

Research paper

Demonstrating cultural competence within health-visiting practice: working with refugee and asylum-seeking families

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What is known on this subject

- Asylum seekers and refugees have difficulty accessing health services in the UK.
- Healthcare professionals may not be equipped to deal with their cultural differences.
- Successful care is partly dependent on the cultural competence of the practitioners.

What this paper adds

- Health visitors need to be able to demonstrate cultural competence in their practice with refugee and asylum-seeking families.
- The health visitors in this study demonstrated that they met most aspects of a five-step cultural competence primary care nursing model.
- External factors such as national legislation and policy hindered their efforts to help with refugee and asylum-seeking families.

ABSTRACT

This qualitative study explored the experiences of health visitors working with refugee and asylum-seeking families in central London, and assessed the dimensions of their cultural competency using Quickfall's model (Quickfall, 2004, 2010). In-depth interviews were conducted with 14 health visitors. Data were analysed using Framework, a thematic-based analytical method. The findings revealed that the health visitors demonstrated aspects of culturally competent care in relation to Quickfall's five-step model which was developed from the literature specifically for working with asylum applicants within a primary care setting. Shortcomings with regard to demonstrating cultural competence were

related to working for an organisation whose work is governed by external factors such as national legislation and policy. In addition, the complexity of the needs of these vulnerable populations and limited resources sometimes compromised the cultural competence of the health visitors. However, they showed many positive examples of how they provided equity, access and non-discriminatory services, health promotion and socially inclusive services.

Keywords: asylum seekers, cultural competence, health visiting, refugees

Introduction

The health problems of refugees and asylum seekers may arise from experiences in their home country, for example, limited health services in times of war (Norredam *et al*, 2006), rape or torture (Silove *et al*,

1997; Burnett and Peel, 2001a). Other problems may be the result of poverty, lack of preventative healthcare such as immunisations, the prevalence of particular diseases such as TB and HIV, or cultural practices

(Woodhead, 2000; Heptinstall *et al*, 2004). Once in the UK, the threat of deportation during the asylum application process and the fear of returning to the situation from which they had made great efforts to escape can make a significant contribution to mental health problems (Phillimore *et al*, 2007). Refugees and asylum seekers may therefore have multiple and sometimes severe health problems, but unfortunately they have difficulty accessing health services in the UK (Burnett and Peel, 2001a,b; Cowen, 2001; Fassil, 2000; Phillimore *et al*, 2007).

When they do manage to access healthcare, the professionals with whom they come into contact may not be equipped to deal with their cultural differences, and this can lead to further exclusion of this vulnerable population (Burchill and Pevalin, 2012). O'Donnell *et al* (2007) found that additional support clearly facilitated the accessing of appropriate primary care for this client group. The cultural competence of practitioners is important in facilitating access to support.

Over the last three decades in the USA and Canada, transcultural nursing (TCN) theory has gained acceptance as a way of promoting culturally competent healthcare for individuals from diverse cultures (Leininger, 1978; Leininger and McFarland, 2002). Cultural competence is represented by a quantifiable set of individual attitudes as well as communication and practice skills that enable healthcare professionals to work effectively with individuals and families from diverse backgrounds. TCN focuses not only on the culturally sensitive care of clients from a variety of backgrounds, but also on poor access to healthcare and the societal structures that exacerbate inequalities.

Leininger (Leininger, 1991; Leininger and McFarland, 2002) has argued that an understanding of cultural diversity is essential to the provision of effective and safe care. She has suggested that clients' cultural beliefs, values and attitudes are an integral part of providing total healthcare services to clients. Beliefs about health and illness have been shown to be very different across various cultural groups (Helman, 2007). The importance of culture in determining beliefs about health and illness highlights the need for professionals to be aware of these differences. Therefore addressing cultural diversity is an important challenge facing nurses, and Leininger (Leininger, 1991; Leininger and McFarland, 2002) has proposed that in researching and comparing nursing care between cultures, it is possible to identify common elements to all, as well as specific factors that relate to a particular culture. Thus, in practice, when assessing and planning interventions, nurses need to take into account both culturally specific and culturally shared factors.

Leininger's work has been criticised by Gustafson (2005), who interrogated the underlying assumptions

of the TCN approach and implicated them in the reproduction of racialised categorisations. She argued that the imposed homogeneity which is evident in many texts about TCN ignores the many differences between group members, such as gender, sexuality, religion, class and economic differences, as well as rural or urban living conditions. Despite these criticisms, Leininger's theories have been influential in nursing, and have led to the development of contemporary models of cultural competence based on her work.

In the UK there has been less interest in cultural competence (Burford, 2001), but in the last 15 years a few models have been proposed which are appropriate for the UK healthcare context. The model presented by Papadopoulos *et al* (1998) consists of *cultural awareness*, *cultural competence*, *cultural sensitivity* and *cultural knowledge*. It emphasises the importance of developing reflexivity and self-awareness among healthcare professionals, including knowledge of their own ethno-history and other cultures in order to deliver culturally sensitive care for their clients (Papadopoulos, 2006).

Quickfall (2004) developed a five-step model for culturally competent primary care nursing in Scotland. The model was initially published in 2004, but was further developed and refined in her thesis (Quickfall, 2010). As most of the previous work had focused on secondary care, Quickfall's model represented one of the first attempts to address cultural competence within a primary care setting. In this paper we use the 2010 model as our theoretical framework. It is described below as a series of five steps, and we also note the main differences from the 2004 model.

- *Step 1: Institutional regard.* This refers to the willingness and ability of an organisation to respond to the specific healthcare needs of minority ethnic groups. If they are to show a commitment to meeting the needs of disadvantaged groups, organisations need to scrutinise their policies, procedures and practices that may serve to disadvantage sections of the community. Services should be non-discriminatory and accessible by all ethnic groups. This step includes the two steps, *Institutional regard* (step 1) and *Access to services* (step 2), from the 2004 model.
- *Step 2: Cultural awareness.* This involves respect for individual culturally based factors such as religion, diet, family and social organisation, and beliefs about health and illness, treatment and their implications for clinical practice. This step is similar to *Cultural insight* (step 4) from the 2004 model.
- *Step 3: Cultural sensitivity.* This recognises that effective communication is essential for the culturally competent assessment of health needs, and requires the translation of health promotion materials and language support to facilitate trusting

relationships between practitioners and asylum clients. This step has considerable overlap with *Cultural communication* (step 3) from the 2004 model.

- *Step 4: Cultural knowledge.* This involves an understanding of how structural factors, such as poverty and social exclusion, affect health. Agencies need to develop in order to address health inequalities. This is a new step in the 2010 model.
- *Step 5: Culturally competent community nursing care.* This final step is a culmination of each of the other stages that centre on three major principles which underlie the culturally competent nursing care of asylum applicants: (1) equity, access and provision of non-discriminatory services; (2) the cross-cultural promotion of health; and (3) the delivery of socially inclusive services. Step 5, *Cultural understanding*, from the 2004 model is now woven through all of the steps in this model.

This paper utilises data from a qualitative study of health visitors working with refugees and asylum seekers, first to use the Quickfall (2010) model to assess their cultural competency, and secondly to assess the completeness of the model proposed by Quickfall (2010) by examining the concordance between the steps of the model and the data obtained.

Methods

Setting

The study was set in a borough of London that has a highly diverse and highly mobile population; it encompasses some of both the wealthiest and the most deprived areas in England. There are wide variations in health status across the borough. Life expectancy for men living in one part of the borough is 83 years, while in another area it is 67 years. This 16-year gap is one of the largest variations in London. The gap for women from the same areas is 14 years, and also one of the largest variations in the city.

The borough has struggled with the impact of a high concentration of refugees and asylum seekers and other transient populations using local healthcare resources. The top five applicant nationalities in the UK at the time of the interviews for this research were Afghanistan, Iran, China, Iraq and Eritrea (Home Office, 2008), and this ethnographic diversity was reflected in the location of the study at the time.

Recruitment and sampling

Health visitors are registered nurses with a post-registration qualification in public health practice.

They work in primary care, with families that have children aged under 5 years. The health visitors who worked in the borough were approached at their main professional meeting, where a presentation provided details of the study with a request for participation. Participants had to be qualified health visitors, have attended the presentation and to have worked in the borough for a minimum of two years. This timespan ensured that they had enough experience to participate in the research. The final sample size was one-third of the 42 health visitors working in the borough. All of the participants received an information letter and a consent form to be signed prior to participation.

Ethical approval

Ethical approval was granted by the local NHS Research Ethics Committee, and research governance permission was obtained from the Primary Care Trust (PCT) Research and Development Team.

Data collection

In-depth interviews were conducted at the various health centres in which participants worked, and were all tape-recorded. A topic guide consisting of ten broad open-ended statements shaped the interviews. This guide was based on concepts identified in an initial literature review, and was given to participants prior to the interview so that they could think about the issues to be covered and their experiences. Each participant was offered debriefing at the end of the interview session to discuss any issues that might have arisen, particularly if any difficult experiences were referred to. This was provided for all of the participants by the interviewer, and commenced once the tape recorder had been turned off. The length of the debriefing was dependent on the participant.

Analyses

The qualitative data from this study were analysed using the Framework approach (Ritchie and Spencer, 1994). Framework was developed at the National Centre for Social Research in the UK. It is an interpretive, thematic method, which focuses on the substantive content of interviews rather than on the structure of accounts or the linguistic devices used within them. Framework is used to analyse applied research methods in that, rather than testing, generating or enhancing thinking within a particular discipline, it is concerned with contributing to the understanding of a contemporary issue (Ritchie, 2003).

Each interview was first transcribed and then analysed using Framework. This involved a constant comparative approach throughout. The themes that

were identified were compared across the data, and interpretations were discussed between the interviewer (JB) and external researchers consisting of an academic supervisor and a doctoral student.

Findings

From the Framework analysis, it emerged that *cultural competence* was a sub-theme of the *facilitators of effective practice* theme. We present the results according to the steps of the Quickfall (2010) model.

Step 1: Institutional regard

Participants were aware that refugees and asylum seekers were often from minority ethnic populations and therefore faced discrimination as well as disadvantages. There were many instances in which participants demonstrated that they were willing and able to respond to the specific healthcare needs of refugees and asylum seekers, but the policies that denied failed asylum seekers rights in the UK often hindered their efforts.

Failed asylum seekers (both families and individuals) were often unable to access other forms of support, so health visitors worked with people who were often in desperate circumstances, such as women and children who, because of their immigration status, were caught in cycles of domestic abuse (Burchill, 2011). Failed applications for asylum meant that families would be made homeless and would disappear from the systems put in place to safeguard children. In some instances, social services would offer families accommodation for only five nights and a free flight back to their home country; families rarely accepted this. When discussing these matters, the following participant talked about taking issues to a more strategic level to influence strategic decisions on policy:

It's about taking cases back through the Domestic Violence Forum if you like to people I know who work in housing who are making the decisions or influencing people making decisions there ... so if you have a really good social worker who knows about domestic violence, they would know that they had a duty to look after the mother and could interpret that to look after the child as well in which case they would go through the Homeless Persons Unit really easily and be re-housed ... if you are working with people in other fields who don't understand those issues and interpret those laws differently then you've got families who are being given tickets to fly back home if you like, because no one is interpreting it as their duty to stay.

(Interview 9)

This participant had witnessed how experienced professionals could interpret legislation differently to others in order to safeguard children. Rather than seeing a family as failed asylum seekers and only offering a return flight back to their country of origin, someone with experience would realise that it would be unlikely for the family to take up that offer, so they would probably return to the perpetrator of violence because they had nowhere else to go. Interpreting this situation as having a duty to safeguard the mother as well as the child enabled the social worker to house them through the Homeless Persons Unit. This example demonstrates that scrutinising policies and practices could allow health visitors to meet the needs of disadvantaged populations.

Participants described some innovative practices that facilitated easier access for those having difficulty accessing services. For instance, there was a specialist team that concentrated on providing access to healthcare for the most vulnerable client groups, including refugees and asylum seekers, working intensively with them with the key objective of referring them back into mainstream services. The team had substantial knowledge of the cultural issues relevant to refugees and asylum seekers, and provided a rolling programme of regular teaching sessions for all staff who regularly came into contact with refugees or asylum seekers, thereby disseminating learning and embedding good practice:

[Specialist team teaching sessions] is the sort of thing that people need to help give them a baseline of knowledge, and I suppose, the support to realise that there are other people they can talk to, to help them and signpost, or help them to signpost their clients in the right direction.

(Interview 9)

Participants spoke of working with women who had been subjected to harmful cultural practices, such as female genital mutilation (FGM). Some of the health visitors had received specific training with regard to FGM and, as part of their health assessment, routinely asked their clients from countries with a high prevalence of FGM whether they had been affected by this practice:

There is one client who came into the refuge who was 21 from Somalia, she had suffered domestic violence so she was in the refuge and during my health assessment I asked if she had undergone FGM, she wasn't entirely sure but when she talked about her health issues it established that she had actually had quite severe FGM, and she was having problems even menstruating ... she was unable to hardly pass blood, she had been stitched up so much, so I referred her to ... and we went together for a joint meeting ... FORWARD [a women's campaign and support charity] specialises in FGM and I set her up for an appointment there and she was referred to a specialist nurse ... who was able to look at potentially reversing part of the FGM and

the client was happy for this to happen and actually did attend.

(Interview 6B)

The following quote demonstrates how the health visitor's confidence in dealing with FGM-related issues had increased as a result of attending the specialised training:

... the female genital mutilation is a very difficult one. ... I have had clients with that and it's asking the question and I think again I found that the few people that I did ask quite often had had it ... when asked they were very open about it and I remember being, until I had the training on it, not being confident about asking and I found that really, really, really useful to do.

(Interview 7)

There were also examples of health visitors demonstrating that they were less willing and able to respond to the specific needs of refugees and asylum seekers, particularly when they thought that individuals and families were abusing some of the services. Some clients expected more resources, such as welfare and benefits, than were necessary or possible. On occasion some participants talked about working with people whom they suspected were economic migrants who had travelled to the UK because they had heard there were generous benefits available; this was generally frowned upon:

... the way I understand divorce is that you and your partner don't see one another again, but then I went in to visit her with a third child from the same man ... they want to get social benefits as much as possible, because they still are really and truly having a relationship with their partner, such are the kinds of abuse that I think needs to be looked into.

(Interview 13)

There was some resentment of the motives behind the behaviour of some of the clients, such as marrying or having children in order to remain in the UK:

I wonder how many people then go on to arranged marriages in order to qualify as a spouse and then the burden to state when there are children and domestic violence later on, or no engagement of parental responsibility ... it is just about why people do take on parental responsibility, the idea that if you have a baby it might strengthen your case [for asylum].

(Interview 3)

Health visitors felt that the quality of their care was compromised at times; they were unable to provide the same quality of service that they would give to mainstream clients. They found that their expertise in core health visiting was repeatedly overshadowed by the difficulties they experienced in learning the systems relating to immigration, housing, welfare and

benefits, and they felt that they lacked the knowledge to deal with these issues. This was particularly evident with regard to issues such as lack of immigration status. The time spent on some of these issues meant that less time was available for other work, and they believed that this impaired the quality of their health visiting function:

As a health professional, how much time can I devote to this family when I know that possibly they might be needing more, that's it, how much do I invest in sort of really going with their identified needs when there are other families who are new, who are resident, who are entitled to services, so it is finding out about my own sort of prejudices, it brought up a lot of my own belief system of morality and judgemental needs, because you know you have only got seven and a half hours in a day and how much can you devote to the families?

(Interview 5)

Step 2: Cultural awareness

The participants revealed a degree of cultural awareness, and had developed knowledge about different cultures. When working with refugees and asylum seekers they drew on their own previous work and life experiences. Some had worked overseas in developing countries and found this of great benefit to their health visiting work. The following extract is from one participant who had spent extensive periods working in developing countries and found that, on each occasion when she returned to the UK, she could empathise with what her clients from those countries were probably experiencing in terms of the shock of a new culture:

I didn't experience culture shock going out, but I always experience culture shock coming back to this country, yes I'm very aware of how people perceive Britain, basically, I have trouble getting back into it ... the choice, the supermarkets always really throw me, just the element of choice ... that shift if you come from a culture where religion is really important to come to a culture where it isn't is very hard to get used to, and also family, just the change ... coming here there is no family around you and the support networks are very spread out.

(Interview 2)

Working abroad helped this participant to realise that being visited at home by health professionals and the notions of health promotion and prevention of ill health were quite alien concepts in many cultures. This knowledge helped her to be more effective in the work that she did with families in the UK. She was also learning to speak Arabic while abroad, and continued to practise the language when back in the UK. One husband who had prevented his wife from attending her child health clinic eventually allowed her to attend

because knowing that the health visitor could speak a little of their language had helped him to develop trust.

Another participant who had worked overseas in a conflict zone also believed that such experience was of benefit when working with refugees in the UK. One example she gave was of trying to treat female burn victims, in a conflict situation, who would rather have died than be undressed to be treated. From this she had learned that other cultures might have priorities that were often very different from her own experience in the UK, and as a result she was able to approach things in a different way if she thought that she was not moving forward with a client. Other participants who had worked in developing countries talked about having first-hand experience of the difficult way of life of people in those countries, which helped them to visualise the journey of the asylum seeker. This enabled them to provide a more empathetic service.

Personal life experiences, such as the death of a family member, were also utilised by some participants in their work. They believed that these experiences helped them to empathise with others who had suffered loss.

Step 3: Cultural sensitivity

The participants frequently worked with refugees and asylum seekers who could not speak English and relied on the use of interpreters. In many cases the use of interpreters was seen as a productive means of exchanging information. The learned skill of using an interpreter was remarked upon, as was the benefit of using the same interpreter with a family during repeated visits, although often this was not possible. Problems associated with using an interpreter were encountered when the family or individual refused to have an interpreter, when only a male interpreter was available for a female client, if the interpreter imposed his or her own views, if people did not want to disclose sensitive information through an interpreter, or if the interpreter was perceived as not being very efficient in his or her role:

I've had some pretty bad examples recently of interpreters where they have actually started giving their opinion, which has been a nightmare, and I guess because they potentially could be from the same culture, the same kind of background and they start adding their points of view.

(Interview 7)

Some of the health visitors spoke of attempting to learn some words in different languages, such as Arabic, whereas others reported the importance of encouraging family members to learn English. It was difficult to invite people who could not speak English to group sessions such as postnatal groups or baby massage classes, because they would not be able to

understand the conversations and would therefore feel excluded. The difficulty of accessing English lessons with a crèche for mothers with young children or babies was highlighted.

One participant's extensive experiences abroad had helped her to work more effectively with interpreters. She criticised her colleagues for complaining about interpreters having conversations with families rather than just interpreting what was being said:

I understand that in some cultures you don't just say 'Hello', you have to ask about the family, and the house, and the whatever, so if you are with a woman for example who is Palestinian and may have been in Britain for 25, 30 years, she is still going to do that process as a translator, even though you haven't asked her to.

(Interview 3)

Some of the participants undertook additional tasks which were outside of their responsibility, in order to gain the trust of the family and assess their needs. These included ringing the utilities company, sorting out the TV licence and even babysitting for the mother so that she could go shopping. Participants saw these tasks as necessary for building relationships, assessing the family, observing parenting and monitoring a child's development.

Effective communication of health promotion messages was considered difficult. Many of the clients originated from countries in which there was little or no investment in government-backed public health campaigns, for example, for healthy eating or stopping smoking. The participants talked about the difficulties they experienced in providing such information alongside preventative health advice, especially when in their native country people were only used to seeing healthcare professionals when they were unwell and required treatment:

Healthy eating advice that sort of thing might be something they don't really see in their country ... I should think maybe it would be more what you learned from your family before and you pass it down rather than the government campaign.

(Interview 12)

Step 4: Cultural knowledge

All of the participants talked about the distinct and complex health needs of asylum seekers and refugees, which differed from those of the general population. Some of these health needs originated in the home country (e.g. TB, HIV, physical problems resulting from conflict or torture, nutritional deficiencies, conditions related to lack of sanitation). In contrast, the health problems of failed asylum seekers who remained in the UK were linked to poor living conditions,

sleeping on friends' or relatives' floors with no access to primary care, and either taking the wrong treatment for medical conditions or not being treated at all.

The mental health of many of their clients was a concern to the participants, including the effect of the asylum process on mental health and the effect of parental depression on children:

I had a family that I still see, she lost her appeal, she was from Kosovo, she lost her appeal three times, she still here ... and the problem was originally the child wasn't eating, the child was only about six months old and wasn't eating at all, the mother was very, very depressed and the father was also, had some kind of disability, limping very badly, young man, and so originally the visit that I started to do, it was to do with food, you know wean the baby and it wasn't feeding and it [breast milk] wasn't coming out, that's how it started and then slowly as things transpired she was getting more severely depressed and she had no, no rights in this country although she was married she had deportation looming in her head.

(Interview 10)

Integrating into the host society was also a problem. One health visitor described working with a family in which the son had become suicidal as a result of his extended family's wish for him to perform an honour killing on his mother. More common experiences included feelings of isolation, difficulty in communicating, discrimination, unemployment, culture shock, difficulty in accessing services, gender issues and specific community issues related to their culture. The health visitors were extremely concerned about the impact of these factors on the children in the families and how, in their professional role, they should protect children from harm.

What is perhaps unique about working with people who have fled a conflict situation, as opposed to working with the mainstream population, is the higher incidence of individuals who have had traumatic experiences of harm through rape or torture:

... the one that I worked with was a very pathetic one, she was put in a refugee camp according to her and she claimed that she was raped during the night and couldn't identify the person, of course she had a baby, you know, as a result of that rape, it affected her very badly emotionally and I worked with her after she had the baby before for about two months and she got re-housed outside of London and that's how I lost contact with her, but she was constantly crying you know, what am I going to tell my parents, what am I going to tell my relatives.

(Interview 13)

The participants talked about a specialised mother-tongue counselling service for refugees, to which they referred individuals. Others referred people to the Medical Foundation for the Victims of Torture, a UK organisation that offers specialist psychological support for the victims of torture.

Additional concerns focused on situations in which there was a lack of stimulation for children, either due to living in overcrowded accommodation with nowhere to play or do homework, or because of the parents' lack of understanding of the importance of play. Lack of stimulation was believed to contribute to developmental problems such as severe speech delay:

I think something that is quite difficult and it is not just confined to refugees but I think it's culturally a kind of concept of play and how you deal with children is that play, um I think it just doesn't exist in the same way in countries where there is a lot more space, there is a lot more cultural concept of everyone sort of looking after each others' children and therefore children almost form their own play groups on their own under the eye of some aunt or grandmother or something and they just kind of get on with it, um, and so the idea of a structured interaction with your child is quite a difficult concept to get across.

(Interview 11)

Poor parenting was a common concern. The participants thought that it could sometimes be due to difficulties in adjusting to a different culture and trying to fit in. They tended to believe that their role was to educate people from a variety of cultures about the different social responsibilities in the UK, such as not leaving the children alone while going shopping, not beating the children, the importance of stimulating the child, child safety when cooking, and nutrition and hygiene. Often the health visitor would provide emotional support to help to teach about appropriate parenting:

... the ways that some of the African cultures believe that they can beat their children and that is quite acceptable, so having to explain to them that that is not acceptable here, you know some families I have worked with just leave their kids at home and they go off down to the shops and they've got a 2- or 3-year-old just at home on their own, then again in Africa that is perfectly acceptable, but here it is obviously not.

(Interview 13)

Sometimes there was conflict between the health visitor and a parent. Different approaches were taken, depending on the situation. One health visitor talked about making sure that she was child focused when assessing families, because parents' priorities were not always right; another saw the health of the mother and father as important because if they couldn't care for themselves they would not be able to care for their children.

It was evident from participants' accounts that sometimes the level of complexity that they were dealing with was too high and they were unsure how to respond to clients' needs. For example, they were not always equipped to work alone with survivors of

torture, and they sometimes described how uncomfortable they were in addressing these issues:

... he wanted to talk about what had happened to him to a point where it was almost, it wasn't comfortable and he came, it was sort of like ... he almost made a career of it, I just felt really uncomfortable.

(Interview 10)

Step 5 Cultural competence

In Quickfall's model, *institutional regard* was shown to be an initial step in the provision of equitable access to primary care services, and included mechanisms for GP registration, language support services and community nursing services (Quickfall, 2010). The participants discussed many examples of innovative practice, such as setting up a baby clinic in more accessible community centres for people who were not attending appointments elsewhere. Some health visitors attempted to learn the languages of their clients and practised them with them as a way of building relationships. The specialist team facilitated a rolling programme of training for frontline staff working with refugees and asylum seekers, and this was regarded as an effective way of sharing knowledge. *Cultural awareness* has been described as being integral to the nurse–client relationship, and the participants demonstrated awareness by developing their knowledge base about different cultures. The third step, namely *cultural sensitivity*, has also been shown to be essential for enabling refugees and asylum seekers to become partners in care for the accurate assessment of health needs and cross-cultural promotion of health.

The following extract demonstrates the extent to which one of the participants perceived transmission of a health promotion message produced in one culture, to be processed in another, as being an important aspect of her work. She explained that, among some refugee families that she worked with, consanguineous marriages were the norm. She felt the need to address this issue with a family whose child had a disability, possibly as a result of the family carrying a recessive gene, but was hesitant about doing so:

... they don't perceive it as a taboo, so it is my problem in a way, but when I raised it recently with a family I had an opening to raise it because one of their children did have a minor disability, and so I was able to talk about their concerns about close relatives in respect of their children ... and they really wanted to talk about it, they were really happy to talk about it and then they did say that they had already really earmarked certain relatives for their children to marry and that they were really quite honestly quite prepared to reconsider.

(Interview 8)

Despite her initial struggle to bring it up in discussion, the participant was aware of the importance of non-judgemental attitudes, but it was not established whether this family was referred for genetic counselling and family history exploration to determine whether there were any recessive gene risks.

Cultural knowledge is the fourth step that promotes socially inclusive approaches to community nursing care, and the participants demonstrated that they were working effectively with clients with a range of problems associated with social exclusion. For instance, occasionally the participants encountered parents and sometimes children who were involved in criminal activities, usually in order to supplement their poor income, whether this involved the father working in the black economy as a waiter, drug dealing, stealing, prostitution, or just selling their food vouchers to use the money for transportation:

... in fact they have got five children who are truant, the mother is involved with drug dealers, she's having men around to her house for whatever reason ... we've got another one, the father's a big drug dealer in the area and the 12-year-old boy has now just been done for armed robbery, so you know you've got really complex issues.

(Interview 4)

The fifth step, namely *cultural competence*, combines all these threads of equity, cross-cultural promotion of health and socially inclusive approaches.

Discussion

Although the findings of this study do not show that every participant in the study demonstrated cultural competence in all of their actions, they do reveal that the health visitors were implementing each of the five steps of Quickfall's model to some extent. However, in terms of *institutional regard*, there were some shortcomings. For example, there were many instances in which health visitors encountered people who had no access to primary care services or were refused access to services such as GPs, social services, benefits, mental health services, services to safeguard children, and so on. UK government legislation, which is designed to make access to health services difficult for failed asylum seekers (Department of Health, 2004), exacerbated this problem for healthcare professionals, too, and frequent changes in policy caused confusion about who was entitled to what. In addition, there were times when the health visitors became resentful or judgemental about refugees and asylum seekers, especially when the level of need was high and resources were limited. These findings indicate aspects of practice that fall below the baseline of cultural competence according to Quickfall's model, but they were being addressed to a certain extent at a local level.

One of the strengths of Quickfall's model is that its development is informed by previous work on culturally competent care published by American and British authors; it takes into account the key elements of a wide range of models. However, taking into consideration the diversity of and cultural differences between healthcare professionals and the families with which they work, and the diverse backgrounds of the healthcare professionals themselves, this model may be seen as restricted by the views of American and British authors. As the workforce becomes increasingly diverse, the concept of what is culturally competent care may evolve further. Additional research into models of cultural competence in a variety of primary care settings may address this issue.

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CONFLICTS OF INTEREST

None.

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