nurses

Source: Douglas, M. K. et al. 2014. *Journal of Transcultural Nursing*, 25(2), 109–121. (It is available for download at this site if you have legal access to the journal – http://tcn.sagepub.com/content/25/2/109.)

issues impacting on culturally diverse communities that is important and that cultural specific competencies and the knowledge underpinning them are there to support the nurse in her work rather than drive the way in which it is carried out. They identified 10 key guideline areas (Table 13.1) which they believe 'should be adapted to the cultural context and setting in which they are used' (p. 111).

EXERCISE

1. As seen in Chapter 2, some guidelines that have been developed previously to help nurses deliver care to culturally diverse societies. Revisit these in the context of the discussion above and the 10 key guideline statements in the full article.

WORKING IN MULTICULTURAL HEALTHCARE TEAMS

If we accept that in today's society in the United Kingdom we have seen a major change in the cultural nature of the health and social care workforce, then we can also assume that this workforce needs support and education to deliver care.

In Guideline 8: Multicultural workforce, it states that:

> **Nurses shall actively engage in the effort to ensure a multicultural workforce in healthcare settings. One measure to achieve a multicultural workforce is through strengthening efforts of recruitment and retention in healthcare organisations and academic settings.**
>
> *(Douglas et al., 2014, p. 114)*

Firstly then we need to encourage people to enter the nursing and other health and social care professions, followed by ensuring that we retain them after qualifying. Mir (2008) stated,

'employing staff from minority ethnic communities is necessary at all levels' and offers the following example where this employment is often missing:

> **Research evidence shows that interpreting by family members, rather than professional interpreters, can result in poor levels of communication with service users and unethical practice. Poor practice includes using children as interpreters, placing a difficult emotional burden on the person doing the interpreting and creating tensions between close relatives. Dedicated interpreting staff are able to build up their knowledge of specialist terminology and develop good knowledge of the service context.**

Return to Chapter 2 to consider some of these observations again.

An interesting study by Kai et al. (2007) considered the experiences and perceptions of a group of multidisciplinary health professionals in relation to the delivery of care to patients 'from diverse ethnic communities' (p. 1766). One of the findings showed the:

> **uncertainty health professionals may experience working with patients of differing ethnicity to their own, alongside professionals' emphasis upon knowledge about cultural difference. This uncertainty may disempower professionals, creating hesitancy and inertia in their clinical practice to the potential detriment of patient care. (p. 1770)**

They offer excellent narrative examples of their main themes in text boxes as well as offering further examples in the text of the themes: professional uncertainty, focus on cultural expertise; professional disempowerment and uncertainty and disempowerment as self-perpetuating. Kai et al. (2007), as with Douglas et al. (2014) also offered a solution to some of their findings, where there should be a 'a shift in emphasis away from knowledge-based cultural expertise towards a greater focus on the patient as an individual'.

This would require however knowledge of cultural and ethnic differences (see Chapter 1) even if it is only to 'provide a context for learning'. Importantly, they raise the issue as earlier in this chapter, where 'healthcare professionals need to be supported to respond to patients as individuals, whose cultural diversity embraces not only ethnicity but other influences such as gender, social background and education' (p. 1772).

EXERCISE

Obtain a copy of this article which is freely available online:

Kai, J., Beavan, J., Faull, C., Dodson, L., Gill, P. et al. 2007. Professional uncertainty and disempowerment responding to ethnic diversity in healthcare: A qualitative study. *PLoS Med*, 4(11), e323. doi: 10.1371/journal.pmed.004032 (accessed 14 February 2016.)

EDUCATION OF THE NURSING AND HEALTHCARE WORKFORCE TO DELIVER CARE IN A CULTURALLY DIVERSE SOCIETY

If the nursing profession is to address the needs of a diverse multicultural society as well as understand the cultural norms of their own work colleagues, then learning about these, as well as the more specific issues we have dealt with throughout the chapters in this book,

has to take place. This learning for the majority of health and social care workforce takes place within both an education and a practice environment, where it is the norm to employ a diverse multicultural and ethnic workforce. (See West et al. (2015) for a summary of a report into diversity and inclusion in the NHS: http://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs.)

A study undertaken by Merrell et al. (2014) is an excellent example of a national evaluation of pre-registration nursing programmes in Wales to 'explore the extent and nature of education relating to race and ethnicity'. (See: http://www.werconline.org.uk/pdf/publications/MerrellEtAl_Final_Report.pdf, accessed 27 February 2016.)

This study in Wales offers us insight into the possible findings from the rest of the UK countries, and it is clear from their recommendations that there is much more work to be undertaken.

A study in Scotland (Lauder et al., 2008, Evaluation of Fitness for Practice Pre-Registration Nursing and Midwifery Curricula) established a lack of knowledge and translation to practice by students in relation to the exploration of the theme: *Preparation for Practice: Working in a Diverse and Multicultural Community*

Findings from this theme:

> **Their actual practice experience of meeting people from different cultural backgrounds appeared to be influenced by where they were placed and this varied across the two professions. (p. 123) and that 'There were, however, indicators that preparation for meeting the needs of diverse communities appears to be focused on very broad principles only and that it may well be integrated throughout curricula delivery, in situations such as PBL, rather than specific modular content' (Lauder et al., 2008, p. 124). Here we can see a University session example followed by two practice ones.**

In one class last year, communication, we learnt about, we were broken up into

> **small groups, we had to do different religions, and do the presentation on those and we have had lectures telling us about transcultural things like that …. The translator services …. We had a health visitor who works with ethnic minorities – Bangladeshi …and she was saying, you know, from her point of view, she gives them some of her experience when she walks in the house and the man does all the speaking but she is talking about this pregnant lady, you know does everything you say goes through the husband actually…**
>
> *(Student nurse Case study K)*

Two practice examples:

> **I've found in practice as well that its very much what's the word…information is available on the ward about their like their eating habits or dying wishes.**
>
> *(Student nurse Case study F)*

> **I didn't realise until I went on community, there are so many different languages, we've got Polish, Albanian, Nigerian…**
>
> *(Student midwife Case study B)*

EXERCISE

1. Consider these two examples of student experiences of being prepared to care for patients from all cultures – what is your experience since commencing your course?
2. What were you taught about different cultures before your practice placement experience (if a student)?
3. If a qualified nurse, consider how you are going to ensure that you have the knowledge about different cultures and religions to support the learning of student nurses in your practice area.

In Merrell et al.'s (2009) study, three major themes were found after analysis of data from interviews, focus groups, questionnaires and a review of curriculum documents. These were curriculum design and content, theory-practice gap and personnel and material resources.

We can consider some of these important findings with regards to the participants who were educators (lecturers and practice mentors) in order to explore your own perspectives and experiences and in fact there are similarities in some of the themes to the Lauder et al. (2008) findings.

Here is an example from Merrell et al.'s (2009) study:

> *Personnel and material resources:* **Here were two main issues: 'Firstly the extent to which users particularly from Black and Minority Ethnic Groups (BME) were viewed as a resource and involved in curriculum development and delivery'; then there were 'findings regarding the availability and range of educational resources used to aid the teaching of race and ethnicity issues' and finally 'findings related to the preparation and training of lecturing staff and practice mentors'.**

EXERCISE

1. If you are a student: Consider how you meet your professional body requirements, for example, Nursing and Midwifery Council (NMC in the United Kingdom) in the practice area and how are you assessed in relation to the value of people from different cultures?
2. If you are a mentor or preceptor, consider how you can help the student nurse to understand how to care for patients, then consider how you will assess their knowledge and caring skills for patients from different cultural backgrounds.

Merrell et al. (2014) have now published the research from their initial project and in a review of the paper Narayanasamy (2014) applaud the approach they take in their recommendations, in that 'this paper calls for prominent space in the curriculum for social justice and anti-discriminatory practices related to multi-ethnic healthcare needs' (p. 502).

Culley (2014), in an editorial, makes specific what the readers of this book will need to consider when they use some of the more specific culturally and ethnically focused evidence-based content, and that is:

> **…while nurses must remain open to the possibility of religious identity impacting on health beliefs, health-seeking behaviour and illness experiences, we should not assume that this is the case from the information on ethnic or religious identity with which we are presented in patient notes. 'Always ask, never assume', is an important axiom of culturally competent care. Nurses must be open to the possibility of ethnic differences but must remain wary of ethnic stereotyping, which belies the complexity of our intersecting identities (as women/men, richer/poorer, older/younger, heterosexual/homosexual) all of which may mediate the experience of illness and influence our care needs. We need to be aware of what might be important to people, but primarily as the basis for the unique interpersonal negotiation with patients about what is relevant to them in the era of superdiversity. (p. 455)**

INTERCULTURAL COMMUNICATION

Throughout the discussion in this chapter, it is evident that to deliver culturally appropriate care in such diverse communities that now exist in the United Kingdom and other countries, it is vital that the health and social care workforce has to be able to communicate with each other and most importantly their patient and client groups. Culley (2014, p. 455) identifies this clearly in the folowing comment:

> **We need to be aware of what might be important to people, but primarily as the basis for the unique interpersonal negotiation with patients about what is relevant to them.**

To be able to undertake this kind of unique interpersonal negotiation with people we need not only to have a cultural understanding or awareness but most importantly we need to have effective communication skills.

If we revisit Douglas et al.'s (2014) guidelines again for implementing culturally competence nursing care, one of the essential guidelines was for cross-cultural communication. It stated that:

> **Nurses shall use culturally competent verbal and nonverbal communication skills to identify client's values, beliefs, practices, perceptions and unique health needs.**
>
> *(p. 112)*

EXERCISE

Access the following research articles and consider the similarities and differences in each one, of effective and noneffective cross-cultural communication between nurses and patients.

1. Jirwe, M., Gerrish, K., and Emami, A. 2009. Student nurses experiences of communication in crosscultural care encoutners. *Scandinavian Journal of Caring Sciences*, 24, 436–444.
2. Plaza del Pino, F. J., Soriano, E., and Higginbottom, G. M. A. 2013. Sociocultural and linguistic boundaries influencing intercultural communication between nurses and Moroccan patients in southern Spain: A focused ethnography. *BMC Nursing*, 12, 14.

3. Taylor, S. P., Nicolle, C., and Maguire, M. 2013. Cross-cultural communication barriers in healthcare. *Art & Science, Nursing Standard*, 27(31), 35–43.

CONCLUSION

This chapter began with a broad overview of why the content was going to be an essential part of learning to be effective in multicultural working and effective intercultural communication with patients, their families and with each other in the workplace. There are studies being undertaken to consider how we can develop and deliver care to the increasing culturally diverse communities we are now living in.

Some of you will be less exposed to living in a very culturally diverse community and others more so. However, all of us need to take cognizance of our professional responsibilities and values when meeting and caring for any individual from any culture regardless of their gender, religion/faith, sexual orientation, socioeconomic background, political convictions/philosophy and physical disabilities/mental disorders (illness – my term) (Cultural Diversity Network: http://www.culturaldiversitynetwork.co.uk/).

CHAPTER SUMMARY

1. It is essential that nurses and other healthcare workers learn how to work together and learn together to deliver culturally appropriate care.
2. Effective communication skills along with an understanding of the needs of people from different cultural backgrounds must be considered in any education and training programmes, with both the health and social care services working together to achieve this.
3. Cultural diversity is one kind of diversity that exists in our UK society today and nurses are at the forefront of being able to ensure equality of care to all people.

FURTHER READING

West, M., Dawson, J. and Kaur, M. 2015. *Making the Difference – Diversity and Inclusion in the NHS. Summary*. London: The Kings Fund.

This document is a summary of a major report examining the issue of diversity and inclusion in the NHS England. One of the key findings as related to this chapter was that people from all religions report experiencing discrimination on the basis of their faith, but reporting is by far the highest among Muslims (p. 2).

Culley, L. and Dyson, S. 2010. *Ethnicity and Healthcare Practice: A Guide for the Primary Care Team*. Bournemouth: Quay Books.

This is a practical guide for community teams and includes a chapter on managing diversity in healthcare practice (Chapter 3).

Laird, S. E. 2008. *Anti-Oppressive Social Work. A Guide for Developing Cultural Competence.* London: Sage Publications Ltd.

This book has a title that you may think does not apply to you. I would urge you to open it and look at the excellent chapters and overall content on a wide range of issues concerning diversity and equality but most importantly about communities with roots in different countries. This is unique way of discussing a wide range of issues across the lives of people originally from other parts of the world. There is India, Pakistan and Bangladesh, the Caribbean, and China. They are rich in detail and offer case studies to illustrate discussions.

WEBSITES

http://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs

This site has a number of research and other reports that the King's Fund has been involved in. This site especially focuses on the Making a Difference: Diversity and Inclusion in the NHS (in NHS England). It also has linked blogs.

http://rnao.ca/sites/rnao-ca/files/Embracing_Cultural_Diversity_in_Health_Care_-_Developing_Cultural_Competence.pdf

This website contains resources for nurses and other members of the healthcare team working in Ontario, Canada. It focuses, as it states, on embracing diversity in health care. The main report offers a wide range of discussion material such as conceptual frameworks, cultural competency tools and a large number of other linked and useful websites. It is good to see how different Canada is approaching the same issues as in the United Kingdom and elsewhere.

http://www.nsna.org/Portals/0/Skins/NSNA/pdf/Imprint_NovDec08_Feat_Jeffreys.pdf

This website links directly with a PDF document written by Marianne Jeffreys called Dynamics of Diversity: Becoming Better Nurses through Diversity Awareness. Again we have insight into how certain areas of the United States are developing content to help students meet people from different cultural groups on placements and developing cultural competencies to care for patients in their multicultural communities.

YOUTUBE SITES

YouTube sites (Checked by author for appropriate content – 27 February 2016)

https://www.youtube.com/watch?v=dNLtAj0wy6I (Cultural Competence for Healthcare Providers – US video focusing on cultural communication)

Very informative short video about interpreters not understanding patients who do not speak English.

https://www.youtube.com/watch?v=JpzLzgeL2sA

This site focuses on Nurturing Cultural Competence in Nursing: Promising Practices for Education and Healthcare from the Oregon Center for Nursing.

To know more about this work and other similar projects you can visit this centre: www.oregoncenterfornursing.org

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Appendix 1

CHRISTIANITY: BELIEFS AND PRACTICES

Christians believe in one God and are followers of Jesus, whom they believe is the Son of God. Jesus was crucified by the Romans for His beliefs, and His life is marked by the following festivals of Christianity:

- Christmas Day – His birth.
- Lent – Which lasts for 40 days (from Ash Wednesday to Good Friday) and marks His 40 days in the desert. This is a time for Christians to reflect on their lives.
- Good Friday – Marks the end of Lent and the day when Christ was crucified.
- Easter Day – Celebrates his resurrection.
- Whitsun – Is celebrated 50 days after Easter (Pentecost). This is an important festival for many Christians; it celebrates the descent of the Holy Spirit to Jesus' apostles after his death (Schott and Henley, 1996).

Christians believe in an afterlife and in heaven (where 'good' Christians are believed to go after death) and hell (where the devil exists and where 'evil' people go).

The different denominations and groups include the following:

- Anglican/Church of England
- Roman Catholic
- Methodist
- Pentecostal
- Seventh-day Adventists
- Baptists

Implications of Christian beliefs for nursing and health care

Christians in hospital may wish to read the Bible, pray and receive Holy Communion. The hospital chaplain will be able to support their individual needs. Holy Communion may be taken at the bedside, if necessary. If their illness permits, patients may visit the hospital chapel for prayers and religious services. For Seventh-day Adventists, the Sabbath day is a Saturday.

Most Christians have been baptized (when they commit themselves to God). Some parents of very sick children and babies may request that they be baptized in hospital. The chaplain or priest can perform this ceremony. Schott and Henley (1996) point out that in an emergency anyone can undertake this ceremony, but preferably someone who has also been baptized.

Roman Catholic priests may undertake to anoint the sick and say prayers. This is a particularly important service for those who are dying.

There are no special death rituals unless these are specifically requested; there are also no objections to post-mortem or transplant of organs on religious grounds.

Appendix 2

BUDDHISM: BELIEFS AND PRACTICES

Buddhism can be regarded as both a way of life and a religion. It is the main religion in Bhutan, Nepal and Tibet. There are two main schools of Buddhism, namely Thervada or 'Teaching of the Elders' and Mahyar or the 'Greater Way'. One branch of Mahyar Buddhism is Zen Buddhism; Tibetan Buddhism is another. Buddhists acknowledge no single God as creator. Instead, Buddhism acknowledges many Gods, but 'these are all seen as lesser beings than Buddha himself' (Neuberger, 1994). Buddhists believe in rebirth, which is influenced by past and present lives. Adhering to Buddhist teaching in each life enables the person to learn from past experiences and to continue to strive for perfection or nirvana.

To achieve this perfect state of existence, Buddhists must follow a path (the Eightfold Path) which encompasses Buddha's Four Truths. According to Neuberger (1994), these noble truths are as follows:

- Suffering is strongly linked to our existence as human beings.
- Suffering itself is caused by our craving for pleasure, which then prevents us from gaining knowledge and insight.
- Human beings will only eliminate suffering by removing wrong desires and selfishness.
- The way to remove this suffering is to keep to the Eightfold Path to enlightenment.

The Eightfold Path (Sampson, 1982; Neuberger, 1994):

1. The Buddhist aims to gain a complete understanding of life.
2. The Buddhist aims to have the right outlook and motives.
3. The Buddhist aims to have the 'right' speech (i.e. not lie or gossip).
4. The Buddhist aims to carry out perfect conduct, which involves being and doing good and not doing evil. This is linked to not taking a life. He or she must not be dishonest or deceitful.
5. The Buddhist must earn his or her own living in accordance with Buddhist teaching – known as the 'right livelihood'.
6. The Buddhist has to practise 'the right effort' (i.e. developing self-discipline).
7. The Buddhist has to develop 'right-mindedness', which is achieved through meditation.
8. The Buddhist aims to practise 'perfect meditation' leading to complete enlightenment.

A ritual which symbolizes entry into the Buddhist faith is an affirmation of faith in three Treasures (Jewels), namely the Buddha (historical Buddha and spiritual ideal of enlightenment), the Dharma (teaching and practices lead to enlightenment) and the Sangha (the spiritual community, i.e. people who practise the Dharma).

Implications of Buddhist beliefs for nursing and health care

Time and space for meditation may be required. Some Buddhists may follow strict rules of hygiene, requiring them to wash before meditation and after defecation and urination. Many Buddhists are vegetarians. Their philosophy of life and rebirth is that imminent death will require that they are in a clear and conscious mind. This may affect the taking of pain-relieving drugs which cloud the mind. Sensitivity and reassurance about the influence of any medication must therefore be shown. Buddhists are usually cremated. There are no special rituals other than specific cultural ones as appropriate.

Appendix 3

HINDUISM: BELIEFS AND PRACTICES

Hinduism is a religion and way of life. A central element in Hinduism is the Supreme Spirit from which the whole universe stems. Everything that happens in the world is categorized as being creative, preserving or destructive, and this is symbolized by the three main Hindu Gods:

- Brahma – The Creator, who symbolizes creative power
- Vishnu – The Preserver, who preserves and maintains what has been created
- Shiva – The Destroyer, who brings all things to an end (Henley, 1983b)

Hindus believe that all living things are reincarnated. This cycle of life is called Sansar. The source of all things (atman) is reborn in another body. Karma is related to the belief that nothing takes place without a reason which is linked to one's responsibility for determining one's actions. Good karma is achieved by following a religious life and doing good to others. The ultimate aim is to be released from this cycle of reincarnation (earthly existence) and reunited with the Supreme Spirit. This is called Moksha.

Duty or Dharma is a very important aspect of Hindu religion, as is purity.

All aspects of bodily functions and emissions are considered impure and therefore polluting. A Hindu's body must be cleansed before worship, especially if they have had contact with impure things. Running water is a purifying agent and Hindus will wish to wash or shower frequently, especially before prayer.

The Hindu Holy Book is known as the Bhagvad Gita. A mala (string of beads) may be used during prayer, and must only be touched with clean hands. A Hindu temple is known as a Mandir, and shoes are removed and women must wear a head covering before entering it. There is no segregation of the sexes in the congregation. These temples have a resident Brahmin (the highest Hindu caste), known as a pandit. Visiting priests and teachers are known as swamis.

Henley (1983b) states that it is 'illegal in India to discriminate on the grounds of caste'. However, it remains important in traditional aspects of Hindu life, such as marriage arrangements. The caste system is based on four main classes which are linked to key roles in Hindu society:

- Brahmins – Mainly the priests
- Kshatriyas – Those who defend and govern
- Vaishyas – Those who produce goods and food (e.g. farmers and tradesmen)
- Shudras – Those who serve the other castes

In addition, there is another class of people, namely the Outcastes or Untouchables. These have no caste and are viewed as those who undertake spiritually polluting jobs.

Implications of Hindu beliefs for nursing and health care

Modesty is very important to both men and women. Women must cover their legs, breasts and upper arms, and they would prefer to be examined by a female doctor. They usually wear a sari and the midriff is very often left bare. Some Hindu women may wear a salwar kameez both during the day and at night. Women wear jewellery in the form of bracelets and a brooch known as a mangal sutra, which is strung on a necklace. These must not be removed unnecessarily. This could have implications for preoperative care, and nurses should ensure that removal is absolutely necessary before removing jewellery that has religious significance, or they should provide alternative arrangements that are culturally appropriate. Many women also wear a bindi – a small coloured dot in the middle of the forehead. Some married women also put red powder (sindur) in their hair parting to indicate their married status.

Men usually wear a kameez and pajamas (trousers with a drawstring) or a dhoti. This a cloth about 5–6 m long, which is wrapped around the waist and drawn between the legs. Older men may wear a long coat (achkan) or a shirt with a high collar and buttons down the front, known as a kurta. Men also wear 'a janeu or sacred thread worn over their right shoulder and round the body' (Henley, 1983b). This should never be removed. Some men may wear a bead necklace or other jewellery of religious significance.

Washing in running water is important to maintain purity. A special jug or bottle (and a water supply) can be provided for patients in hospital toilets and bathrooms. Toilet paper is not traditionally used, and Hindus use the left hand to wash themselves. The right hand is used for handling food and other clean objects. Hindus will wish to shower before prayer, and if this is not possible they must be assisted to wash with running water. Because of their beliefs about pollution, shoes must not be put in the bedside locker with clean things, because the feet are considered to be the dirtiest part of the body. The head is the most sacred part. During menstruation and 40 days after the birth of a child, women are considered to be unclean and polluting. They are not allowed to go to the temple, pray or touch any holy books at this time, and sexual intercourse is prohibited. Some women may not cook at this time.

Many Hindus are vegetarian. The cow is a sacred animal and the pig is considered unclean. Eggs are eaten by many Hindus. Because of their beliefs about pollution, some Hindus will not eat anything that has been prepared in hospital and their families will bring food prepared at home for them. They may refuse to eat or drink in hospital because they are unable to ascertain that the

food or drink is not polluted in some way. Nurses will need to be particularly vigilant with regard to those patients where starvation and dehydration may hinder their progress and care.

Many Hindus will wish to die at home rather than in hospital. This must be considered sensitively, and it should be enabled to take place whenever possible. Hindus are cremated, usually within 24 hours of death. Young children and babies are usually buried. A period of mourning then takes place, and family members very often wear white for 10 days as a sign that they are in mourning.

The recording and acknowledgement of Hindu names are both important. Names will have three parts – a personal name, a middle name (which can only be used with the first name) and the surname (or family name): for example, man – Rajchand Patel, woman – Lalitakumari Sharma. It is important to record all of the names, given that certain family names are quite common (e.g. Patel).

Appendix 4

ISLAM: BELIEFS AND PRACTICES

Islam is the religion of Muslims. Makka (Mecca) in Saudi Arabia is considered to be the birthplace of the prophet Mohammed, and is a place of pilgrimage. Muslims face Makka during prayer (southeast in the United Kingdom). The prayer leader is called the Imam. They believe in one God (Allah) and the Qur'an (Koran) is their Holy Book. Islam is based on five Pillars (duties).

1. Declaration of faith (Shahadah)
2. Five daily prayers (Namaz)
3. Fasting during Ramadan (1 month of abstinence from food and drink from just before dawn until sunset)
4. The giving of alms (Zakat)
5. Hajj – Pilgrimage to Makka at least once during the person's lifetime

Washing rituals are an important aspect of Islamic prayer. Before prayer, the face, ears and forehead, the feet to the ankles and the hands to the elbows are washed. The nose is cleaned by sniffing up water, and the mouth is rinsed out. Private parts of the body are also washed after urination and defecation if this takes place before prayer. Exemptions from prayer are given to women during menstruation and up to 40 days after childbirth. The mentally ill are also exempt, as are the seriously ill. Friday is the Muslim holy day. Women do not generally attend the mosque for prayer, meetings and other functions, although there are some mosques which provide separate prayer rooms for women.

Ramadan is an important time for Muslims. Fasting is compulsory although there are some exceptions, including young children under 12 years, menstruating women and pregnant or

breastfeeding women. Muslims who are ill are exempt, and diabetic Muslims may require readjustment of their insulin to fit in with their Ramadan meal patterns to avoid hypoglycaemic attacks. The zakat (2% of their disposable income given to the needy each year) is collected during Ramadan. The Festival of Eid-ul-Fitr (Festival of Almsgiving) takes place after Ramadan ends.

Implications of Islamic beliefs for nursing and health care

Women may wear a salwar kameez and a chuni or duppata (long scarf). They must be covered from head to foot, except for their hands and faces. They may wear glass or gold bangles, which must not be removed unless absolutely necessary, and only then with sensitivity and reassurance. Men may wear a kameez and pajamas. They also wear a head covering such as a brimless cloth hat or cap during prayer. Whenever possible, women patients need to see female doctors and men patients need to see male doctors.

The Muslim diet involves avoiding pork altogether, and all other meat must be halal. This means that it has been killed according to Islamic law, which involves cutting the throat of the animal so that it bleeds to death. Many hospitals now provide halal meat for patients. Alcohol is specifically forbidden in the Holy Qur'an.

If the patient is seriously ill or dying they may wish to sit or lie facing Makka, and their family may read the Holy Qur'an to them. At death the nurses can turn the patient on to their right side and position the bed so that it faces Makka. The body is not to be washed, and preferably it should not be touched by non-Muslims. Post-mortem examinations are usually forbidden unless there is a legal or medical need for them. Muslims are buried, not cremated, and this must take place as soon as possible after death.

Asian Muslim names do not have a shared family surname. Their own name comes first, followed by the father's or husband's name. Henley (1982) cites the following example:

- Husband: Mohammed Hafiz
- Wife: Jameela Khatoon
- Sons: Liaquat Ali, Mohammed Sharif
- Daughters: Shameena Bibi, Fatma Jan

For recording purposes, this would need to be documented as Jameela Khatoon (wife of Mohammed Hafiz) or Mohammed Sharif (son of Mohammed Hafiz). The male and female naming systems are different. The calling name of a man is usually used by friends (e.g. Hafiz). If it is the second name, then it is usually preceded by a religious name (e.g. Mohammed). This must not be used or recorded as his first or personal name (Henley, 1982). Men may also have a hereditary name (e.g. Quereshi) which they may use as a surname. Muslim women also have two names. The first is their personal name (e.g. Amina) and the second can be either a name which is the same as the UK female title (i.e. Mrs) or another personal name (e.g. Begum). Henley (1982) recommends that the second female name be recorded as the woman's surname, but it is important to remember to record her husband's name if she is married (e.g. Amina Begum, wife of Mohammed Khalid).

Appendix 5

JUDAISM: BELIEFS AND PRACTICES

Judaism is the religion of Jewish people. Early stories are to be found in the Old Testament of the Hebrew Bible. Israel is considered to be a Jewish homeland. There are two main groups – Orthodox Jews and Progressive Jews. The Orthodox Jews follow a religious life which adheres to the traditional interpretation of God's will in the Torah or Pentateuch (handed to Moses by God on Mount Sinai). However, Progressive Jews follow a more modern interpretation of the Torah. Jews pray in the synagogue. They believe in one God, and that the Messiah has not yet come: they do not believe that Jesus was the Messiah. The Laws and the Prophets are written about in the Talmud.

They celebrate the Sabbath, which begins at sunset on Friday and lasts until sunset on Saturday. Work is prohibited during this period, including everyday tasks such as cooking or even switching on lights. Candles can be lit at the onset of the Sabbath. The Passover is celebrated in March/April, when only unleavened bread is eaten. Some Jewish men keep their heads covered at all times, and Orthodox Jewish women dress modestly (e.g. never with bare arms). Married women wear a wig or keep their hair covered at all times.

Jewish festivals include:

- Yom Kippur (the Day of Atonement)
- Rosh Hashanah (Jewish New Year)
- Pesach (the Passover)

Implications of Jewish beliefs for nursing and health care

Jews believe in life after death, and dying patients should not be left alone. They may ask to see a rabbi, who will say a prayer with them. This is often the affirmation of faith or the Sheema. Orthodox Jews can only be buried, and the funeral normally takes place within 24 hours of death. This can sometimes be difficult if death takes place on the Sabbath. When a Jewish person dies, the mouth and eyes can be closed, usually by a son or closest relative. The arms can be placed by the sides of the body.

Orthodox Jews only eat kosher food, and pork and shellfish are normally forbidden. Meat and milk are not eaten together, nor must they be prepared together.

All male babies are circumcised on the eighth day after birth, and this ritual is performed by the mohel, who is a 'trained and registered circumciser' (Sampson, 1982). This is both a medical procedure and a religious ritual, and if the child is still in hospital and there are no medical reasons for not performing the circumcision, then the ceremony should be allowed to continue along with the celebrations (Purnell and Paulanka, 1998).

Orthodox male Jews wear a skullcap (yarmulke) and a prayer shawl (tallith) when praying.

Appendix 6

SIKHISM: BELIEFS AND PRACTICES

Sikhs believe in one God and in reincarnation. A Sikh temple is known as a Gurdwara, and the Sikh Holy Book is the Holy Guru Granth Sahib. The Gurdwara also acts as a community centre for the local Sikh community. Sikhs who have been formally baptized are called Amridharis, and the ceremony is known as taking Amrit (a mixture of sugar and water which is blessed). As a mark of faith Sikhs wear what are known as the five 'K's.

1. Kesh – Long hair. Men wear this in a bun (jura) under a turban. Women may wear plaits and cover their hair with a scarf (dupatta or chuni). Sikh boys will usually wear their hair in a bun on top of their head covered with a small white cloth (rumal) or a large square cloth (patka)
2. Kanga – Small comb worn at all times
3. Kara – Steel bracelet worn on the right wrist
4. Kaccha – Special type of underwear (white shorts)
5. Kirpa – Symbolic dagger/sword

Women may wear the salwar (trousers) and kameez (shirt) with a long scarf (chuni). The salwar and kameez are worn day and night. They will also wear glass or gold wedding bangles, which are never removed unless they are widowed (their removal symbolizes the loss of a husband).

Men may wear a kameez and pajama or kurta (a long shirt with a high collar and buttons all down the front).

Sikhs do not eat halal meat. This is because their meat has to have been killed with one stroke (jhatra or chakar). There is no specifically prohibited meat (Karmi, 1996). However, very few Sikhs eat beef because it is sacred in India and the pig is considered unclean. Many are vegetarian and do not eat fish or eggs.

Implications of Sikh beliefs for nursing and health care

The importance of the five 'K's will influence the care that Sikhs receive. The hair must not usually be shaved, but this may have to be undertaken in cases of serious head injury or surgery. This will cause a Sikh great distress, and they and their family will need much reassurance. The removal of the kanga, kara and kirpan will also upset a Sikh, and a full explanation must be given for this, together with possible solutions for keeping the items close by. The kaccha are never removed, and when changing one leg is usually left on whilst a new pair is put on the other. They may also be kept on in the shower. Men will also wish to keep their turban on when they are in hospital.

A dying Sikh may derive comfort from having passages read from the Granth Sahib. A member of the local gurdwara will undertake this. There are no specific last-office rites, but Sikhs are normally washed and laid out by their family. However, if nurses have to do this it is preferable only to close the eyes, straighten the limbs and wrap the body in a plain sheet with no religious

emblems. Sikhs are cremated and not buried, usually within 24 hours of death. If a body has to be removed from a ward to the mortuary for viewing by relatives it is essential that all Christian religious emblems are removed from the room and replaced by the Khanda (religious symbol of Sikhs) on the altar.

Karmi (1996) states that 'most Sikhs will have three names: a first name, a religious title (Kaur meaning princess for women and Singh meaning lion for men) and a family name'. This last name is not often used by Sikhs because of its links with the hereditary caste system, which they reject. However, to avoid confusion some Sikhs in the United Kingdom have started to use this family name. Henley (1983a) provides examples of how this can be identified by nurses and others.

Non-hereditary family names (Henley, 1983a):

- Husband: Jaswinder Singh (lion)
- Wife: Kuldeep Kaur (princess)
- Sons: Amarjit Singh, Mohan Singh
- Daughter: Harbans Kaur, Satwant Kaur

Hereditary family names (Henley, 1983a)

- Husband: Rajinder Singh Grewal (family name)
- Wife: Swaran Kaur Grewal
- Son: Mohan Singh Grewal
- Daughter: Kamaljeet Kaur Grewal

The patient or family needs to be asked how they wish to be addressed, and the correct names should be recorded in their case notes and nursing records.

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